
BECAUSE WE'RE ALL IN THIS TOGETHER

**THE CASE FOR A NATIONAL
LONG TERM CARE INSURANCE POLICY**

BY

ROBERT M. BALL

WITH

THOMAS N. BETHELL

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INTRODUCTION

THIS REPORT DESERVES CLOSE SCRUTINY by anyone concerned with the problem of long-term care—which means it merits widespread attention indeed. Because we're all in this together, exactly as the title says.

Probably the single most important fact to understand about the long-term care issue is that it is not by any means a problem exclusively of the frail elderly, even though they are the most likely to experience chronic illness. *Long-term care is a family concern*—a problem both for those who need continuing care and for those who must struggle to provide it while at the same time trying to cope with responsibilities such as earning a living, financing the education of children, and meeting other family needs.

Most people who become chronically dependent would of course prefer to remain at home—their own or that of a family member or friend—if at all possible. But the burden of providing continuing care informally at home can exhaust caregivers' physical and emotional resources. On the other hand, the burden of paying for formal long-term care services—whether at home or in a nursing home—can rapidly devastate the financial resources of even a moderately well-to-do family.

Until quite recently, however, the long-term care problem did not command broad public attention. Generally, families tried to deal with it privately, in isolation and frustration, often plagued with guilt at what they perceived as their particular inability to care for a loved one. In fact,

LONG TERM CARE as used throughout this report refers to the planning, administration, financing, and delivery of medical and social services to assist those who become chronically ill, disabled, or infirm, regardless of age, and who require assistance to perform such basic activities of daily living as eating, going to the bathroom, bathing, dressing, and moving about, or who require continuing supervision because of mental impairment.

however, the failure was not personal but societal. We simply have not yet come to terms with the significance of some basic changes that are altering America—changes that have created an increasingly urgent need to develop a systematic national approach to financing and delivering long-term care services.

The most basic of these changes has to do with increased longevity. The simple fact that more people are living longer can have complex effects when coupled with other changes taking place in our society. Consider, for example, changes in generational relationships within families. Historically, the rule (always with exceptions, of course) was that a family consisted of three living generations: grandparents, parents, children. Today the four-generation family is increasingly common, but it does not necessarily follow that when those of advanced age begin to fail, they have more family members to turn to for help. On the contrary, their children are likely to be elderly themselves, may be retired or be experiencing their own physical problems, and thus may have limited resources to offer. Within the next generation—that is, family members in the middle of their working years—the traditional household once was headed by a breadwinner and a homemaker; in time of need the homemaker was also a caregiver. Today, however, the rule increasingly is that husband and wife are both employed outside the home, which means that family caregiving requires herculean efforts in the workplace and at home with children and disabled loved ones.

In households where both spouses work by choice rather than by necessity, adjustments can sometimes be made to accommodate the needs of a dependent family member, but such households are increasingly rare in America. In today's economy, a second income is crucial to the well-being of millions of families. And in growing numbers of single-parent households there is even less maneuvering room when chronic illness creates a family crisis. The solo breadwinner who tries to take on the additional job of caregiver can become trapped in a tangle of conflicts, jeopardizing his or her (more often her) employment or sacrificing the needs of children to try to meet (probably inadequately) the continuing needs of a dependent parent or grandparent.

In theory, families that find themselves unable to care for a dependent person at home have the option of turning to a nursing home for help. But there may be a long waiting list for a bed in a reputable nursing home, and costs have risen so sharply in recent years that even a relatively brief stay in a nursing home can become a staggering burden. In any case very few people consider nursing homes a desirable choice if other alternatives are available. Generally, they turn to nursing homes only when there is no other choice.

These, in brief summary, are the kinds of conditions which, when replicated in sufficient numbers of households, can eventually turn a family crisis into a national crisis. And there can be little doubt that we have reached that point. Within the past two years we have witnessed a sharp increase in public awareness of and concern about the long-term care problem and its impact on families—as has been dramatically confirmed by several recent public opinion surveys.

A national survey conducted in 1987 by RL Associates for our Foundation and the American Association of Retired Persons (AARP) found that almost half of all American families (47 percent) have already experienced a long-term care problem within their immediate families; 61 percent have had experience with the problem either in their immediate families or through close friends, and 20 percent anticipate having such a problem in their immediate family within the next five years.

A survey by Louis Harris & Associates in 1988 confirmed that most Americans, regardless of income, believe that they cannot afford to pay the cost of long-term care, either at home or in a nursing home. It will come as no surprise that 93 percent of those with annual incomes below \$7,500 hold this view, but even among those at higher income levels—over \$50,000 a year—61 percent report that they cannot afford the cost.

Poll after poll confirms that Americans want a federal program to help pay for long-term care—and an overwhelming majority say they would be willing to help pay for such a program with increased taxes.

As these surveys show, there is increasingly broad public recognition that we are all at risk of needing long-term care at some point in our lives and that the burden of paying for that care has become too great for us to manage unassisted. There is intense interest in finding an effective way to insure ourselves against this risk. Policymakers attempting to respond to the public's demand for action must decide whether to enact a universal public program of social insurance or rely mainly on private insurance—or, alternatively, to create a public-private mix.

These are difficult choices, especially in a time of fiscal austerity when lawmakers are reluctant to enact programs carrying big price tags. Various measures to create a national public long-term care insurance program have been introduced in Congress but have run into difficulty because of the cost. There is an understandable tendency to hope that the private insurance industry, perhaps with some help from government, can adequately handle the problem. The obvious appeal of such an approach is that it would remove a large part of the cost of long-term care insurance from the government's ledger books. But there are very serious questions about how much of the job the private insurance industry can realistically be expected

to do, and at what cost to those who would, under such an approach, have to buy protection in the marketplace.

Robert M. Ball is unusually well qualified to assess the relative advantages and disadvantages of public and private approaches to long-term care insurance. He has devoted an exceptionally long and productive career to shaping, administering, and guiding the evolution of the nation's Social Security programs under nine presidents. His career had its beginnings exactly a half-century ago, when he went to work at the Social Security Board (now the Social Security Administration) in 1939. He played an increasingly important role in shaping the program during the Truman and Eisenhower years and then served as Commissioner of Social Security from 1962 to 1973, under Presidents Kennedy, Johnson, and Nixon. In 1977 he became the Carter administration's chief informal adviser on Social Security issues; in 1983 he played a leading role on the bipartisan commission that reformed Social Security funding, saving the system from the threat of insolvency brought on by the effects of back-to-back recessions in 1979–80 and 1981–82 and creating a financing structure to protect the system for the next several decades. He has also worked actively in the health field. He was instrumental in the passage of Medicare in 1965 and served as the program's chief administrator during its first seven years. After leaving the government he was a scholar at the Institute of Medicine at the National Academy of Sciences. He continues to consult and write widely on Social Security and health policy matters and serves as chair of the National Academy of Social Insurance. Probably no one in Washington has a better understanding of the pros and cons of public and private insurance than Bob Ball. He makes no secret of his belief in the importance of social insurance, but his fairmindedness and objectivity have long since earned him the respect of those who may disagree with his philosophy.

In preparing this report, he has been ably assisted by Thomas N. Bethell, a Washington writer-editor with long experience analyzing and reporting on key domestic social policy issues. Formerly the research director of the mineworkers' union, in recent years he has produced reports and other publications for organizations as diverse as the Center for Community Change, Field Foundation, Occupational Safety and Health Law Center, Economic Policy Institute, Rural Coalition, American Association of Retired Persons, and this Foundation (for which he edited, among other publications, the recent report, *On the Other Side of Easy Street: Myths and Facts About the Economics of Old Age*).

Ball and Bethell have collaborated to produce a report which is not only timely, thoughtful, and thorough but which will also appeal to a broad audience. Their report will clearly be of value to policymakers already

familiar with the complexities of financing long-term care. But perhaps its greatest virtue is that it succeeds in demystifying a complex issue without oversimplifying it and, in so doing, guides the non-expert reader toward the kind of informed understanding that produces concerned, effective advocacy. Section by section, this report explains:

- 1** LONG TERM CARE is one of many unresolved national health-care policy problems requiring attention and as such should be addressed as part of a coordinated effort. Unlike other health insurance challenges, a long-term care program will require the development of policies designed to meet the needs of two groups: those who *need* care, and those who *provide* it. Thus there is a pressing need for a system that supports *a continuum of care*, from informal, intermittent home-based care through community-based care and institutional care. In the absence of such a system, we have developed an overreliance on costly nursing-home care, with often disastrous consequences for those who cannot afford it.
- 2** MANY AMERICANS (including many policymakers) are only just now beginning to appreciate how closely and inexorably the long-term care problem is tied to basic demographic trends—principally the aging of America—and as such constitutes a rapidly growing challenge as the size of the infirm and potentially infirm population grows. Alzheimer's and other progressively debilitating illnesses illustrate the point dramatically. With the risk of developing such an illness many times greater at age 85 than at 65, and with the 85-and-older population increasing faster than any other population subgroup, there is an urgent need for a national policy that will help families to cope when such illnesses strike. In the absence of such a policy, existing stresses and overreliance on institutionalization can only be exacerbated.
- 3** MEDICARE provides health insurance for most costs associated with acute care for the elderly and disabled, but the program was never designed to cover long-term care in institutions or at home. Medicare was not designed to address the personal-care needs of the chronically ill—that is, to help them function as independently as possible as long as possible or to cover the costs of institutionalization when it becomes necessary. Yet in most families these represent the major costs associated with long-term care. Medicare coverage of short-term nursing-home stays has been improved, and a limited respite-care benefit will become available in 1990, but the basic need to cover home and institutional care services remains unaddressed.

- 4** MEDICAID, in the absence of alternatives, has become our public long-term care policy of last resort, currently covering about 40 percent of the nation's nursing-home bill. But Medicaid's complex means-tested eligibility criteria have caused countless problems for those seeking protection against the runaway costs of care, as has its failure, as a general rule, to cover long-term care in the home and community. At the same time, the increasing share of Medicaid resources going to long-term care is straining state budgets and the ability of the program to serve other low-income populations. Although recent reforms have made qualifying for Medicaid assistance less burdensome, further improvements are needed. But even if these were enacted, the program would still have the basic drawbacks of a means-tested approach under which protection is available only after applicants have exhausted their own resources.
- 5** PRIVATE LONG TERM CARE INSURANCE, although a relatively recent development, is being aggressively marketed by increasing numbers of companies, and some of the newer policies are superior in many ways to most of the policies considered better-than-average as recently as two or three years ago. And increased public awareness of long-term care costs coupled with the absence of a universal public insurance program can be expected to stimulate development of policies that are further improved—but only up to a point.

One problem is that private insurance cannot provide the answer for most of those who are most immediately in need of protection—the elderly and marginally infirm—either because of the high cost of age-related premiums or because pre-existing medical conditions are grounds for rejection. For younger buyers, premiums may be lower initially, and qualifying for coverage may not be a problem, but most policies pay fixed indemnity benefits that are unrelated to the actual costs incurred for care. Perhaps more importantly, few policies provide even marginally adequate protection against the impact of inflation on the value of benefits that are not likely to be needed for many decades. Policies that do offer relatively adequate protection against inflation tend to be much too expensive for people of modest incomes. This illustrates one of the basic dilemmas facing the insurance industry: offering a better policy means paying higher claims costs, which means requiring higher premiums, which in turn means a smaller potential market.

For those who can afford it—that is, those with comparatively high incomes and with substantial assets to protect—purchasing private long-term care insurance may make good sense. But it makes little sense to expect private insurance to meet the broader needs of the population as a

whole. Aside from the fact that inherent limitations severely restrict the ability of private insurance to offer adequate, affordable products to those of modest means, private insurance is inherently cost-ineffective.

Added to the cost of private insurance are the costs of advertising, agents' fees and commissions, and profit. These costs can be significant, as experience with Medigap insurance has demonstrated. On average, of every dollar collected in Medigap premiums, only about 60 cents are returned as benefits; the rest goes to defray these kinds of overhead costs. Furthermore, while cost containment represents a major challenge for any system of health insurance, a balkanized, loosely regulated private insurance system cannot be expected to deal with the problem. Nor can private insurers effectively enforce quality-of-care standards—a matter of particular importance in nursing homes and other extended-care facilities and in the developing field of home-care services.

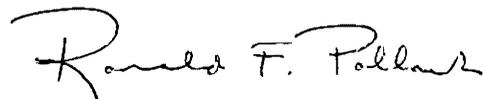
- 6** THE FINAL SECTION of this report builds on the foregoing discussion, outlining an approach to long-term care that creates complementary roles for public and private insurance. Broadly speaking, the model used is that of Social Security, which in the case of retirement income is designed to provide basic protection when earnings stop but which also (because it is not means-tested) encourages people to provide additional protection for themselves in the form of pensions, savings, and accumulated assets. A similar approach is recommended for long-term care insurance. The public long-term care program as envisioned here covers home care, respite care, and nursing-home care. The program would offer a broad home-care benefit and would cover the cost of a stay in a nursing home for up to a year, or longer if the patient has a spouse or other dependents in the community. Private insurance can be sold to cover the program's cost-sharing requirements and to protect patients' assets from being used to pay the costs of care in situations where a nursing-home stay exceeds the public program's one-year benefit and the patient has no dependents in the community. Aside from creating a logical although not crucial role for private insurance, this approach has the important advantage of meeting the priority needs of long-term care at relatively manageable cost.

It should be noted that in publishing this report we do not necessarily endorse in its entirety the long-term care program envisioned by Mr. Ball. Many approaches to providing long-term care protection are possible; this is one. What this Foundation can and does unequivocally endorse, however, is the kind of informed discussion that this report will help make possible.

Recently, with the long-term care debate heating up while federal budgets appear frozen or at least intractable, there has been much confusion and not a little misinformation about whether there is in fact a need for a major program of public long-term care insurance. Call it wishful thinking if you will, but there are some people in Washington and around the nation who would much prefer to see this problem privatized—by turning it over, more or less entirely, to the private sector, with substantial subsidization by the government if need be to help insurers reach those who could not otherwise afford to buy coverage. But responsibility for providing long-term care protection cannot be so easily disposed of. Leaving aside the question of whether taxpayers should in effect be compelled to subsidize the private insurance industry, this report very clearly demonstrates that there are inherent limits to private insurance that are essentially insurmountable, and the need for a public program thus becomes clear and unmistakable. And the report outlines various funding options that can lead to providing protection for all of us at a cost that will be manageable for each of us.

The plan outlined in this report would bring a much-needed measure of security to millions of American families who are today entirely unprotected against the costs of long-term illness. We can and should feel free to argue about the details, but this report leaves no doubt about the need for a universal public program. Anything less will only perpetuate the present inequitable system under which a comparatively small number of people manage to buy protection for themselves at considerable cost while most people are left unprotected.

That approach represents the worst possible way to protect against the kind of risk represented by long-term illness. Everyone runs the risk of suffering a protracted and expensive disabling illness, but we know, of course, that the risk will not actually occur in most cases. On the contrary, the risk will occur to a relatively small number of us, but at very high cost when it does occur. When the occurrence of a risk is unpredictable but the costs associated with each occurrence are predictably high, the logical solution is to spread the cost of protection as broadly as possible, with each of us contributing and thereby saving toward the average risk. Ultimately, of course, that is why a universal public program is inherently so much more cost-effective, and why, in the case of long-term care, it makes good sense: because we're all in this together.



RONALD F. POLLACK
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PART 1

LONG TERM CARE: WHERE WE ARE NOW

LONG TERM CARE is much in the news. Americans are increasingly aware that large numbers of chronically ill and disabled men and women who require continuing care are either not receiving the care they need or are at risk of being bankrupted by the cost of that care. There is increasing awareness, too, that long-term care is not exclusively a problem of the elderly but is in fact an intergenerational problem—a family problem—both because disabling illness can occur at any age and because the burden of providing and paying for care can affect the whole family.

If it is true that we are beginning to see the problem with greater clarity, does it follow that a satisfactory solution is in sight? Unfortunately, no. For policymakers, long-term care remains a complex and vexing challenge. No one knows that better than the members of Congress who have struggled for the past several years to address the problem.

There is an emerging consensus that additional federal legislation is needed. But there is as yet no agreement about how best to organize and pay for a system of long-term care that will guarantee the availability and quality of the care required while fairly distributing the high cost of services needed by a relatively small part of the total population. Congress, facing many difficult decisions about spending priorities, is understandably nervous about the cost of any major long-term care initiative.

The Reagan administration held firmly to the position that most Americans can afford to protect themselves by buying private insurance, and that the federal role should be limited to assisting the poor. The Bush administration has not yet announced a position but from campaign statements

appears inclined toward essentially the same view. But this approach ignores or at the very least downplays the serious limitations of private long-term care insurance. Premiums are expensive, policies may carry many restrictions that severely limit the scope of coverage, benefit levels that might seem adequate now will be worth much less in the future because of the effects of inflation, and many of the policies currently in force are focused on paying for nursing-home care, although the need to cover home-care and community-care services is at least as urgent.

It is increasingly clear that the federal role cannot be as limited as some would wish, both because of the inherent limitations of private long-term care insurance and because Medicare and Medicaid require improvement in any case. But the dilemma remains of trying to decide how far a public long-term care program should be expected to go, at what cost, and with what kind of role for private insurance.

The purpose of this report is not to explore every aspect of long-term care but to focus on the essentials, in an effort to make a difficult subject more accessible. In doing so, however, it is useful to recall Einstein's observation that things should always be made as simple as possible—but not simpler.

The long-term care problem is sometimes oversimplified by proponents of various policies—and, perhaps unavoidably, by reporters trying to compress a complex subject into a minute of broadcast time or a few paragraphs of type. But the subject can also be made unnecessarily complex. One can become so preoccupied with eligibility criteria, delivery systems, relationships between state and federal governments, financing, distributional effects of tax policy, etc., that the main points are lost.

The details, of course, are important, but most people are understandably impatient about them. They want to know just two things. If they are struggling with a long-term care crisis right now, they want to know if help is on the way. If they anticipate a possible crisis in the future, they want to know how best to prepare. The challenge, then, is to explore this issue in a way that respects its complexity without losing sight of its urgency.

In taking this approach, it may be necessary to modify some of our preconceptions about the best way to create a system that guarantees adequate care at a cost the nation can afford. Instead of arguing about public versus private solutions, we may decide we must have both. If so, we will need to develop roles for government and the insurance industry that logically complement each other. And we may decide that until we know more about costs, we cannot afford to make all the improvements we want. If so, we will have to choose among conflicting priorities, proceeding cautiously—but still proceeding.

Such a process is bound to be painful, and the product is bound to be imperfect. But there is a degree of historic logic in approaching the problem this way. For better or worse, the United States has never had a unified system of health insurance. Instead we have been building something of a mosaic, periodically adding pieces and trying to figure out what part of the picture to work on next. Whether this mosaic will ever be complete—let alone a complete success—is debatable. There is a case to be made, perhaps, for scrapping it and starting over. Unless we decide to do that, however, our task is to work with what we have, to build on what is already in place. So we must try to find the right perspective from which to view the existing mosaic in order to figure out how to make the existing pieces fit together better and where to add new ones.

In that context it is important to keep in mind that long-term care is one of many unmet health-care needs in our society. The importance of addressing this problem must be weighed against the need, for example, to do something about the estimated 31 million Americans under age 65 who have no health insurance protection at all.¹ It must be weighed against the need to finance better prenatal care, care for mothers and infants, and health programs for disadvantaged children and for people with AIDS. It must be fitted into efforts to control the runaway costs of health care in general, to spend more on research on the causes and treatment of disease, and to create a far more effective system of health care administration than we have today. This is not to suggest that long-term care is of higher or lower priority than any other need, but to propose that we keep in mind the problem of fitting it into an unfinished mosaic. Unless we can somehow figure out how to put all the pieces together simultaneously, we will have to make hard choices about how many of our resources to devote to any one piece while others await attention.

NEEDED: A CONTINUUM OF CARE

At the outset it is important to underscore the necessity of developing a coherent national long-term care policy that simultaneously addresses the needs of two groups: those who *need* care, and those who *provide* it. In this respect the long-term care crisis differs from other health-care challenges. Usually the primary need is to help the patient. But in the case of long-term care, providing support to family caregivers may be equally important.

Millions of Americans of all ages currently suffer from health problems which chronically impair their ability to function without help.² Most do not need to be institutionalized; they do not necessarily require assistance

around the clock, day in and day out, for months or years at a stretch. But they do need care of various kinds. The level varies from case to case. Some require daily help with most or all of the activities of daily living.³ Others are semi-independent and may need only intermittent help. Characteristically, the needs of the chronically ill change over time; the system that provides care must be prepared to respond accordingly.

There is a need, in short, for a system that supports a *continuum of care*—a key point that cannot be stressed too strongly. In many cases the care needed may be more social than medical; it can often be provided by family members and friends, augmented by paid caregivers as necessary. Most of those who need continuing care can remain at home most of the time if a competent helper is there when assistance is required. And it is clearly in the interests of all concerned—patient, family, community, taxpayers—to build a system that helps people to remain at home if they prefer to do so. Institutionalization should ordinarily be the last resort.

There, however, lies our dilemma. We do not yet have a national health-care policy explicitly aimed at helping everyone, regardless of age, to function at their highest possible level of independence. Such a policy would logically emphasize preventive health care, rehabilitation, and services to help maintain and sustain independent living—recognizing, too, the importance of informal caregivers and seeking to relieve them of their burden from time to time by providing respite care, alternative care arrangements such as adult day-care centers, and other services designed to support those who provide unpaid voluntary care at home.

Lacking such a policy, we have become dependent upon an inflexible and inequitable two-tier long-term care system. The affluent few can afford to provide a continuum of care for themselves by paying out of pocket for whatever services they require. But those without substantial financial resources are likely to end up being institutionalized—and risking impoverishment in the process—because of the lack of alternatives.

In the absence of a range of long-term care services, we have developed an over-reliance on nursing homes. It is true, of course, that for many people who can no longer look after themselves, a nursing home may be the best place to be. But there are at least four reasons why a policy that relies disproportionately on nursing homes is inadequate.

First, the great majority of people who need long-term care would strongly prefer to live at home with family or friends, or in a home-like setting with companionable small groups, or even alone if circumstances permit. Often when we send people to nursing homes we are imposing a “solution” that would be rejected if there were a choice.

Second, although nursing homes are on the whole better operated and

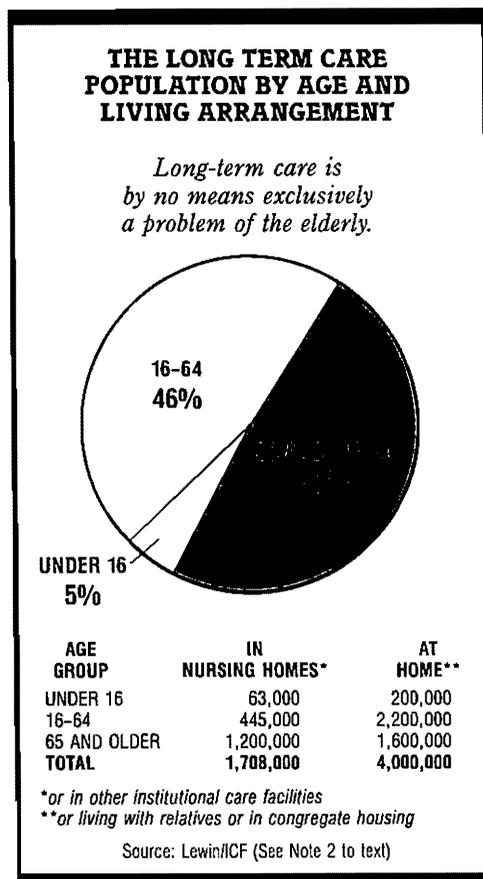
better regulated than in the past, they still vary greatly in quality. The best of them emphasize rehabilitation whenever feasible and are resourceful about helping to maintain the vital spark in those who no longer can hope to live independently. But other nursing homes are little more than warehouses, where the quality of care may be marginal or inadequate by any reasonable standard.⁴

Third, nursing homes provide a quasi-medical approach to a problem that often is primarily social. There are, of course, different levels of nursing-home care, but institutionalization at any level may represent an administratively clumsy way to care for a patient who is not bedbound. In many cases it should be possible to provide equivalent care at comparable or lower cost and with greater flexibility by developing home-care plans that avoid the administrative rigidity characteristic of institutions.

Fourth, nursing homes have become extraordinarily expensive. In 1988 the average cost of a year in a nursing home was estimated to be about \$25,000 nationwide—and was much higher than that in some locations.⁵ Very few American families can manage such outlays; most elderly people who go to a nursing home run the risk of exhausting their resources within a few months.⁶

Home care, it should be noted, is not always less expensive than care provided in a nursing home, and a public long-term care program focused primarily on paying for home care could not be expected to represent a net saving to the taxpayers, because many people who do

not now receive paid-for care at home would be able to avail themselves of such services. But on a case-by-case basis, and especially in situations where paid-for care augments care provided informally by family members, home care should often prove less costly—which is one of many reasons why it should be a key part of a continuum of care, and why we are paying an increasingly high price for failing to develop alternatives to institutionalization.



For years, Americans have been anxiously watching the rising cost of health care, but until recently most people tended to believe that the elderly and disabled were very broadly protected by Medicare, the federal health insurance program. As people approached retirement they were likely to become aware that Medicare requires cost-sharing, and they bought private “Medigap” policies (if they could afford the premiums) to help cover Medicare’s deductibles and copayments. That done, however, they were likely to believe they were fully protected against not only the costs of hospitalization and physician care but against other long-term care costs as well.

Not so. Medicare has always been focused mainly on paying for active treatment of episodes of acute illness and recovery, and has been much less focused on paying either for preventive care or for so-called “custodial” services to maintain those experiencing long-term chronic illness or disability whose primary need may be for help in performing the activities of daily living. Medicare provides only limited coverage for care in a skilled nursing facility and provides no coverage at all for most home-care situations.⁷

THE LIMITS OF PROTECTION

Public awareness of Medicare’s limitations grew in 1987 and 1988 during the congressional debate on the Medicare Catastrophic Coverage Act. The new law addresses some aspects of long-term care—notably by improving Medicaid protection for spouses of nursing-home residents facing impoverishment—but its name is something of a misnomer. The name seems to imply that Medicare now provides protection against medical catastrophes, period—and there is no doubt that the cost of long-term care would fit the definition of a catastrophe for most households. But, as the legislation’s sponsors stressed all along, while it does expand Medicare coverage in general and limits the liability of beneficiaries for various costs, it does not attempt to address most long-term care situations.⁸

Medicaid, financed jointly by the federal government and the states, does pay for nursing-home care, and states can use Medicaid funds to support some home- and community-based services.⁹ But it should be remembered that Medicaid was never intended to be an insurance program. On the contrary, it is a means-tested assistance program intended to help poor people pay their medical bills; before they can qualify for help, applicants must be able to prove that they have essentially exhausted their own resources.

Despite this limitation, there is understandable confusion about whether Medicaid has somehow evolved into a program for the middle class as well

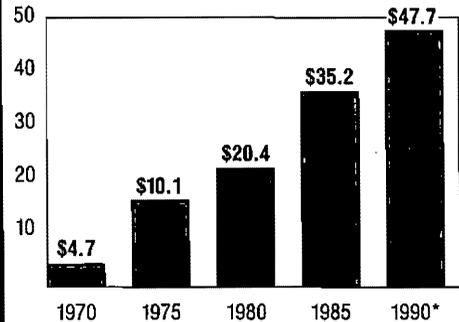
as for the poor. Medicaid's role has indeed changed. Long-term care costs are now so staggering that many people who once might have had every reason to believe they would be self-sufficient all their lives are forced to turn to Medicaid for help when they exhaust their resources, simply because nothing else is available. In doing so, however, they have been stretching Medicaid's resources, too, and have contributed, through no fault of their own, to skewing Medicaid's original purpose. A program intended to serve broad categories of needy people, particularly families with children, is increasingly driven by the need to help large numbers of the elderly meet the costs of long-term care.

Private long-term care insurance represents at best a limited solution. Even with improvements in existing policies, private insurance will be attractive primarily to those whose resources are sufficiently ample to cover the cost of paying substantial premiums for partial protection against the risk of having those resources eroded by the costs of a long-term illness. Similar drawbacks apply to recent proposals to establish tax-sheltered individual medical accounts (IMAs) patterned on individual retirement accounts. Even with favorable tax treatment, very few Americans could possibly self-insure against an unquantifiable risk which, if it occurs at all, may befall them decades from now when the costs of care will be much higher, nor would most people save enough to pay the high premiums required to buy real protection in old age.

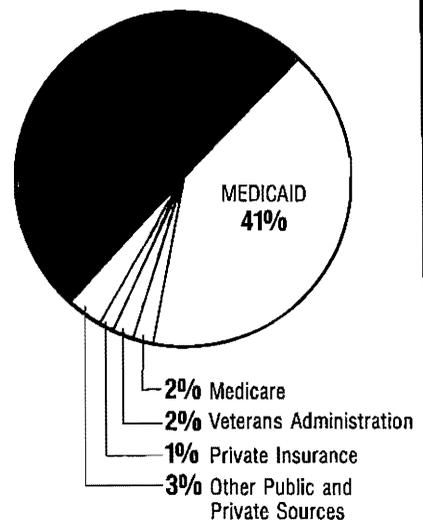
So we find ourselves at a crossroads. The need for action is clear, and the cost of inaction is high. But we may not have the resources to do everything that probably ought to be done, and we

THE GROWING BURDEN OF LONG TERM CARE: WHAT WE SPEND ON NURSING HOMES

Total Expenditures
for Nursing Home Care
(in billions of dollars)



... AND WHO PAYS THE BILL



Source: Health Care Financing Administration
Distribution of Payment Sources
for Fiscal Year 1986

*Estimate for 1990 based on \$38.1 billion actual outlays for 1986 plus inflation at 5.8% per year.

must make difficult choices among competing priorities. Where do we go from here?

To answer that question, we must understand how we got where we are now. We must understand the essential elements of the current long-term care financing system—to the extent that it can really be called a “system” at all—and we must explore the feasibility of a policy based primarily on private insurance. Finally, we must explore the advantages and disadvantages of an approach that uses both public and private resources to meet future needs.

PART 2

LONG TERM CARE IN PERSPECTIVE: WHEN A PROBLEM BECOMES A CRISIS

THE LONG TERM CARE CRISIS that confronts us today did not arrive unannounced. The crisis has been developing for decades. Partly for that very reason, we have been slow to recognize it as a crisis, and slower still to respond.

In some respects the crisis is the inevitable result of population trends that are transforming our society. We are not just growing, we are growing older. That is hardly news, but some of the implications are still not widely understood.

At the beginning of this century we were a nation of 76 million with an average life expectancy of 50 years. Since then our population has more than tripled and we live half again as long. Today there are nearly 250 million of us, and average life expectancy is 75. A man who survives to the threshold of old age (still arbitrarily defined as 65) can typically expect to live another 15 years, and a woman at the same threshold can typically look forward to living another 19 years.¹ Averages being averages, millions of men and women can now expect to live beyond age 85—*far* beyond, in many cases.

Aided by advances in health care and by social policies that have provided improved access to that care, the ranks of the elderly have been growing at a much faster rate than the under-65 population (in which the effect of the postwar baby boom has been partially offset by the decline in birth rates that followed it). In 1950 the 12.3 million elderly accounted for 8.1 percent of the total population. In 1990, it is estimated, the 30 million elderly will represent nearly 13 percent; and in the year 2030, the projected 65 million elderly will account for 21 percent.²

Within the elderly population, the numbers of the “oldest old”—men and women 85 years of age and older—are increasing at a still faster rate. In 1900 hardly anyone lived to age 85, and the 1940 census counted only 365,000 people who had reached that mark. But by 1980, there were 2.2 million of the oldest old, accounting for about 1 percent of the total population—a

significant milestone in the context of health-care policy, since the oldest old are by far the leading consumers of long-term care services.

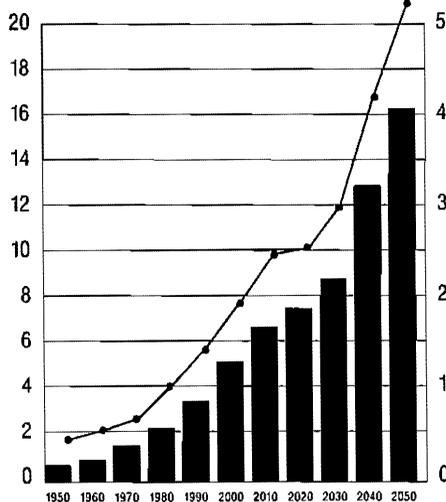
Now this population is *really* starting to grow. In 1990 there will be more than 3 million of the oldest old, and there will be more than 5 million by the year 2000.³ Comparative growth rates are striking: in the past 25 years the population of the U.S. as a whole has increased by about a third, the elderly population has nearly doubled, and the oldest-old population has tripled.

These trends will continue, leading to an even more dramatic age redistribution. The 65-and-up population is expected to double again within 40 years, but the 85-and-up population will have nearly tripled again by that time.⁴ At about the same time, the huge baby-boom population born after World War II and now traversing middle age will arrive at the threshold of advanced old age, and its ranks will swell the 85-and-older population to more than 16 million by the year 2050.⁵

GROWTH OF THE 'OLDEST OLD' POPULATION: 1950 TO 2050

The 85-and-over population, the age group most likely to experience chronic disabling illness, is also the fastest-growing part of the U.S. population as a whole.

Left scale (bars): Population of the oldest-old in millions
Right scale (dots): Population of the oldest-old as percent of total U.S. population



Source: Census Bureau

We cannot afford to underestimate the significance of these trends. A complaint frequently heard these days from some political commentators is that the elderly are getting more than their fair share of attention from policymakers.⁶ Aside from being factually inaccurate and needlessly divisive, this kind of complaint really misses a key point. *The implications of an aging society are felt by both the elderly and the non-elderly.* In particular, non-elderly caregivers find themselves increasingly burdened, often forced to make painful choices between working and caring for someone—choices that affect the whole family. The sons and daughters of the elderly are the

ones most at risk. They may be faced with spending tens of thousands of dollars to pay for nursing-home care for a seriously impaired parent or, alternatively, bringing that parent into their own home. Either way, they may have to choose to spend time and money on their parents at the sacrifice of their own children. Thus it is no exaggeration to say that from a family perspective everyone will benefit from paying increased attention to developing policies aimed at the special needs of a very large, very old population.

The rapid future growth of the 85-and-up population suggests, in fact, that we should be getting into the habit of thinking of “the elderly” as not one but two population groups: the younger elderly (those in their 60s and 70s) and the oldest old (those in their 80s and beyond). Although this, too, seems a somewhat arbitrary way to categorize people, there are some important distinctions between the not-so-old and the oldest old.

Most of the younger elderly are relatively healthy most of the time and are able to function independently. As a group, they have a high rate of recovery from illness. Among couples, one spouse is generally able to take care of the other when temporary episodes of illness occur. But most of the oldest old are gradually overtaken by chronic illness and infirmity, and eventually become partially or totally incapacitated. They are also far more likely to be alone—literally, if one spouse has outlived the other, or figuratively, if both spouses are still living but neither is strong enough to take care of the other. If they need help, it is likely to be more demanding, more complicated, and more difficult to manage.

Long-term illness or disability can strike at any age, of course, but the probability is much greater for the very old than for any other age group. More than 6 million elderly Americans, most of them over 75, have difficulty coping unassisted with one or more of the basic activities of daily living.⁷ That is a large number of dependent and potentially dependent people, certainly large enough to merit the attention of policymakers concerned about future trends—especially since the supply of family caregivers is shrinking at the same time that the population in need is growing.

ALZHEIMER'S: A CASE IN POINT

Alzheimer's disease illustrates the dilemma. Alzheimer's and other severe dementias currently afflict about 2 million Americans, the great majority of them elderly. The odds of developing Alzheimer's increase dramatically with age, doubling approximately every five years after age 65. At that age, the odds are about one in 100; at age 85, the odds are one in four.⁸ With the

population most at risk likely to double before scientists find a way to control the disease, there is little doubt that Alzheimer's will remain a leading scourge of the very elderly for years to come, and thus will be an increasingly complex and costly challenge to our society as a whole.

Alzheimer's typically begins with loss of the ability to remember routine things such as whether the stove is off. Then victims begin forgetting who or where they are. They may risk being injured (from wandering in the night, for example) and eventually are likely to stop eating or to become incontinent; finally they become nonfunctional and require round-the-clock supervision. From a policy perspective, the key point about this characteristic pattern is that the patient's needs do not remain constant but change over the course of time—sometimes gradually, sometimes abruptly, and not always predictably. Thus our response needs to be flexible, taking into account not only the changing circumstances of the patient but also the impact of the disease on the patient's family and friends.

An Alzheimer's victim may be able to continue living at home for a long time after the initial diagnosis is made, if someone is there to provide the necessary care. But caring for an Alzheimer's victim eventually consumes enormous amounts of time and energy and can be physically and emotionally exhausting. For the caregiver, Alzheimer's can mean riding a rollercoaster: this week the caregiver may be able to cope with the patient alone, next week the victim may lapse into utter helplessness for hours or days at a time and the caregiver may be overwhelmed. Or the victim may suddenly become abusive. The caregiver may be forced to arrange for institutionalization—possibly on short notice and without knowing for how long. Thus the disease poses the kind of dual challenge that goes to the heart of the long-term care crisis: *Who will help the victim? And who will help the helper?*

These questions are inseparable, but we have not yet learned to think of them that way. Nor have we fully come to terms with the societal changes that are making it more and more difficult to find answers.

Until recently, our society would have answered both of these questions with the same word: "Women." Women were, by an overwhelming margin, both the primary providers of care and the primary source of help when a caregiver needed relief. Men went to work, women stayed home, families stayed rooted in the same community, mothers could call upon daughters for help, and when mothers and daughters needed relief they could often call upon other women in the community. That world is rapidly vanishing; nearly everywhere in the United States these family and community patterns are now the exception rather than the rule.

American families are generally much smaller now and are likely to be dispersed by geography or divorce or both. In 1935, only one out of every seven married women under 65 held a job. Today, more than half of all married women under 65 are employed, and among women who have not married or who are not currently married, the figure is three out of every four.⁹ Even so, women are still the primary providers of care. But when they are also workers they may have to make painful choices, and the demands of trying to be both caregiver and breadwinner may become irreconcilable.

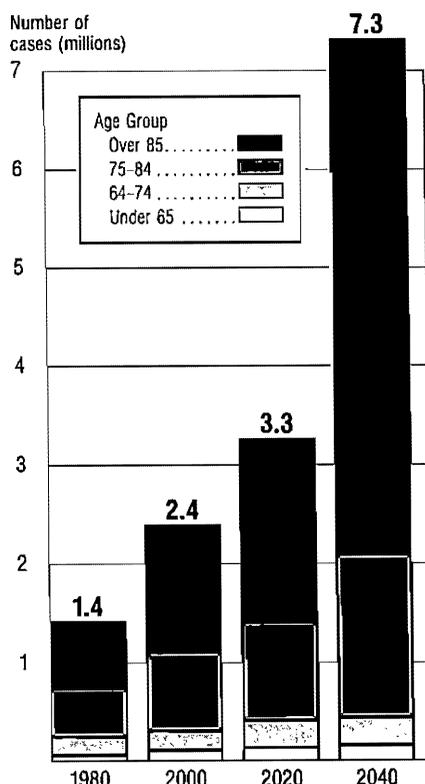
Other demographic and social trends exacerbate this problem. Increasing numbers of the very elderly live alone—generally women who have outlived their husbands (among the 85-and-older population, the ratio of women to men is 229 to 100).¹⁰ The nearest relative may be thousands of miles away and unable to respond when a disabling illness develops. Or the nearest relative may be just down the street but not up to the challenge—because the children of a 90-year-old may be in their 60s or 70s. Grandchildren may want to help, but the grandchildren of the oldest old are often middle-aged themselves and may, as noted previously, find themselves caught between the responsibilities of raising children and trying to aid elderly relatives—perhaps more than one generation of elderly relatives.

Which brings us back to Alzheimer's disease, and to the reasons why victims of Alzheimer's and similar dementias account for about half of the nation's 1.3 million elderly nursing-home patients.¹¹ In some cases they are there because the severity of their disability leaves no alternative. But many victims

LONG TERM CARE POLICY: THE CHALLENGE OF ALZHEIMER'S

As the aging population grows, we can expect to see dramatic increases in the number of cases of Alzheimer's and other severe dementias that strain the physical, emotional, and financial resources of family caregivers.

CURRENT AND PROJECTED CASES OF SEVERE DEMENTIA IN THE U.S. BY AGE GROUP, 1980-2040



Source: Congressional Office of Technology Assessment

who are in the relatively early stages of these illnesses are in nursing homes primarily because no alternative is available. And the main reason for that is that we have not yet developed policies to provide adequate supplemental support for caregivers.

From a policy perspective, our response to Alzheimer's says a great deal about our response to long-term care in general. We have been slow to recognize the implications of Alzheimer's disease in an aging society—slow to realize that the disease is as widespread as it is, and slow to recognize that it will become even more widespread as the aging population grows. Optimists that we are, we hope that reports of progress in isolating the causes mean that a cure will soon be found, although the researchers themselves caution us that even if research breakthroughs take place within the next few years, we should not expect to see widespread control of dementias for many years after that. This suggests that we should be preparing to care for 2.4 million to 3 million cases of severe dementia by the year 2000, just a little more than a decade from now.¹² But we have made no such plans. On the contrary, instead of acknowledging the pervasiveness of the disease and developing a range of care options, we have acted as though Alzheimer's can be handled mainly by a network of informal caregivers who are available at all hours, have no other responsibilities, and can cope with any and all manifestations of the disease. We have acted, in short, as though we are still living in the past.

OFFERING MORE OPTIONS

We should not be surprised that this approach is not working very well. When caregivers burn out, no system of respite care is ordinarily available to provide temporary relief.¹³ Thus the only option available for many Alzheimer's victims is premature placement in a nursing home—which may not be equipped to handle the patient's special problems. Only about 5 percent of the nursing homes in the United States have developed special programs to help Alzheimer's victims function at their highest possible levels.¹⁴ In many nursing homes, Alzheimer's victims are kept heavily medicated or under physical restraint. The justification sometimes given is that the overburdened staff must be free to attend to other patients, but that is hardly a legitimate excuse. The only honest explanation is that we have not yet faced up to the policy implications of Alzheimer's disease, just as we have not yet come to terms with the challenge of long-term care in general. If we were to state, as a matter of policy, that Alzheimer's victims should be institutionalized only when alternatives are not feasible, it would follow

logically that we would adopt a more realistic approach to home care, based on the assumption that a relative or friend who accepts the responsibility of serving as primary caregiver will ordinarily have other responsibilities and should be able to count on going off-duty from time to time, under a respite-care plan worked out with a local care-coordinating agency.

Again, it should be noted that in pursuing such a policy our primary motive would have to be humanitarian rather than financial. On a case-by-case basis, we might hope to save some of the money we now spend on institutionalization, but we could not expect to see any savings overall. As more people become eligible for paid home-care services, the cost to the public of caring for them will obviously be greater than if they were supported solely by private caregivers. And more people growing old means more people who will need care, which means spending more dollars on care, regardless of the approach.

But costs are costs, whether they appear as public expenditures or not. We pay a terribly high price for the haphazard system we have now—a system that offers a range of care services to some people but not to others, in some parts of the country but not in others, at a cost that some can afford but most cannot. In the long run it can only make sense to replace such a system with one that distributes both services and costs more equitably by making services available to all, at a cost that all can afford, with quality protected by standards that are consistent from state to state.

A CONTINUUM OF CARE: KEY ELEMENTS

The guiding principles of a comprehensive long-term care plan are discussed in Part 6. But this is a good place to sketch briefly, in broad strokes, the key elements of a continuum of care, so that we can compare it to what we have now. From a prospective patient's point of view, a continuum-of-care approach should have these characteristics:

■ **INDEPENDENCE:** As a general goal, someone of any age who suffers from a long-term illness or disability should be able to get help in order to function as independently as possible for as long as possible. In line with that goal, a continuum-of-care plan should emphasize prevention of illness, maintenance of functioning, and rehabilitation whenever possible.

■ **CLEAR ELIGIBILITY CRITERIA:** Individuals should be able to qualify for services if they meet carefully defined disability criteria, with the explicit understanding that each patient's needs may change over time and should be periodically reassessed.

■ **HOME CARE:** Where no family member or friend can serve as primary caregiver, and where the patient requires more or less constant assistance, institutionalization may be unavoidable. But when circumstances permit—that is, if the illness or disability is such that the patient can continue to live at home with the help of a caregiver, with supplemental paid-for care as needed, at a lower cost than institutionalization, and with all concerned desiring such an approach—the care plan should be designed to facilitate and sustain a non-institutional arrangement.

■ **RESPIRE CARE:** When a spouse or other family member or friend serves as primary caregiver, the care plan should be designed to make it feasible for the caregiver to obtain additional help from time to time, including relief at times when the caregiver must be away from home.

■ **COMMUNITY CARE:** If the patient's circumstances suggest the need for a mix of home-care and community-care services, these should be provided and properly coordinated. If it makes sense, for example, for the patient to go to a day-care facility a few times a week and if this is feasible, the patient and caregiver should be assisted in working out a satisfactory arrangement.

■ **ACTIVE SUPPORT:** The care plan should be supportive and flexible, responding as necessary to changes in individual circumstances. If, for example, the patient becomes progressively less ambulatory and the helper is frail, the plan should provide for increased use of qualified home-care services. If the time comes when the patient needs full-time semi-skilled or skilled care, the patient and caregiver should be offered assistance in deciding whether the patient should go to a nursing home.

■ **PLANNING:** Elderly people should be able to receive assistance in planning ahead, not only when health fails but beforehand—in deciding, for example, whether to enroll in a continuing-care retirement community.¹⁵ But the emphasis should be on responding to requests for help and offering choices rather than dictating actions as a condition of receiving help.

■ **COST-SHARING:** Cost-sharing should be part of any long-term care plan, both to provide an incentive for relying on informal, unpaid care when possible and to help control the overall cost of the program. But cost-sharing must be kept within reasonable limits in order to ensure access to services for all who need them. Moreover, Medicaid eligibility criteria must be revised so that in all states anyone unable to meet long-term care costs through other means can count on qualifying for Medicaid. The care plan must be designed to protect against the impoverishment of the family and, in the case of long-term nursing-home patients, to protect the income and assets of anyone who is expected to return to the community or

who is responsible for supporting a spouse or other dependent(s) in the community.

Added together, these criteria provide a yardstick against which to measure the long-term care coverage available today under existing public and private programs. A look at Medicare, Medicaid, and private insurance will show why so many Americans are currently unprotected against the cost of long-term care.

PART 3

MEDICARE: A HOLE IN THE UMBRELLA

MEDICARE, enacted in 1965 as an integral part of the Social Security system, provides health insurance for persons aged 65 and older and for persons under 65 who are severely disabled. The program currently covers 29.4 million elderly and 3.2 million non-elderly disabled persons.¹

The Medicare program overall is a proven success—a social insurance program that works, making health care available to millions of people who would not otherwise be able to afford it. Because of the rapidly rising cost of health care generally, the adequacy of Medicare's future funding has received much attention recently and is a legitimate subject of concern. There can be little argument, however, that the program will continue to be vitally important. But Medicare is not and never has been all-encompassing. It was not designed, for example, to address what has become the major cost of long-term care—helping the chronically ill to function as independently as possible for as long as possible.

Medicare is a two-part program. Part A, which pays hospital bills, automatically covers anyone 65 or older who qualifies for Social Security (or the Railroad Retirement program) and any disabled person who has been receiving Social Security disability benefits for at least two years. Part B, which pays doctors' bills and covers various outpatient services, is an optional program available for a monthly premium (\$31.90 in 1989).² Virtually everyone who is eligible for Part A opts to participate in Part B.³ Medicare is a cost-sharing program; both Part A and Part B require payment of deductibles and copayments. Beneficiaries pay these out-of-pocket or buy private supplemental insurance policies to fill gaps in coverage (which is why such policies are collectively known as "Medigap" insurance). The federal-state

Medicaid program handles Medicare premiums, deductibles, and copayments for qualifying low-income beneficiaries.⁴

Neither Medicare nor private "Medigap" insurance covers the majority of long-term care situations, regardless of whether the patient is at home or in a nursing home. It is true that Medicare pays part of the cost of physicians' fees regardless of whether the treatment is for an acute episode or a long-lasting condition, and pays most of the cost of hospital care when such care is required for treatment of chronic as well as acute conditions, but the cost of these services accounts for only a small fraction of all long-term care costs.

As a rule, Medicare covers home-care and nursing-home expenses only in situations where skilled nursing care is required for a relatively brief period of time as part of a program of recovery from acute illness, or in connection with hospice care for the terminally ill. Medicare does not cover routine, ongoing personal care services to help people cope with the basic activities of daily living such as eating, going to the bathroom, bathing, dressing, and moving about. Under the new Medicare Catastrophic Coverage Act of 1988 the program is beginning to cover a somewhat broader range of situations requiring skilled nursing care, but still will not usually cover personal care or, indeed, most other long-term care needs.⁵

When a convalescing patient is moved to a skilled nursing facility, where care can usually be provided at a lower total cost than in a hospital, Medicare will cover up to 150 days of skilled care per year (under the new law—the old limit was 100 days per "spell of illness") but with the important restriction that coverage is limited to situations requiring the availability of round-the-clock skilled nursing care. Medicare typically has been paying for only about 30 days of nursing-home care in the minority of situations that are covered at all.⁶ This is unlikely to be changed in any major way by the new law.

Medicare's home-care benefit is similarly restrictive. Medicare will pay only for services provided by a Medicare-certified home health agency to patients who are confined at home, are being actively treated by a physician, and require intermittent (not full-time) skilled nursing care or therapy (physical or speech) as part of a plan of convalescent care. When these conditions are met, Medicare will pay for the visits of a home health agency, but only for services addressing health conditions considered unstable and related to recovery, up to a limit (under the new law) of 38 consecutive days of care per illness. Coverage does not include homemaker services, preparation or delivery of meals, or (with limited exceptions) personal care. These restrictions effectively rule out Medicare coverage for most long-term home-care situations.⁷

Unfortunately, news reports about the new Medicare Catastrophic Coverage Act may have created additional confusion about what Medicare will now cover. Although the new law represents the most significant expansion of Medicare coverage since 1965, the legislation focuses mainly on medical catastrophes of limited duration—that is, on the catastrophic costs of protracted hospitalization and related treatments for the acute-care phase of illnesses such as cancer, heart attacks, and stroke. The law does set new limits on the out-of-pocket expenses that Medicare patients can incur for hospitalization and physicians' care, and for the first time provides limited coverage of the cost of prescription drugs bought by the patient. But the law only slightly expands Medicare coverage for nursing homes and home health care.

The Medicare Catastrophic Coverage Act does include a new respite-care benefit, under which, beginning in 1990, Medicare will cover a maximum of 80 hours per year of paid home-health-aide and personal-care services to relieve a spouse, relative, or other unpaid caregiver caring for a Medicare beneficiary who cannot be left alone. (To be eligible, the beneficiary must be chronically dependent and unable to perform at least two of the activities of daily living and must have met the new out-of-pocket cost limits either for physician and other outpatient services or for outpatient prescription drugs.)⁸ The new respite-care provision is a true long-term care benefit—but a very limited one.

The Medicare Catastrophic Coverage Act represents an important step in the right direction, however, closing (or at least narrowing) some important gaps in coverage. By far the most important gap still remaining is long-term care—particularly personal care, whether received at home or in a nursing home. Long-term care legislation introduced in both the House and Senate in 1987 and 1988 marked the beginning of a new focus on Medicare's limitations and on strategies to overcome them. Now Congress and the Bush administration have an opportunity to address this unmet need.

PART 4

MEDICAID: A LONG TERM CARE POLICY BY DEFAULT

MEDICAID is currently the only program, public or private, that makes a sizeable contribution to paying for long-term care. Seven out of every ten nursing-home residents depend on Medicaid for some degree of help; the program pays about 40 percent of all nursing-home charges.¹

Enacted in 1965 to make health care more broadly accessible by helping broad categories of low-income people to cope with their medical bills, Medicaid has become a program with a dual mission. On the one hand, it is intended to cover the acute-care costs of population groups that might otherwise be unable to avail themselves of medical services—notably children, who account for about 42 percent of Medicaid recipients.² On the other hand, as the only public program that provides financial support in most long-term care situations, Medicaid has become, by default, the safety net for increasing numbers of the elderly and disabled poor, including large numbers of middle-class Americans devastated by the extraordinary burden of paying for nursing-home care. With long-term care now accounting for about a third of all Medicaid outlays, these two facets of the program are increasingly in competition for limited funds.³

Medicaid is jointly funded by the federal government and the states. The federal government pays from 50 to 80 percent of program costs, in matching funds adjusted annually according to a formula based on each state's per-capita income.⁴ But federal control of the program is limited. The states administer the program and have broad flexibility to determine program design and scope. Total program outlays depend on what the state is willing to put up; eligibility criteria, benefits, and reimbursement policies vary

widely. State payments for long-term care services in 1986, for example, amounted to \$11,021 per recipient in Connecticut; \$9,588 in New York; \$6,968 in California; \$4,343 in Iowa; and \$4,045 in Arkansas.⁵ The Medicaid program is, in essence, not one but 50 programs, all operating within broad federal guidelines but otherwise autonomous. Medicaid over the years has become a bewildering maze of complex and often confusing regulations—frightening for patients and their families and exasperating for legislators, policy analysts, and advocates of change. Creating more consistency within the program nationwide has been and continues to be an urgent challenge.

Medicaid's long-term care benefit covers home care as well as nursing-home care, but until recently the emphasis in almost all states has been heavily on institutional care. In 1986 about 90 percent of all Medicaid spending for long-term care went to nursing homes.⁶

States have begun moving to encourage the use of home-care services to replace or supplement institutionalization, but this is by no means a uniform trend nationwide. New York alone accounts for about 60 percent of all Medicaid outlays for home health care.⁷

One reason states have been slow to support home-care services is that they must seek special waivers in order to receive federal matching funds for many of these expenditures, and federal income eligibility criteria for home- and community-based care are generally much more restrictive than for nursing-home care. Nevertheless, home health care is now the fastest-growing component of the Medicaid program.⁸ (It should be noted, however, that this is in part a reflection of the increasing emphasis on home care in New York and a few other states and is by no means the pattern everywhere.)

Qualifying for Medicaid assistance can be very difficult, even for people whose resources clearly are insufficient to cover the cost of long-term care. Thirty states and the District of Columbia have comparatively flexible programs that, in effect, permit enrolling any elderly person who cannot meet the cost of care even if the applicant might not otherwise be poor enough to meet Medicaid's restrictive means test. But in the rest of the states, individuals with monthly income above state-specified limits may not be able to qualify for Medicaid even if they are using every dime of their income to cover the cost of nursing-home bills and there is nothing left over for other household needs.

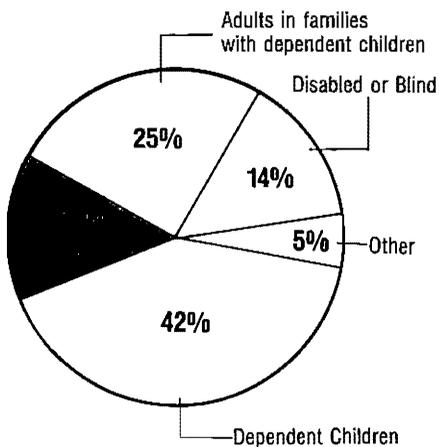
Why, it may be asked, would so many states choose to be so stingy, especially when states can receive federal matching funds to help cover the cost of so-called "medically needy" programs? The problem, of course, is that when a state enlarges the pool of potentially Medicaid-eligible citizens it must budget more state funds to assist them. States that choose not to

operate "medically needy" programs are tied to restrictive eligibility criteria linked to eligibility for the federal Supplemental Security Income (SSI) program. In such states, no one can qualify for Medicaid whose total income exceeds 300 percent of the federal Supplemental Security Income payment to a single person living at home.⁹

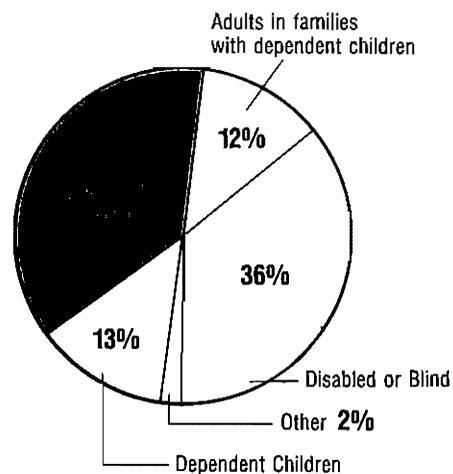
HOW LONG TERM CARE OUTLAYS ARE STRAINING MEDICAID RESOURCES

*Although only 14 percent of all Medicaid beneficiaries are elderly,
they account for 37 percent of all Medicaid payments.
Two-thirds of Medicaid outlays for the elderly go to nursing homes.*

**DISTRIBUTION OF
MEDICAID BENEFICIARIES**



**DISTRIBUTION OF
MEDICAID PAYMENTS**



MEDICAID BENEFICIARIES AND PAYMENTS

	Beneficiaries (millions)	Payments (billion \$)
Elderly	3.5	\$ 15.1
Dependent Children	10.4	5.1
Adults in families with dependent children	6.2	4.9
Disabled or Blind	3.4	14.9
Other	1.4	0.9
Totals	24.9	\$40.9

Source: Health Care Financing Administration
(Beneficiaries: Estimated, Fiscal Year 1988; Payments: Actual; Fiscal Year 1986)

Since 300 percent of the SSI payment currently equals only a little more than \$1,000 a month, this is clearly a very restrictive limit, given that the cost of a nursing home can easily exceed twice that amount. Thus someone with an income of, say, \$1,200 a month could be spending it all on nursing-home bills and falling behind by \$800 a month but would still be unable to qualify for Medicaid. Moreover, states are permitted to set even more restrictive income limits, and many do. In Delaware, for example, anyone with income higher than \$632 a month cannot qualify for Medicaid.¹⁰

What happens to people in such states who are denied Medicaid coverage? During the course of a stay in a nursing home, they are likely to spend everything they have to meet their bills—leaving nothing for the support of a spouse, if there is one, or for any other personal expenses. And if they fall behind in their payments, as seems inevitable, and cannot meet more than a fraction of the cost of care, they risk being given inadequate care (at the very least) unless family or friends can cover the cost.

Because Medicaid is not intended to help those who can pay their own way, applicants must not only meet income criteria but must also be able to demonstrate that they are essentially without other financial resources. The total cash value of assets cannot exceed a very strict limit (\$2,000 in 1989 for individuals, \$3,000 for couples). Some assets are protected: a home is ordinarily not counted as an asset if a nursing-home resident is likely to return there or if a spouse or minor dependent is living there. Also protected—but only within very strict limitations—are personal and household belongings and such “assets” as burial insurance and cemetery plots. But property, savings accounts, and most other liquid assets must be sold or otherwise disposed of before Medicaid eligibility can be established.

Merely getting rid of assets does not, however, guarantee eligibility for Medicaid. If it is determined that assets were disposed of for less than fair market value (say by a gift or an irrevocable trust to children) within 30 months prior to applying for Medicaid, eligibility may be postponed. (The 30-month “look-back” has just recently gone into effect; previously it was 24 months.)

Over the years, qualifying for Medicaid has devastated the resources of many elderly couples in situations where one spouse has had to go into a nursing home and the other remains at home, because the combined income and assets of the couple have been lumped together in determining initial eligibility and the couple’s income has been used thereafter to help pay nursing-home bills with little regard for whether the spouse at home had enough to live on. Couples have been forced to exhaust their life savings in order to qualify for Medicaid and then have had to turn over essentially all of their income in order to maintain eligibility.

Until recently, about the only way they could protect themselves was to conceal resources or go through a divorce in order to have a court divide their resources. Otherwise they were held hostage to what has been essentially the governing principle of Medicaid: recipients must pay as much of the nursing-home bill as they can before Medicaid will pay the balance (in actual practice reimbursing care providers according to formulas that vary from state to state). States have been required to allow nursing-home residents to keep at least \$30 per month in income as a personal-needs allowance, and have been free to make this allowance higher.¹¹ But the question of how much of the couple's income the spouse at home has been able to keep has depended (as with so many other Medicaid matters) on what state the couple lives in.

In Oklahoma, for example, the practice has been to permit the spouse of a Medicaid recipient to keep nothing; the state may require that all of their income be used to help cover the cost of care. In California the spouse may keep up to \$550 a month. In most states the amount of income that can be set aside for the use of the spouse at home falls in the range of \$300 to \$450 a month.¹² As a practical matter, with these kinds of limitations the spouse at home usually must turn to family members or friends for help; if such sources of support are unavailable, the spouse is unlikely to be able to afford the cost of keeping a home and thus may end up being forced to go to the nursing home too, or to subsidized housing.

This situation is changing. Congress has attempted to address the broad problem of spouse impoverishment by adopting, as part of the Medicare Catastrophic Coverage Act of 1988, a number of improvements in the Medicaid program that become effective in October 1989. The two most important are these:

■ **ASSETS:** For purposes of determining initial eligibility for Medicaid, the treatment of assets is simplified. After exempting protected assets, the total value of a couple's assets is determined and the spouse remaining in the community is permitted to retain half—within limits. The state must permit the spouse to retain at least \$12,000 in assets (assuming, of course, that the couple has that much in the first place), and may permit higher amounts, up to a maximum of \$60,000. (For future years these limits are linked to increases in the Consumer Price Index.)

■ **INCOME:** The state must permit the spouse living at home to keep at least part of the couple's income—about \$1,000 a month initially, with the actual amount linked to the federal poverty level for a two-person family. Beginning in October 1989, the spouse at home is entitled to retain, from the couple's income, an amount at least equal to 122 percent of the poverty

level. (The poverty guideline for a couple is \$668 a month in 1989; thus 122 percent of that will be \$814.) Protected income is to be increased to 133 percent of the poverty level in 1991 and to 150 percent in 1992. These are minimums; within overall federal guidelines, states are permitted to adopt more liberal limits (up to \$1,500 a month in 1989).

Even with these important improvements, however, qualifying for Medicaid will continue to be difficult, and Medicaid assistance will still come with strings attached. To some extent this is unavoidable. Restrictive eligibility criteria are necessary in any means-tested program to protect it from being used by people who are not really poor enough to qualify for help and who may be looking for ways to avoid using their own funds to meet costs. But when severe restrictions encumber the *only* program protecting against major long-term care expenses, conflicts and controversy are inevitable.

A husband and wife who have struggled for decades to build a modest savings account may, quite understandably, seek to protect assets for other contingencies—or just to try to maintain a reasonably adequate standard of living—rather than watch helplessly as their resources are depleted by a stay in a nursing home. So there is a temptation to under-report or shelter assets when applying for Medicaid. Since relatively few of the elderly can afford private insurance (even if they can pass insurers' health screening criteria, and leaving aside for the moment the adequacy of the policies available), it is not surprising that middle-income people rearrange assets to meet Medicaid eligibility criteria. But when they do, they end up hurting the poor, because the poor suffer most when states respond to increased pressure on Medicaid resources by cutting back on services.

To the extent that Medicaid's original purpose continues to be skewed by the long-term care needs of a rapidly growing elderly population, the program is of course less able to serve the broad spectrum of low-income people for whom Medicaid was originally designed. States are caught between conflicting pressures: to make more funds available for long-term care while trying to maintain a balanced commitment to others in need. Because large numbers of those most in need are children, the Medicaid program finds itself increasingly embroiled in controversies about the old robbing the young. However unfair that charge may be, the longer the problem remains unresolved the more it will be heard.

Efforts to control Medicaid long-term care costs have led to shortages of nursing-home beds and to quality-of-care problems. One common cost-control device has been to hold down the number of available nursing-home beds through strict limitations on authority to build new facilities. As a result, most nursing homes are filled nearly all of the time, and many have

long waiting lists. Medicaid patients may find themselves at the bottom of the list—because they are rarely full-fee patients (since states impose reimbursement limits), and nursing homes are likely to give preference to a private patient who can be charged full fees (at least for awhile). And some nursing homes keep their operating costs in line with Medicaid reimbursement rates by providing only minimal services to Medicaid patients, in some cases segregating them on wards that may not be adequately staffed.¹³

For all of these reasons, Medicaid has been and still is a very mixed blessing for recipients and their families, notwithstanding the program's obviously important role in financing long-term care.

THE LIMITS OF REFORM

How feasible is it to look to a modified Medicaid program as the best way to provide improved long-term care services to more people at reasonable cost in the future?

Further improvements in the program are obviously needed and could have far-reaching effects. For example, states could and should be required to make Medicaid assistance available to all those who cannot pay for necessary care even if their income and assets would otherwise be too high to qualify for Medicaid. In other words, the “medically needy” approach now used in three-fifths of the states should be extended to the rest, with consistent eligibility criteria nationwide.

Federal guidelines should be liberalized so that states are less restricted in using Medicaid funds to pay for long-term care services at home or in other noninstitutional settings. Reimbursement rates should be reformed; moving toward equalization of Medicaid and private pay rates and paying rates that reflect the level and intensity of the care provided would help control the tendency to treat Medicaid patients as second-class citizens. And Medicaid-assisted nursing-home residents should be permitted to keep more of their income for personal needs.

Coupled with the improvements enacted by Congress in 1988, these kinds of changes would certainly make Medicaid less burdensome for applicants, recipients, providers of care, and program administrators. Building the necessary momentum to enact major Medicaid reforms is difficult, however, not simply because they would be very expensive (far more expensive than the improvements enacted in 1988 because these reforms in the aggregate would be much broader) but also because Medicaid, for all its importance, is still a welfare program and, as such, cannot always count on

the kind of popular support that is needed to push through sweeping reforms.

Even if all of the most important reforms were to be enacted, however, some basic drawbacks would remain. Medicaid would still be a means-tested program, with eligibility still based on having to turn one's pockets inside out to prove penury. And the program would still not protect people against the risk of being overwhelmed by health-care costs; it would simply help more people sooner, without requiring them to suffer the extreme financial hardship and humiliation that people have been forced to endure as the price of receiving Medicaid help.

People with resources marginally greater than permitted by Medicaid would still be tempted to look for ways to shelter their assets, legally or otherwise, in order to qualify for Medicaid in the absence of a more universally available program. Program benefits and quality would still vary greatly from state to state. And administrative changes alone would not, of course, relieve the states of the thankless task of trying to stretch Medicaid funds to serve the competing needs of different population groups. That problem would, if anything, be exacerbated by liberalizing Medicaid's long-term care eligibility criteria.

There are, in any event, inherent problems with continuing to rely primarily on a means-tested approach like Medicaid. Perhaps most basic is the fact that people who have worked and supported themselves all their lives resent deeply the notion of being forced to submit to close financial scrutiny before they can qualify for help. They would much prefer to have the opportunity to plan ahead and protect themselves in advance by contributing to a social insurance program such as Social Security. People quite naturally prefer programs that they can call upon as a matter of earned right, rather than being forced to go through the wringer of a means test to prove impoverishment. It is not surprising that public support for Social Security and Medicare is much greater than for Medicaid.

Relying on Medicaid alone has been a poor substitute for developing a more comprehensive long-term care policy. Until such a policy exists, however, Medicaid will continue to be the only support program for millions of people. And an improved Medicaid program will still be needed in the future to protect low-income people by supplementing any new system of insurance, public or private—paying premiums, filling in copayments and deductibles, and paying for care not covered by insurance.

But what about those who are trying to protect themselves right now against the unknowable, unforeseeable risk of requiring help at some point in the future—and who hope to avoid becoming dependent on Medicaid? Where can they turn? Can they buy private insurance? If they do, will they be protected?

PART 5

‘WHY CAN’T I JUST BUY AN INSURANCE POLICY?’

LET’S ASSUME FOR THE MOMENT that you are 70 years old, married, retired, and living on a combined income of about \$20,000 a year (close to the average for elderly couples in the United States).¹ You and your spouse are both in good health, but you are concerned about protecting yourselves against major expenses if either of you should become chronically ill or impaired at some point in the future. So you decide to look for a suitable long-term care insurance policy, asking basic questions like these:

“Are long-term care policies available for people like us? Will we qualify for coverage? Will we be able to afford the premiums? Will the policy cover home care as well as care provided in a nursing home? Will it cover all of the costs of care? Will we be protected against inflation?”

Questions like these seem straightforward enough. But you will find, to your frustration, that few of your queries can be answered with a simple yes or no. In most cases the answers will be equivocal. There is, in fact, a simple answer to only the most basic question. Is private long-term care insurance available? Yes. But whether it is available to you, at a cost you can afford and with the kind of coverage you want and need, is another matter.*

* Insurers generally acknowledge that adequate long-term care insurance, with its age-related premiums, is prohibitively expensive for most of those who are already old, and some insurance industry representatives will also concede that, regardless of age, the market is likely to be limited mainly to those with sizeable assets to protect. However, some advocates in the public policy arena still promote the idea that private insurance can provide a more or less universal solution to the problem of financing long-term care. It seems necessary, therefore, to explain in some detail why this is not the case—focusing first on a retired couple of modest means because it is this population group that is most immediately concerned about trying to guard against the risk of incurring major costs related to chronic illness or disability and because there still seems to be much confusion about whether private long-term care insurance can somehow be designed to broadly meet the needs of this group.

Approximately 100 insurance companies are now marketing long-term care policies.² The market has been developing rapidly, policies are improving, many of the worst features of the older policies are disappearing, and the new policies being offered through employers or associations generally cost less and have other advantages over those sold individually. As a rule, however, regardless of whether you buy a policy individually or through a group, you will find that private insurance may not cover all long-term care situations, pays fixed benefits that will lose much of their value as inflation takes its toll, and is likely to be very expensive, especially at your age. You can expect to encounter these kinds of problems:

■ **HIGH COST:** Understandably, the older you are when you first buy a long-term care policy, the higher the premium (as with life insurance). Currently a 65-year-old individual buying a better-than-average policy can expect to be charged \$800 to \$1,000 a year (depending on a number of variables discussed in the following pages); for a 70-year-old, the premium will typically be over \$1,500, and some policies are considerably more expensive than that.³ For couples, premiums are usually about twice as high, depending on whether a discount applies. And, as a rule, the more comprehensive the coverage, the higher the premium.

Can you afford the cost? Roughly half of all the elderly couples in the United States are living on less than \$20,000 a year. Those at the low end of this income range are impoverished; the rest may not be living in poverty but certainly are not so far from it that they have much surplus income to spend.⁴ When meeting routine monthly household expenses is a struggle, it is hard to imagine how a couple could possibly afford to set aside more than two months' income each year to buy twelve months' worth of partial protection against the uncertain and perhaps distant possibility of needing long-term care.

Can you safely assume that your premiums will stay the same in the future? No. Premiums may be based on "attained age" or "issue age." Premiums based on attained age are increased periodically (usually every year, sometimes less often) as the policyholder grows older. Premiums based on issue age (that is, the age of the policyholder when the policy is first issued) are routinely marketed as "level premiums," and the promotional material says that "once you are accepted, your rates do not increase because you grow older" (or words to that effect), but when you read the fine print you will see that the company reserves the right to raise rates for broad categories of policyholders (for example, all policyholders within a state or within the same general age range).

That language is there for a reason. The insurance industry still has comparatively limited experience with long-term care insurance and lacks

reliable data with which to price policies.⁵ Most companies have tried to protect themselves by charging premiums high enough to cover reasonably pessimistic claims-cost estimates, but no one knows for sure what the costs of claims will actually be. Moreover, as more companies begin to compete for what is increasingly perceived as a potentially large market, some companies may seek to attract customers by taking a chance on low premiums, knowing that many people won't continue with their policies and assuming that premiums can be raised later.

Insurance regulators are aware of the problems arising from the lack of reliable data, but see little hope of determining optimum ranges for long-term care insurance rates until they have had more opportunity to monitor claims and company responses.⁶ Meanwhile, for the next few years at least, consumers will have little if any protection against unexpected premium increases.

Charging a higher premium to older buyers is, of course, a basic principle of life insurance, and from an actuarial point of view there are valid reasons to charge older people more for long-term care insurance. But this means that for all practical purposes private insurance

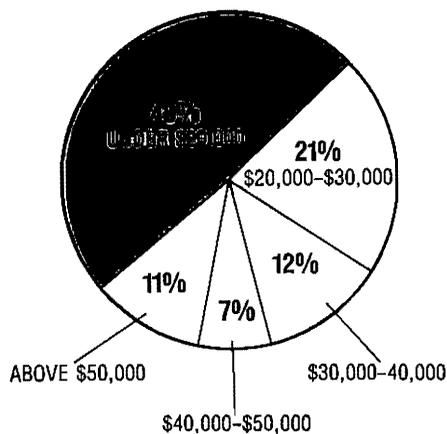
will not be available to the great majority of the 75-and-older population who can hardly afford to spend thousands of dollars a year to maintain coverage.⁷ For the 3 million oldest-old Americans, the issue is even more clear-cut, because all but a few insurers simply will not sell a long-term care policy to anyone over 80.

■ **ELIGIBILITY RESTRICTIONS:** Even if you have the money to pay for the policy you want and are within the age limit, you may be turned down. Because long-term care insurance is a relatively recent development and is naturally of greatest interest to the elderly, companies worry about attracting too many buyers who have reason to believe they will use the coverage being purchased. To control for this, companies screen applicants carefully, often requiring both a detailed questionnaire and an investigation of medi-

CAN ELDERLY COUPLES AFFORD TO BUY PRIVATE INSURANCE?

With annual premiums for couples costing \$2,000 or more, long-term care insurance is likely to be readily affordable only for those with incomes above \$50,000. But they are a small (11%) minority of all 65-and-older couples.

INCOME DISTRIBUTION OF ELDERLY COUPLES



Source: Social Security Administration

cal records, and may reject anyone with health problems that appear to increase the odds of needing care. Some companies reportedly have rejection rates as high as 30 percent.⁸

Cancer, heart disease, diabetes, emphysema, and multiple sclerosis are some of the conditions that might obviously disqualify someone for long-term care insurance, but some companies take a considerably broader view of what might constitute grounds for rejection. For example, a history of occasional treatment for arthritis could be sufficient grounds for rejection, even if the problem has never been severe—simply because arthritis is a condition that may worsen. There are no industry-wide standards, so being rejected by one company does not mean that another will not accept you. But it may mean that you are unable to buy the policy of your choice.

A company may agree to sell a policy to someone with certain types of pre-existing conditions, but the policy will ordinarily include a waiting period during which the company will not pay for any care required for that condition. The waiting period may be as brief as three months or as long as two years (not uncommon for heart conditions).

Policies usually include other kinds of waiting periods. Most policies stipulate, for example, that coverage of nursing-home costs will not begin until after you have been in the nursing home for a specified number of days (generally 20 or 100, sometimes as long as 365). Some allow you to choose how long these “elimination” periods will be; if you agree to longer periods, the policy will cost you less, but a modest reduction in your premium may not be worth the savings when you realize how quickly your financial resources can be depleted by a stay in a nursing home. A 100-day wait, for example, could mean incurring out-of-pocket expenses of \$6,000 to \$10,000 at current nursing-home rates.

Most policies are marketed with certain standard exclusions from coverage—such things as self-inflicted injuries and injuries resulting from war—but policies are also likely to include other restrictions that may be ambiguous. Many policies state, for example, that they do not cover mental and nervous disorders and “disorders without demonstrable organic origin” (or, sometimes, “without organic foundation”). How does such language apply to Alzheimer’s and related diseases?

When asked if their policies will cover such diseases, many insurance agents are vaguely affirmative—but the language itself is disturbing, because a diagnosis of Alzheimer’s can be confirmed with absolute certainty only by an autopsy or brain biopsy. Large numbers of the elderly are gradually incapacitated by mental and nervous disorders, so any language in a policy about “demonstrable” organic disease should be viewed with concern (as should any other ambiguities, for that matter). Partly because of

pressure from insurance commissioners and the courts, insurers in the future will probably reimburse on the basis of competent diagnosis, regardless of whether the organic origin of disease can be demonstrated beyond doubt. Meanwhile, however, there is no certainty that many of the policies currently in force would honor such a claim. The moral: “Don’t take the agent’s word for it—read the fine print.”

■ **POLICY RENEWAL UNCERTAINTIES:** Nearly all policies are marketed as renewable, but careful scrutiny is warranted here too. Some policies are guaranteed renewable (although perhaps only after a sizeable premium increase). But others are “conditionally” renewable, which means that the company can drop you without cause as long as it does the same thing to everyone else within a particular class or geographic area (generally, all policyholders within a state). And a few are renewable at the company’s option, which means that the company can arbitrarily cancel your policy at any time—perhaps after many years of collecting premiums from you.

Fewer cancellable policies are being marketed now, because competition for the long-term care market (and pressure from some state insurance commissioners) is forcing insurers to accept more risk. But conditionally renewable policies are really not much better, because they do not protect buyers against wholesale cancellations. Ironically, you should be especially concerned about the possibility of cancellation if your premiums seem pleasantly low. As things now stand, a company could collect premiums for some years—and then, quite legally, cancel its conditionally renewable long-term care policies altogether, leaving policyholders with nothing.

Guaranteed-renewable policies are increasingly the norm, but even these have a major drawback. In almost all cases, these policies have no cash surrender value, which means that policyholders who find themselves forced to discontinue coverage—because they cannot afford the premium increases or for other reasons—are left entirely without protection. Insurers could, of course, offer policies with a non-forfeiture feature that provides continuing partial protection, with the amount of protection based on the amount paid in. But very few of the long-term care policies sold thus far carry this kind of consumer protection.

■ **LIMITED COVERAGE:** All long-term care policies cover nursing homes, but not all policies cover all levels of nursing-home care. A policy may cover only certain kinds of facilities and certain kinds of care. These restrictions can be confusing—and costly, if it turns out that the policy does not cover the nursing home you are in or the kind of care you need. Again, it is vitally important to read the policy carefully. Reading a promotional *description* of the policy is not good enough.

Policies are generally designed to follow the basic definitions in federal laws, but these are not always clear in practice, especially since the relevant laws are changing. Until recently, the norm has been to recognize three levels of nursing-home care: skilled, intermediate, and custodial. As a rule, *skilled care* means round-the-clock supervision and treatment as necessary by a registered nurse under a doctor's direction; *intermediate care* means care provided to those who do not need the availability of round-the-clock skilled nursing care but who do need periodic nursing attention (injections, bandage changes, and so forth); and *custodial care* means care provided to those who do not normally require skilled nursing care but who do require assistance with the routine activities of daily living.

Not all nursing homes offer all three levels of care; many nursing homes offer both skilled and intermediate care, and the distinction between these levels is tending to disappear, but most custodial facilities do not offer skilled care. Because few long-term care policies are all-encompassing, a policyholder will not necessarily qualify for nursing-home benefits just by being in a nursing home.

The most restrictive policies will pay only for care provided in a Medicare-certified skilled nursing facility.⁹ Other policies will pay for care provided in any skilled nursing facility or in a nursing home where skilled nursing care is available. These policies will *not* pay if the policyholder requires *only* custodial care—that is, ongoing help with the basic activities of daily living but not skilled nursing care.

Other easily-overlooked restrictions may have the same effect. Some policies, for example, will pay only if admission to a nursing home follows a period of hospitalization and only if care is being provided for the same illness that was treated in the hospital. This clause would effectively exclude coverage in many situations where disability develops gradually and someone goes to a nursing home without having been previously hospitalized.¹⁰ About half of all nursing-home admissions do not directly follow hospitalization.¹¹

Similarly, some policies require that a patient must have required skilled nursing care before the insurer will pay for custodial care. By one estimate, as many as 46 percent of all nursing-home residents could not meet this requirement.¹²

These kinds of restrictions are disappearing from policies as the market evolves, but their existence in many of the policies currently in force suggests that policyholders should re-read their policies. If such restrictions are found, the policyholder can reasonably insist that the policy be modified to eliminate them. (If the insurer declines to do so, it may be time to find another insurer.)

Until recently, most long-term care policies covered only nursing-home care, avoiding the more difficult problem of home-care coverage by excluding it entirely. Some policies cover home care only as a rider; that is, you pay a higher premium to have a home-care benefit included in your policy.

Even when home care is covered, it means different things in different policies. Some policies will pay only if skilled nursing care is required at home during a period of recovery from an episode of acute illness. Others effectively rule out coverage for home care in many situations by making benefit payments contingent on prior hospitalization or confinement in a skilled nursing home and on filing a claim within a specified number of days after being discharged. Restrictions like these may protect insurers against ambiguous claims, but they can have the effect of denying coverage to Alzheimer's victims and many others who suffer from progressively disabling conditions that may not require treatment in a hospital or nursing home until the late stages of disability. Moreover, those confined to a nursing home for any substantial period of time almost never return to the community, so a policy that covers home care after 90 days in a nursing home, say, offers a benefit that may be illusory.

Most policies also limit home-care coverage to certain kinds of services. Some will pay for home health aides and personal care services but not for rehabilitation therapy. Some will pay for therapy but not for personal care. Some will pay for services provided in the community, such as adult day-care centers; others will not.

■ **LIMITED DURATION OF BENEFITS:** Almost all policies limit the duration of coverage, expressing these limits either in dollar amounts or periods of time. Some policies seem to offer more generous provisions than is actually the case. For example, a policy may be sold as providing coverage for up to seven years in a nursing home, but with a limit for any one stay of, say, two years. With most policies, in order to receive benefits for a repeat stay, you must have been out of a nursing home for at least six months. Thus for all practical purposes the coverage limit is two years, not seven. People don't go in and out of nursing homes as they do hospitals, accumulating short-term stays. Almost no one who stays in a nursing home for two years (or anywhere near that long) is going to leave, stay out for six months, and then return to a nursing home.

The problem of time limits applies also to home care, only more so. Some policies that cover home care only for convalescence or rehabilitation impose a 60-day limit on benefit payments. Other policies impose varying limits depending on the level of care. (As a rule such policies impose similarly varying time limits for different levels of nursing-home care.)

■ **INADEQUATE BENEFITS:** Almost without exception, long-term care policies sold by commercial insurers pay an indemnity rather than a service benefit. This means that the company does not pay for the actual cost of the services you receive; instead the usual practice is to pay you a flat daily amount or to reimburse for charges incurred up to a fixed daily limit. If the services you receive cost more than that, you pay the difference.¹³

Benefit levels vary considerably from policy to policy. Some offer a range, paying higher benefits if you pay a higher premium. Benefits payable for nursing-home care may be as low as \$20 a day or as high as \$150; most policies currently fall within the \$50-to-\$80 range. (The benefit payable for home care, when available, is generally half the amount payable for nursing-home care.)

There are four reasons why an indemnity benefit is inherently inferior to a service benefit. The first is obvious: if the maximum benefit payable is lower than the costs incurred, you must pay the difference out of pocket.

Suppose, for example, that your policy pays \$50 a day while you are in a nursing home. If the nursing home charges \$80 a day (about average in many cities), you will have to pay more than a third of the total bill out of pocket. At that rate, if you remain in the nursing home for a year, your uninsured liability will be at least \$10,000 (and probably closer to \$12,000, because the policy will typically have a waiting period of at least 20 days before any payments begin).

An out-of-pocket outlay of this magnitude may be manageable if you have a comfortable income and substantial savings and have assumed all along that your insurance will be used mainly to supplement your own resources. If, however, you bought insurance with the hope that it would really take care of you in a crisis (the premise on which most insurance advertising is clearly based), you may be in for a shock.

True, it may not be necessary for you to try to insure against *all* of the costs of staying in a nursing home, since some of those costs are for food and shelter, and you would incur such expenses regardless of whether you are living at home or in a nursing home. When you become a permanent resident of a nursing home, there may no longer be any household expenses (assuming that you no longer maintain a home), and since roughly a third of all nursing-home costs are attributable to room-and-board costs, a policy that pays \$50 a day toward a total cost of \$80 might not be far short of adequate.

But this is likely to be true only if you have no responsibility for anyone else. In the case of a couple with one spouse in the nursing home and the other at home, the nursing home will substitute for a smaller part of total household costs. In that kind of situation, unless you have given up your

home you will still have to meet most of your customary household expenses even with one of you in a nursing home.

If you are trying to cover all household costs on a combined retirement income of \$20,000 a year, you will obviously be unable to cope with a gap of \$10,000 or more between your insurance payments and your nursing-home bills. But with private insurance the only way to protect against being exposed to this risk is to pay a much higher premium for a policy paying higher benefits—a “solution” that is just not realistic for people of modest incomes and limited assets.

The second disadvantage of flat indemnity payments is that they do not deal with variations in nursing-home costs. A \$50 benefit may be adequate (or nearly so) today in the *average* situation, but certainly will not be adequate in cities like New York and Washington, where nursing homes typically cost upwards of \$100 a day.¹⁴ And indemnity policies cannot possibly protect against situations where unusually complex care requirements may produce costs far above average, with these high costs continuing for months or years on end. Only a defined service benefit fully protected against inflation can provide adequate protection against such circumstances.

The third drawback of the indemnity approach is that the insurer has no active involvement in controlling costs or setting quality standards and thus may indirectly support substandard nursing homes. And the insurer usually offers little if any guidance when a family must select a nursing home. Some companies offer minimal support services such as a toll-free telephone number where consumers can call for basic information about what to look for, but this is no substitute for actively scrutinizing facilities and monitoring the quality and cost of services.

The fourth and ultimately the most serious drawback of indemnity benefits is that they do not adequately deal with the problem of inflation. The result, of course, is that within 10 or 15 or 20 years after purchase, the value of the policy has been seriously eroded, and the benefit covers much less of the cost of care than when first written. The longer the gap between when a policy is written and when it is needed, the worse this problem becomes.

Nursing-home costs are rising rapidly.¹⁵ Suppose you buy, at age 65, a level-premium policy that costs you \$1,000 a year in premiums and promises to pay \$50 a day in benefits. Suppose you need that policy 20 years from now. If the cost of a nursing-home stay, now averaging about \$70 a day nationwide, rises at just 5 percent a year (a conservative projection), it will have reached \$200 a day within 20 years. You will have spent \$20,000 in premiums (actually much more when you add the interest that could have

been earned on other kinds of investment) on a policy that will cover only a fourth of your actual costs, and a year in a nursing home could easily cost you more than \$54,000 out of pocket.

Some insurance companies offer a rider covering what is described as an inflation adjustment. In return for paying a much higher premium (typically 30 to 40 percent higher), you are promised a benefit that is increased each year (generally by 5 percent) for a limited number of years (usually not more than ten). This approach does not provide satisfactory inflation protection.

To begin with, the surcharge is unaffordable for most people, and in any case the adjustment covers only a limited amount of inflation for a limited period of time. If inflation in the cost of care increases at a higher rate, or if you need coverage many years after the adjustment period ends, your supposedly “inflation-protected” policy will not have protected you against the risk of incurring very substantial out-of-pocket expenses.

Furthermore, in most such policies the annual adjustment is simply an add-on that is not compounded. Thus, if the policy pays \$50 a day with provision for a 5-percent annual increase, the benefit will be increased by \$2.50 after the first year, another \$2.50 after the next year, and so on. The base figure remains \$50 throughout. With a ten-year adjustment limitation, the original benefit will be capped at \$75. But in the real world of inflation, cost increases are compounded; if something costing \$50 this year increases in cost at a rate of 5 percent a year, the base figure rises each year, too, and in ten years the item will cost \$81.45—not \$75.

That seemingly small gap of \$6.45, in the context of the daily cost of nursing-home care, adds up to another \$2,354 in out-of-pocket costs over the course of a year. And the effect of compounding grows sharply over time, even at the relatively modest rate of 5 percent a year. Within just five years after the ten-year adjustment stops (with the benefit capped at \$75), the cost of what was originally a \$50 item will have reached \$104. At that point the coverage gap will have widened to \$29 a day—nearly \$10,600 a year.

The gap will, in fact, be even wider. Remember that this illustration is based on what happens to an item that starts out costing \$50 a day. When the base figure is \$70 (roughly the average cost nationwide of a day in a nursing home in 1988) and it increases at 5 percent a year, after 10 years it will cost \$114. Within a decade after purchasing the “inflation-protected” policy, the coverage gap will have just about doubled—from \$20 a day (the difference between the \$50 benefit and the \$70 cost) to \$39 a day (the difference between the inflation-adjusted \$75 benefit and the \$114 cost). That adds up to \$14,235 a year in uninsured liability.

Most policies advertised as “inflation-protected” are, in short, something far less than that. But private insurers have little maneuvering room. There is no way they can responsibly promise true inflation protection at anything approaching an acceptable price. They could, of course, simply agree to provide a service benefit, but that would be extremely risky for them unless they can somehow control what services will cost 30 or 40 years from now. They might try to do that by entering into agreements with nursing homes to provide services in the future within cost limits fixed now, but then the nursing home assumes the risk and could easily be forced out of business if inflation is higher than anticipated—unless the agreement is written to allow for periodic renegotiation, in which case the insurer once again loses control of the inflation problem.¹⁶

INFLATION AND THE YOUNGER BUYER

Thus far we have mostly been looking at the costs and limitations of long-term care insurance purchased individually by relatively elderly buyers. Let us suppose, however, that you start shopping for a long-term care policy at the age of 40 or 45 instead of 65 or 70. Can you do better?

Yes and no. You will pay a much lower premium at the outset, but the other drawbacks and disadvantages will still apply. And the inflation problem will be just as intractable, if not more so, because of the greater gap between when you purchase the policy and when you need it (assuming, of course, that you ever do need it).

For the typical 40-year-old purchaser in good health, an “inflation-protected” policy with a ten-year adjustment period cannot possibly come close to providing adequate protection. Assume that you are 40 years old in 1990 and buy a long-term care policy with a \$50 daily benefit that is to be increased by 5 percent a year for ten years. At the end of the adjustment period, the benefit will, as noted previously, be capped at \$75 a day when you are 50 years old. But the odds are that you will not need the benefit for at least another 30 years after that. If the cost of nursing-home care continues to rise at 5 percent a year, by the year 2030 the cost will have reached about \$520 a day.¹⁷ At that point your “inflation-adjusted” policy will cover *less than 15 percent* of the actual cost of your care.

You could, of course, try to protect yourself now against what you estimate the impact of inflation will be many years hence by buying a policy with a daily benefit much higher than \$50. If you assume that you will need the benefit 40 years from now and that the cost of care at that time will be in the vicinity of \$520 a day, and if your goal is to have your insurance cover

about two thirds of the cost of care, you will conclude that you should buy a long-term care policy that pays a \$350 daily benefit. But such a policy, even if available, would be both prohibitively expensive and needlessly over-protective for many years. To buy such a policy at age 40 with a level premium would mean paying perhaps as much as \$1,000 a year.¹⁸ Leaving aside the question of whether you might have better ways to invest that much money for the next 40 years, you would be over-insuring yourself for decades, until the cost of nursing care rises sufficiently to meet the benefit level.

Suppose, however, that you are able to find a policy that offers the opportunity to adjust for inflation periodically and indefinitely. What will it cost? Assume, again, that you are 40 years old in 1990 and that your goal is to carry sufficient insurance to cover about two thirds of the daily cost of a nursing-home stay. You decide to purchase a \$50 policy, having concluded that a \$50 benefit is at least marginally adequate when the average cost of a nursing-home stay is about \$75 a day nationwide. You plan to acquire more insurance as inflation cuts the value of the benefit—buying it, of course, at the higher price applicable to the older age attained at the time of each purchase (and, in all probability, subject to medical screening).

This kind of policy would be truly inflation-protected. But the cost, although perhaps appearing reasonable at the outset, could become very high. The initial premium for a policy with a \$50 daily benefit and a 20-day waiting period, sold individually, could be expected to be in the neighborhood of \$260 a year.¹⁹ But if we assume that nursing-home costs increase at a rate of 5 percent a year and that the premium is adjusted accordingly—that is, to reflect both the increasing cost of services covered and the increasing risk of needing those services as you grow older—the premium will have risen within ten years to about \$364. You will be paying about \$727 a year at the age of 60; \$1,260 at 65; \$2,333 at 70. All told, over the course of 45 years you will have paid in more than \$340,000 on this policy—when you include the interest earned on your premiums.²⁰

YEAR	AGE OF POLICYHOLDER	ESTIMATED ANNUAL PREMIUM	DAILY BENEFIT	ESTIMATED DAILY NURSING HOME COST
1990	40	\$ 262	\$ 50	\$ 75
1995	45	296	64	96
2000	50	364	81	122
2005	55	485	104	156
2010	60	727	133	200
2015	65	1,260	169	254
2020	70	2,333	216	324
2025	75	4,752	276	414
2030	80	10,901	352	528
2035	85	24,424	449	674

Anyone who takes the trouble to go through this kind of exercise will think long and hard before investing in long-term care insurance. If you are a younger would-be buyer, the dilemma is stark: you can buy a policy that will have withered away in value by the time you need it, or you can invest a small fortune to protect its value.

It is hardly surprising that the insurance industry sells very few individual long-term care policies to younger buyers. Companies are having somewhat greater success selling to younger people through employers, but it seems doubtful, given the limitations, that very large numbers of workers will ultimately buy coverage that way either.²¹ Some will no doubt respond to marketing efforts because the cost of long-term care has been so much in the news recently, but the lapse ratio among such buyers is likely to be very high as the value of their protection shrinks and as their awareness of the inflation problem (and the cost of dealing with it) grows.

Most younger people are not actively worrying about the infirmities of old age. Even if they are, they are likely to buy this kind of insurance only if they do not understand the inflation problem and if they fail to look closely at other major drawbacks typically found in long-term care policies—such as having no cash value if allowed to lapse after many years of paying premiums. And if, like most working-age people, they have more immediate financial concerns, such as paying for a home or putting children through college, they are just not going to be able to give high priority to buying long-term care insurance.²²

MARKET POTENTIAL IN AN AGING SOCIETY

But what about the potential market among older buyers? In an aging society that is increasingly aware of both the cost of long-term care and Medicare's limitations, is there not a huge potential market for private long-term care insurance?

Certainly the market has room to grow. Thus far, insurers have reportedly sold about a million long-term care policies.²³ That equals less than two percent of the 50-and-up population that represents most of the potential market. Most of the policies now in force have been sold within the past year or two. Sales can be expected to continue rising dramatically for some time, but they will undoubtedly hit a plateau long before covering the majority of elderly people. Even if the cost were to come down (a big if), premiums would still be too expensive for most of the elderly to afford.

For those at the upper end of the economic scale—people with substantial resources to protect and with substantial income available to spend—

long-term care insurance may be a sensible precautionary investment, and their heirs may be particularly interested in seeing that they have such coverage. But most people of modest means will have to take a gamble—remaining uninsured (because they must use what funds they have on more immediate needs such as food and shelter), hoping that they'll never need expensive long-term care, and, if they do, relying on Medicaid.

As the industry acquires more experience with claims and costs, policies will become somewhat more attractive—for those who can afford them and who pass the health screening process. Companies will continue to adjust the terms and conditions to make policies a bit more generous here, a bit less restrictive there: fewer eligibility restrictions, shorter waiting periods, longer benefit duration periods, and expanded coverage of some home-care services. But these will be relatively marginal improvements. There are basic reasons why private insurance cannot be expected to become the primary provider of long-term care protection for most middle-class Americans, let alone for families of more modest means. These reasons have to do with some of the fundamental ground rules that govern private insurance (all kinds of private insurance, not just long-term care) and which limit the industry's maneuvering room.

RULE 1: INSURE ONLY MANAGEABLE RISKS. Private insurance is predicated on being able to predict costs with reasonable accuracy. A company marketing an insurance plan must have a good idea of how many claims will be filed and what they are likely to cost, must be able to control the circumstances that determine whether claims are honored or denied, and must be able to control the costs of marketing the plan, administering claims, and settling disputes. And in the case of long-term care insurance, which is being sold to protect against a risk that may not occur for 30 or 40 years, they must be able to predict beyond normal time horizons. Insurers can get into difficulty when they misjudge any of these costs.

Adverse selection—disproportionate enrollment by individuals who expect to experience the insured event—is always a risk for insurance companies. Other things being equal, buying health insurance is obviously a higher priority for those who believe they will need it than for those who are more optimistic (justifiably or not) about their health prospects. But companies must try to enroll a range of policyholders that replicates the group experience on which the insurance company's cost estimates and premiums are based. Companies run into difficulty here. The long-term care market is not broadly based, and claims experience is limited. Experience can be acquired eventually, of course, but experience alone will not necessarily make the risk easy to manage. The delivery of long-term care services is inherently complex—particularly in the case of home-care ser-

VICES, where it can be very difficult to determine what services should be provided and paid for and under what circumstances.

Even if the market grows substantially, the population seeking coverage is still likely to consist mostly of the elderly and others who will apply because they believe they will soon need the protection being offered. Companies will have to continue efforts to weed out high-risk applicants. The conflicting interests of insurers and would-be purchasers are obvious and troubling. If, for example, you are beginning to develop symptoms that suggest the possibility of chronic heart trouble in the future, you will think it only sensible and reasonable to seek insurance protection. But if an insurer concludes that you might become a high risk, you will not be allowed to buy its insurance—unless the company has signed up such a large pool of healthy policyholders that it does not bother to screen for those with possible problems.

RULE 2: AVOID AMBIGUOUS RISKS. Insurers must try to avoid two kinds of ambiguity that can arise when a claim is filed. First, the policyholder should not be able to control the occurrence of the insured event. (That, of course, is why insurers do not pay when someone commits suicide soon after purchasing life insurance.) Second, the company must be able to determine whether the insured event has actually occurred. From the company's point of view, the more explicit the event the better. With long-term care, the occurrence of the insured event may be far from explicit, and trying to clarify and control ambiguities can be complex and costly.

The basic questions may seem clear enough: has the policyholder developed an unanticipated chronic condition of sufficient severity so that he or she cannot perform a specified number of the activities of daily living without help? If so, are the policy's other terms and conditions met? In theory, if the answer to both of these questions is yes, the company pays. In practice, however, many long-term care situations are more ambiguous. Can the degree of disability be readily determined? Does it vary from day to day or week to week? Is the condition temporary? Is informal care being provided? Does the situation call for formal care? In a nursing home, or can care be provided at home? By whom? How often? With what frequency should the policyholder's condition be reviewed, and by whom? At what point should the policyholder be expected to enter a nursing home? Who should make that decision? What happens if the policyholder disagrees? Who determines the appropriate level of nursing-home care? And who decides when the policyholder's situation has changed, and whether coverage should continue at all?

Insurance companies are uncomfortable with this kind of ambiguity. To deal with it adequately requires active case management by trained person-

nel, which is time-consuming and costly. A policyholder's care requirements may change—indeed, almost certainly will change. With progressively disabling diseases such as Alzheimer's, many reassessments may be required over time. Active management of care is, in most cases, possible only where there are enough beneficiaries in a given location to justify the cost of case-management services. In many parts of the country this is not likely to be the case for individual companies.

Companies seek to define risks precisely not only to assure that claims can be paid or denied with reasonable efficiency at reasonable administrative cost but also to assure that the company's decisions have a good chance of being upheld when challenged. The handling of a long-term care claim may be contested by the policyholder or by the policyholder's relatives or by the providers of services. Disputes, costly in themselves, can lead to protracted court battles and to scrutiny by state insurance regulators. Judicial reinterpretations and regulatory action may leave a company exposed to much broader liability than anticipated.

It should be noted that although some of the problems of ambiguity apply equally to public programs, there is a marked difference in this case. If Congress believes that a court has too broadly interpreted the intent of a government program, it can change the law. A private insurance company, on the other hand, as one party to a contract cannot narrow a court's reinterpretation of that contract. Thus the only way to guard against unintended liberalization of policy provisions is to write policies that avoid ambiguities—a difficult task in a field as inherently ambiguous as long-term care. That is one of the reasons why most long-term care policies have tended to be narrowly restrictive.

The problem of disputed claims and their unforeseeable consequences is more manageable with nursing-home care than with home-care services. By and large, insurance companies will ordinarily agree to pay benefits while the client is in an approved nursing home, once the insurer's screening criteria have been met (prior hospitalization, exclusion for pre-existing conditions, etc.). But if a home-care policy appears to offer broad coverage, efforts to limit services or apply other restrictive requirements could lead to major challenges and might turn out to be unenforceable. This is one of the reasons why until recently many insurers have not offered home-care coverage at all or have offered it only as an extra-cost rider, with coverage explicitly restricted to post-hospital or post-nursing-home care.

Insurers who decide to offer broad home-care coverage, perhaps necessarily to compete for the market, may be increasingly tempted to avoid the pitfalls of managing the delivery of services by simply adopting identical eligibility criteria for nursing-home and home-care coverage and then sim-

ply limiting the amount of the home-care benefit to a fixed percentage of the nursing-home benefit—or paying what is really a cash disability benefit that can be used any way the beneficiary chooses (as is provided in at least one plan marketed through employers).²⁴

With either approach, the insurer, after determining that the required level of disability has been met, leaves it up to the patient and family to decide what services they want. They pay, out of pocket, any costs that exceed the limit allowed by the benefit. If they are paid a cash disability benefit, of course, they are free to pocket the benefit and provide care informally themselves.

Policyholders and their families may like what they perceive as relatively complete freedom to manage the care needed by the patient, but from the standpoint of social policy this approach will almost certainly be less satisfactory in the long run than a managed-care system that looks at need on a case-by-case basis and tries to fit the services to the need. It can be assumed that almost every policyholder who meets the disability criteria will use the benefit to the maximum allowed, but sometimes that will fall considerably short of the need and in other cases it may be excessive.

The unmanaged, hands-off approach to insuring long-term care leaves much to be desired, but it may be the most practical way for insurers to handle home-care coverage. Since individual insurance companies will seldom have sufficient concentrations of beneficiaries in a given area to justify establishing and operating their own managed-care systems, the alternative is for them to purchase care management services from organizations serving several companies. Whether that can become feasible on a nationwide basis remains to be seen—and it becomes less likely if a sizeable number of companies opt out, choosing instead a cash disability payment approach to long-term care.

RULE 3: CONTROL INDUCED DEMAND. Like adverse selection, induced demand for newly covered services is a problem that makes insurance companies anxious. It was only a few decades ago, in fact, that the insurance industry refused to write health insurance of *any* kind because of its fear that the newly insured would rush off to the nearest hospital, whether or not they had any reason to go there. The industry's anxiety about uncontrollable induced demand was allayed only after Blue Cross demonstrated that insuring large numbers of people did not automatically lead to such overutilization of services as to bankrupt the insurer.²⁵

The insurance industry's fears of that kind of induced demand were exaggerated, but in the case of long-term care there is reason to worry about induced demand, and it should be acknowledged that the problem exists

and is troublesome regardless of whether coverage is provided privately or through social insurance.

The problem is relatively manageable in the case of nursing homes, because most people, even if they have insurance, can be expected to resist going to a nursing home unless there is no alternative (although it is doubtless true that a family struggling to provide care may be more inclined to urge a chronically ill family member to enter a nursing home sooner if insurance is available). In the case of home care, however, concern about induced demand is justified. After all, in the absence of insurance, there are many places in the nation where home-care services either are not available at all or, if available, are not in great demand because so few people can afford them. If more people had insurance, more people would substitute paid-for care for informal, family-provided care. How much additional demand for paid home-care services would develop? Nobody really knows.

Nor can anyone know precisely what will happen to the cost of home-care services when demand increases, but it can safely be assumed that the cost will increase. Today, home-care workers are, as a rule, poorly paid and have few benefits (such as health insurance), and in most states the quality of home-care services is poorly regulated. Greater demand will mean pressure for higher standards and better regulation, resulting in higher labor costs when service agencies, seeking to attract and keep good people, offer better wages and benefits.

In attempting to control for induced demand for home-care services, insurance companies have three choices: (1) Continue marketing very restrictive policies, or (2) Try to take on the difficult, time-consuming, costly and potentially controversial decisions of a managed-care system, or (3) Adopt the approach described at the end of the discussion of Rule 2 and accept the inevitability of most beneficiaries using benefits up to the maximum allowed.

The first choice avoids the problem of induced demand by avoiding broad coverage of home care—but since this is the type of long-term care that most people want, competition is forcing companies to broaden coverage. The second choice is, as noted, not going to be practical in most cases except where managed-care services can be organized to serve several companies at the same time.

Insurers opting for the third choice recognize that paid-for care will be added to or substituted for a considerable part of the informal care now provided by family and friends, and charge premiums high enough to cover the anticipated cost. With this approach, insurers can limit the impact of induced demand only by requiring policyholders to meet a stringent test of disability before a claim will be approved and then either by capping the

benefit (at a percentage of the nursing-home benefit or at a percentage of the costs incurred for home-care services) or paying a simple cash disability benefit without regard to how care is provided.

This approach assumes that most families with severely disabled relatives at home will use the benefit to the maximum and will pay out of pocket or continue to rely on informal family-provided care for anything else that is needed. It can be argued that this approach at least has the advantage of providing a less costly alternative to admission to a nursing home. But here too there is a conflict between insurers and consumers. Benefit limits may represent the only way for insurers to control induced demand, but they may impose hardships on consumers with a legitimate need for more comprehensive home-care services.

DILEMMA: BETTER IS COSTLIER

The insurance industry's ground rules are not made to be broken. The industry lives by them. Stretching the rules creates uncertainty about costs, and that kind of uncertainty makes insurance companies nervous. Because uncertainty is, in any case, likely to characterize the long-term care insurance market for many years to come, insurers will continue to take steps to limit their exposure to risks and, to the extent that competition allows, will charge premiums high enough to include sizeable margins of safety.

That may be the only prudent strategy open to the industry. But for consumers the result is that policies are sold with too many strings attached, cost too much for most people, and are not available at any price to those with the most immediate need for protection: people who are already disabled, or who have a history of disability, or who are at risk of becoming disabled soon.

In their efforts to improve long-term care policies, insurers face a real dilemma. They know that the restrictions built into present policies are unpopular (and a few of those restrictions, such as prior-hospitalization requirements, are being removed). They know, too, that people want home-care coverage. And they know that buyers want genuine protection against inflation. They know exactly what consumers want—but the dilemma is that when those wants are met, the cost goes up very considerably, shrinking the market for the newly improved policies.

This dilemma is well illustrated by one of the more recent entries into the field of individual long-term care insurance: a policy developed by The Travelers Company after consultation with a committee of the Independent Insurance Agents of America (IIAA).²⁶

The biggest difference between this policy and others (and what makes this product particularly expensive) is the home-care benefit, which is considerably broader than what has been generally available. Eligibility for either nursing-home care or home care is based on a finding that the applicant is unable to perform three of the activities of daily living, but once this requirement has been met, the individual can choose whether to use the insurance to pay for care at home or in a nursing home. The home-care benefit (which also covers adult day-care) will reimburse 80 percent of the charges incurred by the patient, up to the equivalent of the maximum daily nursing-home benefit. Thus, with a policy paying \$100 a day for a nursing-home stay, the maximum reimbursement available for home-care (or adult day-care) services is \$100 in a situation where the policyholder is incurring charges totalling \$125 a day (\$100 being 80 percent of \$125).

The policyholder has the choice of several daily rates for nursing-home coverage up to a maximum of \$150 and may also choose among three waiting periods (or excluded periods) before benefits begin: 20 days, 100 days, or 365 days. The home-care services covered are broadly defined, and there is no requirement of prior hospitalization or confinement in a nursing home. Reimbursement is for services used, without close attention (as in a managed-care approach) to what services are required. Total benefits—nursing-home and home-care services—are payable up to the daily limit multiplied by five years.

Applicants below age 70 are screened on the basis of a questionnaire, with examination of medical records if the answers raise doubt about the applicant's health status. At age 70 and above, applicants' medical records are examined routinely.

The generosity of the home-care benefit must, of course, be paid for through higher premiums. For the \$100-per-day benefit level with a 20-day waiting period (the most common waiting period in current policies), the premium at age 70 is \$2,892.²⁷ The policy can be bought through age 79, but the premium increases rapidly. At age 74, for example, it is \$4,614; at age 76, it is \$5,958. And, as with almost all other long-term care policies, no cash surrender value is built up.

Buyers are offered two extra-cost options directed at the problem of inflation protection. One option provides for an inflation adjustment to the daily benefit that begins with the first day of receipt of benefits, with subsequent increases in the benefit based on changes in the Consumer Price Index.²⁸ This protection is contracted for when the policy is bought. Policies are sold beginning at age 40. At that age, the annual premium for a \$100-per-day policy with a 20-day excluded period is \$377, and the surcharge for inflation protection beginning upon receipt of benefits is a

modest \$30, bringing the total to \$407. But if bought at age 70 the surcharge is \$570, bringing the total premium to \$3,462. If bought at age 74, inflation protection would cost \$880, bringing the total to \$5,494.

A second option, aimed at maintaining the value of the benefit until a claim occurs, can be bought separately or in combination with the option just described. With this second option, in the first year the policyholder pays the premium for the chosen daily benefit amount at the rate for the attained age. Thereafter, as the Consumer Price Index rises, the policyholder is periodically given the opportunity to buy additional coverage (in \$10 units at the rate for the newly attained age). The opportunity to keep the benefit up to date with the CPI is limited to a doubling of the original benefit amount.

This policy represents greatly improved protection over most individually sold policies that have been offered—and it is therefore more expensive. Not many elderly people can afford it. There are plans to offer a similar policy with a three-year limit on payment of benefits—which would make it more broadly affordable but less broadly protective, again illustrating the inherent dilemma of adequate coverage versus affordable premiums.

Another approach to private long-term care insurance is to add it to a life insurance policy. Under this arrangement, the insurer adds a rider to the life insurance policy providing for a percentage of the death benefit to be applied to the cost of long-term care (reducing the death benefit accordingly). For example, a policy with a \$100,000 death benefit and a \$10,000 cash value might stipulate that 2 percent of the death benefit, or \$2,000, could be paid to the policyholder during each month that the policyholder needs long-term care. During each month that long-term care was being paid for, the death benefit and the cash value would be reduced by 2 percent until the coverage was exhausted, the insured died, or the policy matured; anything left over after the insurance company recovered the prepaid amounts would be paid to the policyholder or to his or her beneficiaries. As of the end of 1988, at least nine insurance companies were offering such life insurance riders, and about 4,500 people had reportedly purchased this kind of long-term care coverage.²⁹

ARE 'GROUP' PLANS BETTER?

Thus far, the limitations of private insurance have been discussed largely in the context of policies sold individually. Suppose, however, you have the opportunity to buy long-term care insurance through an arrangement advertised as a group plan—either at work or through some sort of affiliation

(members of a retirement community, for example, or a travel club or senior citizens' organization). Are there likely to be significant advantages? Will such plans be able to resolve or at least minimize the kinds of problems that limit the availability and appeal of policies sold individually?

Although there are comparatively few of these so-called "group" plans in effect now, more are being developed, partly in response to all the publicity that long-term care has recently received. Within the past two years, some large corporations and a few state governments have begun offering long-term care coverage to their employees or retirees, and some insurers are marketing similar policies to members of large health maintenance organizations and retirement communities and associations.

It needs to be understood that although these plans may be promoted as "group" plans, they have little in common with what is normally meant by the term "group insurance." What makes group insurance work is that the cost is paid (or at least heavily subsidized) by an employer buying coverage for an entire workforce. With such coverage, many of the problems of individually purchased insurance are in fact made manageable. The problem of adverse selection, for example, is largely avoided because those covered are not making individual choices to buy or not buy insurance. Risks are pooled, and the cost of the policy is based on covering low-risk as well as high-risk employees. Because employers pay all or most of the cost, the problem of affordability—that is, how to insure people who otherwise couldn't afford the premium—is dealt with.

Very few employers, however, are likely to be actively interested in buying group long-term care insurance. Employers who currently provide some degree of health insurance for retirees (almost entirely hospitalization and physician-care coverage) are concerned about the size of the commitment they have already made. Generally they want to limit rather than expand that commitment. Unions, for their part, are unlikely to make this kind of insurance a high priority, because in most cases they are struggling to address more immediate problems than the need to protect members who may have retired decades ago—the usual situation of those most in need of long-term care protection.

Currently, in fact, there appears to be only one employer-paid group plan under consideration: an experimental two-year pilot program initiated by the United Auto Workers and Ford Motor Company. The UAW-Ford pilot, which went into effect in April 1989, provides long-term care insurance for about 4,800 workers at two Ford plants in Louisville, Kentucky, and for about 800 recent retirees who formerly worked at those plants, retired after September 1987, and live in the immediate Louisville area. Dependents are also included. Eligibility is based on chronic inability to perform two or

more of the activities of daily living. Through a contract with the Jefferson County [Louisville] Department for Human Services, the program provides case management of home- and community-care services (subject to an annual cap per user of \$8,200 in the first year and \$8,400 in the second year) and custodial care in a nursing home (up to 365 days per admission). Blue Cross and Blue Shield of Michigan is the insurance carrier involved. The pilot program is very limited in scope; there are expected to be about a dozen beneficiaries in each of its two years of operation.³⁰

'GROUP' PLANS AS MARKETING DEVICES

What about the long-term care policies being sold to current employees through their places of employment? The key to the definition of true group insurance is that everyone in the group is covered. These plans do not fit that definition. They are, rather, marketing devices: the insurer, hoping to control promotional costs by obtaining access to concentrations of potential consumers, works out an arrangement with the employer, who agrees to promote a voluntary plan that the employee pays for.

In some cases, a long-term care plan may be offered as one of many benefits that the employee can choose among (the so-called "cafeteria" or "boutique" approach to providing employee benefits, popular because employees have a sense of freedom of choice). But selecting benefits from a menu requires trade-offs; an employee who chooses Benefit A must generally agree to forego Benefit B, in whole or in part. Some programs, for example, offer employees the option of shifting part of their group life insurance to long-term care insurance.

These are, in reality, individual plans sold in group situations, with all of the potential drawbacks of individual insurance and few of the advantages of group insurance. True, there may indeed be savings in promotional and administrative costs (because it is obviously cheaper to reach people in clusters than one by one), employees may like the convenience of paying for insurance through payroll deductions, and employer-approved plans may be of comparatively high quality. And if a plan is sold to a genuine group (a group formed, that is, for some purpose other than buying insurance), it may be possible to avoid adverse selection without careful screening even at relatively low participation rates—as low as, say, five to ten percent in a large group of employees. But many of the inherent difficulties of individual plans remain.

Employees of American Express, for example, are offered employer-promoted long-term care insurance that allows them to choose between a

plan that pays \$100 a day for nursing-home care and \$50 for covered home-care services, or a plan that pays half as much. The less expensive option would cost a 40-year-old employee only \$108 a year. But if the employee needs coverage 40 years from now, the benefit, not very high to begin with, will have been so sharply reduced by the effect of inflation that it will have little real value—unless the employee arranges to keep updating coverage, paying much higher premiums as the years go by.

In a few cases, group purchasing of insurance may mean that there will be opportunities to provide managed care—if, for instance, a number of large employers using the same insurer obtain a sufficient geographical concentration of beneficiaries. In such cases, the use of professional care managers may be warranted, and they may be able to provide beneficiaries with a measure of quality protection. But the potential also exists for care managers to be caught in a conflict between the insurer's need to control induced demand and the beneficiary's need for comprehensive home-care services. Care managers also serve as gatekeepers, and the insurance company owns the gate. This conflict is only partially mitigated when the insurer hires a third-party organization as care manager, since the contractor naturally hopes to have its contract renewed.

Concern about induced demand will also be reflected in limits on the duration of benefits or in caps on the total benefits payable in any individual case. Thus members of the insured group will be left exposed to much the same kinds of risks as individual policyholders. They may be better protected, but only to a degree.

Still, some of the most innovative changes can be expected from these so-called group plans. Typically they are being sold to relatively young people who are offered the opportunity in some cases to buy protection not only for themselves but for their parents.³¹ Employers may also sponsor the marketing of policies to retired employees. The best plans cover a full range of services (although of course they all limit the total amount of care they will pay for). And at least one plan now available includes vesting after ten years of payments, with a paid-up benefit equal to 30 percent of the original benefit and rising 3 percent with each year of participation up to 75 percent of the original benefit.³²

An Aetna plan that pays a simple cash disability benefit, allowing the policyholder to choose whether care will be provided at home or in a nursing home and paying benefits regardless of whether formal care services are contracted for, is attractively simple and flexible; it can offer help to families who may, with some financial assistance, be in a position to provide a large part of the needed services themselves. One version of this plan, currently being offered to retired employees of the state of Ohio,

requires no health screening (if purchased shortly after retirement) and pays a disability benefit when a policyholder becomes unable to perform two or more of five specified activities of daily living.³³ Benefits are paid after a 90-day waiting period that applies whether the patient is being cared for in a nursing home or at home. The home-care benefit is half the nursing-home benefit, and is payable (after the disability test has been met) regardless of whether home-care services are bought at all.

The benefit is sold in \$10 increments, up to a maximum of \$100 per day. Lifetime benefits are limited to \$18,250 times the number of \$10 units purchased. In other versions of the Aetna plan, a death benefit is payable to a designated beneficiary if the policyholder dies before receiving benefits. The death benefit is limited to the amount of the premiums paid in (without interest). Aetna plans also offer an inflation adjustment in units of \$10 or \$20, with the cost determined by the policyholder's newly attained age but without regard to the policyholder's health. The usual plan also has a non-forfeiture feature (requiring a higher premium) which provides continuing protection at the same benefit level if premium payments stop, but with the duration reduced to what can be purchased by the funds thus far accumulated. Interestingly enough, in the plan being sold to Ohio state retirees (the largest group now buying an Aetna long-term care plan), in order to keep the cost down neither return of contributions nor non-forfeiture protection were included.

For the relatively well-off, a cash disability benefit plan may be particularly attractive, since they can more easily handle a shortfall between the amount of the benefit and the cost of services and are meanwhile left entirely unencumbered by troublesome procedures and controls. On the other hand, the benefit amount is almost certain to be inadequate in many situations and in other situations will exceed the costs actually incurred. So the dilemma of adequate protection versus high cost is real here, too.

Another way of trying to handle the inflation problem is to charge a level premium rate from the date of purchase for a benefit that increases automatically. Prudential expects to offer such a plan to members of the American Association of Retired Persons (AARP) later this year.³⁴

Under this plan the \$50 benefit would be automatically increased 5 percent each year, compounded, until the policyholder enters benefit status. If the policy is purchased at age 50 (the earliest age that someone can become a member of AARP), the cost would be considerably more than two and a half times as high as the \$240-a-year premium for a similar AARP policy being sold without inflation protection. At age 65, the premium for the policy with inflation protection will be about twice the premium for a policy without such protection; at older ages, as the period over which

inflation protection is provided shortens, the difference continues to narrow. The Prudential policy is expected to exclude the first 45 days of home care and the first 90 days in a nursing home from coverage. The maximum lifetime number of nursing-home days covered would be 1,095, and the maximum number of home visits is expected to be roughly 700. Eligibility for home-care coverage would be based on a physician's certification that the policyholder would require nursing-home care in the absence of the home-care benefit. AARP will also be offering a \$75-a-day policy.³⁵

As currently planned, the inflation-protected policy will not have a non-forfeiture feature. Thus a policyholder might contribute for many years and then, if unable to continue payments, would have nothing to show for past contributions. (Nor, if the policyholder dies before receiving benefits, would it be possible to convert the paid-in premiums into a death benefit for a designated beneficiary.) But adding a non-forfeiture feature equal to what the individual had been accumulating under a level premium plan to meet higher costs later would raise the price by perhaps 10 to 15 percent.

With its automatic adjustment of benefits, this plan meets the inflation problem head-on—but, in doing so, clearly becomes too expensive for most older people. And it should also be borne in mind that although the intention is to charge a level premium, the rate can be raised for the group as a whole if experience suggests the need to charge more than anticipated. Once again, the dilemma is clear. *The more of the inflation problem a policy tries to meet, the smaller the number of people who can pay the cost.*

The best of the policies now being sold or in the planning stage, both individual and group, demonstrate that private long-term care insurance can be designed to provide an important supplement to a broad public insurance plan. Insurers know, however, that the improved policies they are offering are beyond the reach of most elderly people. Indeed, they know that affordable, adequate private insurance for those who are already old is a contradiction in terms. They know, too, that it makes little sense for them to try to sell expensive insurance to people of almost any age who do not have sizeable assets to protect. They recognize, then, privately if not in their public statements, that the role of private insurance in long-term care is quite limited, not just for now but for the future.

Some representatives of the insurance industry have been comparatively forthcoming on this point. Two executives at one major insurance company, describing their long-term care marketing experiences in a recent article, concluded:

“People do not beat a path to your door to buy long-term care insurance just because it is available . . . We have also learned that not everybody who wants long-term care insurance should be encouraged to purchase it. There are ethical and moral considerations . . .

“[Long-term care insurance] is mostly a means for people to preserve their assets and to prevent the need to spend down assets to Medicaid eligibility levels. If an applicant has little or no assets to preserve, it is unclear if they should be encouraged to buy this type of protection.”³⁶

This kind of candor suggests that within the industry there is ample awareness of the inherent limits of long-term care insurance. Industry spokesmen who say otherwise may be hoping to get some help from the government.

GOVERNMENT PROMOTION OF PRIVATE PLANS

Some industry spokesmen argue that long-term care policies could be made more broadly comprehensive and affordable if the federal government and the states would take certain steps to help insurers limit their risk or to provide tax or other advantages to purchasers—in other words, to subsidize the purchase of private insurance. Suggestions for federal action include:

- Allow taxpayers to set up tax-exempt savings accounts—the medical equivalent of an individual retirement account—with which to pay for long-term care or buy insurance in old age.³⁷

- Give taxpayers a tax credit or a deduction from taxable income to offset the cost of insurance premiums.³⁸

These proposals might improve the outlook for sales of private long-term care insurance policies. But few people believe they would have more than a modest effect on the overall extent of coverage. And these proposals have serious drawbacks.

The basic problem with tax breaks and other subsidies is fairly obvious. People who receive them are usually in favor of them, of course. But preferential tax treatment reduces tax revenues overall, requiring taxpayers as a whole to pay more to make up for the income retained by those receiving special treatment.

Proposals have been circulating for some time to allow taxpayers to invest in special, partially tax-exempt retirement funds for long-term care—a concept similar to individual retirement accounts (IRAs). People who prudently save against health risks, so the argument goes, deserve a break—just like people who prudently save for retirement. The idea of an individual medical account (IMA) may seem appealing, but it is badly flawed.

In the first place, a fund that could be used only to pay for long-term care is unlikely to develop broad consumer support. IRAs can be used for any

retirement-related purpose, but even with that latitude they have not been notably successful.

Moreover, experience with IRAs suggests that most of the taxpayers who would invest in IMAs—with or without restrictions on use—would be from among the well-off minority. IRAs are not much used by the great majority of taxpayers with modest incomes. In 1985, fewer than 15 percent of all moderate-income taxpayers made IRA contributions; in contrast, 76 percent of those with incomes above \$100,000 used IRAs to reduce their tax liability.³⁹ Although the tax code has subsequently been modified to reduce the tax advantages of IRAs for most high-income taxpayers, the point remains that such plans are attractive mainly to those who are affluent enough to be interested in strategies to marginally reduce their tax liability.⁴⁰ Lower-income taxpayers, especially those who do not itemize, rarely make spending or investment decisions on the basis of whether a tax benefit is involved. Thus a strategy to offer preferential tax treatment through IMAs or tax deduction of premiums would most help those who need help least, while doing little to protect those with limited resources.

Various other proposals to promote the sale of private insurance have surfaced in several states and have attracted some support from state governments. This is not surprising; in the absence of federal action, the states have little choice but to try on their own to reduce the burden of nursing-home costs on Medicaid and to provide their citizens with better options than those now available. States acting alone can hardly be expected to adopt a broadly applicable social insurance program with no means test, because of the cost, the mobility of the population, the risk that employers may avoid states that impose such costs, and the risk that states operating good social programs will attract people from states that do not. With their maneuvering room thus restricted, states have been considering proposals of limited application that would be quite inappropriate as solutions to the problem nationally.

Among the proposals under study are:

- In determining an applicant's eligibility for Medicaid, exclude assets equal to the amount that private insurance has paid for that individual's long-term care;
- Provide a guarantee of extended coverage from public funds, either through individual private insurance companies or through a state-sponsored pool, once an individual buys private insurance coverage for the length of time considered "affordable" according to the individual's income and assets;
- Provide state reinsurance of private policies sold to high-risk and

lower-income people, to encourage insurance companies to sell in these markets.

■ Provide direct state subsidies to middle- and lower-income people to help them purchase private insurance.⁴¹

The basic problem with offering special treatment under Medicaid to those who buy private insurance is that a program intended to help the poor would end up guaranteeing to finance the extended nursing-home stays of those who are relatively well off and who otherwise might have bought more insurance or used their own assets to pay their bills. Providing asset protection to the well-off hardly seems an appropriate use of Medicaid funds. This approach really doesn't protect the poor; rather, it helps those who can afford some degree of private insurance coverage and especially the well-off who can afford more extensive coverage but would have less reason to pay for it if automatic eligibility for Medicaid were available. There are, in addition, practical questions raised by a policy of ignoring Medicaid eligibility requirements over many, many years (as this approach would call for), through successive state and federal administrations that might have very different ideas about how to deal with these problems.

Direct subsidies, including reinsurance, run up against the dilemma that either the private plans will not do very much or they will cost the government a lot—more, perhaps, than the savings in Medicaid they are intended to achieve. It can be expected, however, that in the absence of a national public insurance plan, the states will understandably continue to explore every proposal that holds out the possibility, however remote, of reducing the Medicaid costs that are beginning to overwhelm many state budgets.

A somewhat separate problem is the tax treatment of long-term care insurance. The Internal Revenue Service has issued rulings in individual cases that would exempt interest on the reserves for long-term care insurance the same way that it exempts interest on reserves for guaranteed renewable health and accident policies bought by individuals, but the IRS has not yet made a broadly applicable ruling. Nor has it ruled on whether the policyholder would have to pay a tax on the benefit on receipt.

In the case of long-term care insurance sold at young ages, interest earnings will be very substantial and benefits ordinarily long deferred. The situation is somewhat similar to funding for the future health benefits of retirees, for which present law does not now allow the accumulation of tax-free interest. Although there is a case to be made for exempting interest in both these situations, the cost to the federal treasury could be very large.

Given the size of the deficit and the great need to increase support for public services, Congress will want to consider carefully the ramifications of

adding to the public cost of private benefits. Exempting interest earnings on long-term care insurance funds from taxation would be an advantage, of course, only to those purchasing these plans (usually the better off) while requiring everyone else to pay higher taxes to make up for the revenue loss to the Treasury.

INHERENT LIMITS

Greater effort and experience will help insurers to sell more policies to more people than in the past. Design changes based on better data will help. Bending some of the rules that the industry lives by will help. More aggressive marketing will help. But inherent limitations will put a stop to the growth of the long-term care market long before private insurance can offer real protection for most people. There are several reasons:

- In the absence of employer-paid group insurance or very widespread buying by younger workers (both unlikely), private insurance will continue to be faced with the problem that those who are most interested in buying protection will be those who most expect to need it—those who anticipate going into a nursing home or requiring extensive care at home. Insurance companies that are serious about staying in the long-term care field will have to protect themselves against adverse selection by setting high premiums or maintaining restrictions on eligibility or both.

- People want comprehensive home-care services, not just nursing-home care. Plans that fail to offer both will be increasingly unattractive. (They may also contribute to bad social policy by inducing more institutionalization than is necessary.) But, for the reasons previously described, providing a broad home-care benefit will be quite expensive, and managed care is feasible only in limited situations.

- It is very difficult for private insurers to provide benefits on a service basis—that is, to provide reimbursement for the actual cost (or some percentage of the cost) of services rather than paying the policyholder either a flat cash indemnity or reimbursing for costs incurred up to some flat maximum of so many dollars per day. To pay a service benefit, the insurer must determine appropriate (and adequate) levels of reimbursement and impose limits on payments to the more expensive facilities and services. This means becoming heavily involved in cost controls and quality assessments of long-term care providers—something that insurance companies understandably prefer to avoid. Agreeing to cover the cost of a service means, too, that one must be willing to increase payments when the cost of

the service increases. An insurance company can do that only by selling coverage on a year-to-year basis and adjusting premiums accordingly, as is the prevailing practice with acute-care health insurance, or, if charging a multi-year premium, by setting it high enough to cover the company's highest inflation estimates. This is made much more difficult when the protection being sold is for an event that is unlikely to occur for many years.

■ The problem with premiums for individually-paid coverage as compared to employer-paid group insurance is not only that they are too high for most people but that premiums are not subsidized for high-risk policyholders (as is true with employer-paid group health insurance) and are an inherently regressive way to provide protection. A premium is a flat dollar amount, and, whatever the amount, will represent a greater burden for people of modest means than for the well-to-do—and insofar as the premium is related to risk, say by age, it is a greater burden for those at high risk. In nationwide social insurance (as with employer-paid group insurance), it is possible to subsidize both the lower-paid and those with the greatest risks. But if an insurer were to try that with policies sold individually—subsidizing some policyholders at the expense of others—it would lose business to competitors offering policies at lower cost to those at low risk.

■ Insurance companies can enlarge the pool of potential consumers with the help of government subsidies, but leaving aside questions of fairness and regressivity, the industry still could not provide coverage to the great majority—because millions of younger consumers will still attach low priority to the notion of paying to protect against a risk that may not loom large for many decades, and millions of higher-risk older consumers will still be unable to meet the expense of even a subsidized premium.

■ To some extent, the industry can reduce the high per-capita costs involved in marketing individual policies by selling through employers and associations, but for policies sold individually the per-capita cost of agent fees, advertising, and administrative expenses must unavoidably remain relatively high, and all such costs must, of course, be fully covered by the premium if the company hopes to stay in business. These costs may act as a significant barrier to the growth of the long-term care insurance market.⁴²

What, then, can we expect from private insurance? Premiums will remain high for all the reasons previously discussed (although some companies will be tempted to lower their premiums initially to attract business, counting on being able to raise them later). Insurance will remain unavailable to those with the greatest need for protection: people who are over specified age limits or who have health conditions that make them high risks. Policies will

continue to carry restrictions on eligibility for benefits and on the duration of any benefits paid. Coverage of home care will be either quite limited or quite expensive. The industry will not be able to develop a broadly affordable solution to the inflation problem and will continue to write policies that make payments primarily on an indemnity basis.

Reliance on financing through premiums related to risk but not to earnings or income will keep policies beyond the reach of those with low or moderate incomes. Those most interested in purchasing long-term care protection—men and women approaching the age when the risk of chronic illness increases—will be unable to afford age-adjusted premiums. And it will not, of course, be possible for insurers to cover the already disabled elderly, since for them the risk has already occurred and premiums would have to equal 100 percent of the cost of the services they require.

For all of these reasons, private insurance alone cannot provide more than a fairly modest part of any overall solution to the long-term care dilemma.⁴³ This does not mean, of course, that in the absence of a universal government program it is unwise for those who can afford insurance to buy it. Nor does it mean that in the long run there is no role for private insurance as a supplement to social insurance. Quite the contrary. It *does* mean, however, that relatively few people will be able to afford enough private insurance to meet their needs without help from some other source.

Consumers should not be forced to choose between private insurance and Medicaid. The choice is too narrow; neither can provide adequate protection. The prospects for both will become much brighter, however, if the United States adopts a universal public program that provides *basic protection for everyone*, leaving anyone who wishes to do so (anyone, that is, who can afford the cost and pass the screening criteria) free to purchase supplemental protection. This approach—a public program supplemented by private initiatives—works well in the case of retirement income. Social Security is a truly universal program of retirement income, but it was never intended to be a *total* program providing all the retirement income that anyone would ever want or need. It provides a platform upon which to build; pension plans, both public and private, are built on the base that Social Security provides. There are good reasons to approach the long-term care problem the same way. Budgetary constraints alone practically guarantee that in drafting and enacting a public plan it will be necessary to choose priorities, leaving some needs unmet. That will create an important and appropriate complementary role for private insurance—a role that builds logically upon a platform of public insurance that provides basic long-term care coverage for all.

PART 6

DEVELOPING A LONG TERM CARE POLICY: WHERE DO WE GO FROM HERE?

IT IS CLEAR that the costs of long-term care will continue to climb in the years ahead. One way or another, those costs must be paid. We have a choice. We can continue to react to the problem in an unplanned, haphazard way that puts the burden almost entirely on the chronically ill and their families, with a program of public charity picking up the cost when they exhaust their own resources (and any private insurance they may have been able to afford). Or we can plan ahead, pool our resources, and protect everyone at manageable cost.

Only a plan that anticipates the needs of society as a whole and spreads the risk as broadly as possible can meet the need at a cost that is bearable for each of us. As we have seen, private insurance cannot possibly do the job alone. Medicaid, even if greatly improved, will still be a safety-net program. The Medicare program requires much modification if it is to address most long-term care situations. Our goal, then, should be to develop an approach that compensates for the shortcomings of Medicare, Medicaid, and private insurance while building on their strengths to create a total system that provides truly universal coverage.

What we need, it seems increasingly clear, is a four-part approach similar in concept to the retirement income system that has evolved in the United States:

- Social insurance, providing basic protection for everyone.
- A private insurance supplement, offering to cover what the public program does not.
- Individual savings, augmenting social insurance and private insurance.
- An improved Medicaid program protecting low-income people against costs not covered by the other parts of the system.

In planning where we go from here, it will be necessary to make choices about the roles of each of these four parts. Various proposals before the public give more emphasis to one or another, but any plan that deals adequately with the problem of long-term care costs will have to rely on some combination of the four.

SOCIAL INSURANCE AS A BASE

The case for building on a social insurance base is compelling. The broad foundation on which the other parts will rest must be inherently strong. Social insurance derives its unique strength from the principle that the best form of self-protection is mutual aid on a universal scale; when everyone contributes, everyone can be protected. That is, of course, the principle upon which we have constructed our Social Security system, which now provides nearly universal protection against the hardships that may be suffered when earnings stop because of retirement, disability, or death.

Private insurance, in contrast, although based on the principle of pooled resources, has the inherent drawback that protection is inevitably limited because the pool of participants is limited—for all the reasons explored in Part 5. Individual savings are important but cannot possibly provide the foundation for a long-term care policy because few people can save enough to insure themselves fully against the possibility of incurring expenses that cannot be predicted in advance. Medicaid is, of course, not an insurance program at all but a means-tested program with the drawbacks of any public charity: poverty or near-poverty is a prerequisite for eligibility; the process of qualifying for help can be both difficult and degrading; and public support for adequate funding cannot be relied on.

Social insurance thus has unique advantages as a base upon which to build:

■ **COVERAGE:** Social insurance can provide equitable protection for essentially the entire population. It is true that low-income beneficiaries may require help to meet cost-sharing requirements (as is the case with low-income Medicare beneficiaries who receive such help from Medicaid), but a social insurance program does not force anyone to *become* poor as a condition of qualifying for coverage or paying for covered services.

■ **EARNED BENEFIT:** As a rule, the families who will benefit from social insurance will have contributed to it, paying at least part of the cost of the benefits they may later receive. Thus their earned right to receive benefits is generally recognized—a crucial difference from the prevailing attitude toward benefits paid through means-tested programs. Eligibility for social

insurance benefits is usually based on establishing that one has worked and contributed; eligibility for welfare, on the other hand, requires a statement of personal helplessness. The connection to working and contributing gives social insurance its uniquely positive character and accounts in large part for its strong public support.

■ **EQUALITY:** In a social insurance program, everyone is in the same boat. Thus there is broad support for maintaining the well-being of the program and protecting the quality of benefits. This is in sharp contrast with means-tested programs, which, because they divide the community into two groups—those who have and those who have not—tend to divide the delivery of health care the same way, with one system for those who have resources and another system, often inferior, for those who are forced to turn to welfare.

■ **DEDICATED FINANCING:** Social insurance programs are essentially self-financing, in that they are financed primarily by earmarked taxes. This gives them stability, helps to protect them from year-to-year funding competition with other programs, and encourages long-range planning. Funding problems can be anticipated in time to make any necessary modifications.

Building a long-term care program on a universal social insurance base makes sense not only because of these general advantages but also because many of the problems of individually purchased private insurance can be avoided. For example:

■ The problem of adverse selection disappears, because with everyone covered there is no need to try to screen out bad risks. No one has to worry about being refused coverage because of pre-existing conditions or uncertain health prospects. Nor can a competitor skim off the best risks.

■ Low-income people can be covered at relatively affordable cost, in part because the cost of coverage is so broadly distributed and because the financing system can be designed progressively (unlike individual premiums) to put the lowest burden on those with the lowest incomes. And protection continues regardless of any changes in household economic circumstances, so there is no need to be afraid of a premium unexpectedly becoming unaffordable.

■ Full inflation protection can be more easily provided because the base to which contribution rates apply—payrolls, incomes subject to taxation, and estates, for example—rises as inflation rises. Other cost factors may cause increases in contribution rates, but inflation does not do so unless it outpaces the growth in incomes. Even if this happens—for example, if long-

term care costs outpace wage increases—the rate adjustment is smaller and less frequent than for a premium-financed benefit.

■ Payments toward social insurance protection need not vary with age, and a related problem is resolved immediately, because those already old or disabled can be covered as soon as the program goes into effect. The additional cost of covering them can be met in part through special financing (such as a surcharge on estate taxes), rather than by charging premiums so high as to be unworkable, as would be necessary if private insurance were to attempt to cover them.

■ Controlling costs and enforcing quality-of-care standards is difficult with any kind of health plan, but there is a better chance of doing so under a social insurance system. Because it pays for services rather than simply paying a flat indemnity to a policyholder, the program becomes directly involved in determining the adequacy of services provided and the appropriateness of costs charged.

■ A plan that pays for services rather than paying an indemnity also protects the patient by limiting, in advance, what the patient has to pay out-of-pocket (beyond predetermined copayments and deductibles), thus avoiding the risk of incurring costs for special services or for care in high-cost areas that may far exceed the coverage limits in an indemnity plan.

■ A universal system of managed care, although still difficult to administer, becomes feasible over time under a social insurance plan, because all who require care are covered under a unified system. Managed care offers the best hope of providing helpful care coordination for the patient while also controlling the use of unnecessary services that burden any insurance system, and should make feasible a better balance between home care and institutional care. (The other side of this coin, of course, is that a managed-care system may not always agree to pay for services sought by a patient and family, unlike some indemnity insurance policies that impose no restrictions on the selection of services and restrict instead the dollar amount available to the policyholder to pay for those services. Thus there may be trade-offs between complete freedom of choice versus the risk of not being adequately insured.)

■ A universal system can greatly reduce the problem faced by a potential buyer of private long-term care insurance who must struggle with the fine print of various policies carrying different technical exclusions. Alzheimer's and other dementias, for example, would clearly be covered; there would be no conditions attached to the renewability of a policy; and there would be no doubt about whether personal care services were covered.

■ A social insurance plan largely eliminates certain substantial costs that cannot be avoided in the case of individually purchased private insurance: agent's fees, advertising and other promotional costs, and comparatively high per-capita administrative costs.

■ With social insurance, ultimate responsibility for program purpose and content remains in the hands of Congress and the President. There is thus less risk of court reinterpretations unexpectedly altering the intent of the insurance plan and imposing unanticipated costs on insurers and policyholders—a risk that forces insurance companies to price policies high enough to cover such potential costs. With a social insurance program, court decisions can be modified, if need be, by corrective legislation (as was done several times during the evolution of Social Security's disability coverage).

All of these points argue for using social insurance as our basic defense against the cost of long-term care, with private insurance serving as a supplement that can be used to fill in copayments and deductibles and to cover whatever the basic plan does not. It should not be inferred, however, that administration of a public long-term care insurance plan will be easy. On the contrary, it will be complex and difficult. Administering the home-care benefit will be especially challenging. Controlling for induced demand—in this case the tendency to replace informal family-provided care with formal paid-for services when insurance becomes available—may be a formidable problem for a long time, even with a managed-care system. The point is not to suggest that social insurance magically solves all problems but simply to emphasize that it does not suffer from many of the drawbacks that limit the effectiveness of private insurance.

GOALS FOR A SOCIAL INSURANCE PLAN

What, then, are the broad goals that should guide us in developing a long-term care program building on a social insurance base?

■ *The plan should be universal and contributory.* This is fundamental. Since we are all at risk, a program to which all (or nearly all) contribute is the best way of guaranteeing the availability of services to anyone who may need care, and is the fairest way of distributing the costs of the program among all who are protected by it.

■ *The plan should be an integral part of our Social Security system,* either as an addition to Medicare or as a new title in the Social Security Act. As with

other Social Security programs, the plan should be self-financed through new dedicated taxes, an approach that does not add to the federal deficit.

■ *The plan should be designed to cover anyone who becomes chronically ill or disabled, regardless of age, although it may be necessary to reach this goal in phases, in order to control costs while acquiring administrative experience.*

■ *The plan should cover both home care and nursing-home care, recognizing that the chronically ill and disabled require access to a continuum of care building upon informal care provided primarily by family members and friends.*

■ *The plan should be designed to serve patient and caregivers alike.* Much emphasis should be given to providing formal home-care services as a supplement to informal family care and to providing respite-care services that will help to reinforce the commitment of those who serve as primary caregivers.

■ *The plan should be supportive*—designed and administered to *actively* help patients and caregivers obtain access to necessary services so that the informal family caregiving relationship, where it exists, can be maintained and strengthened. Individual care plans, carefully developed to provide the optimum mix of care services, will be essential to the success of the overall program. Where appropriate, care plans should emphasize preventive-care and rehabilitation services that foster the highest possible degree of independent functioning while also controlling costs. And care plans must be flexible so that they can be modified as necessary when a patient's circumstances change.

■ *The plan should be based on paying for necessary services* rather than making indemnity payments to beneficiaries, thus protecting beneficiaries against inflation and providing an administrative incentive to control the cost and quality of the services provided. Reimbursement limits should be incorporated in the plan, with rates established prospectively and adjusted periodically.

■ *The plan should be designed to encourage broader availability and improved delivery of alternative long-term care services, including those provided by continuing-care retirement communities and other group residential arrangements, health maintenance organizations and social/health maintenance organizations.* Although these now serve only a relatively small part of the long-term care population, their evolution nationwide can be enhanced by a program that pays a share of the cost of the services they provide.

■ *The plan should include cost-sharing provisions, both as a means of controlling the overall cost of the program and of encouraging continued reliance on informal caregiving wherever feasible.*

■ *The plan should incorporate stringent cost and quality controls, paying only for care provided by institutions and home-care providers that meet high standards. Funds should be made available for training grants and other initiatives to help caregivers (both informal and formal) improve their skills, to improve the availability of long-term care services, and to upgrade the quality of existing services. Paid caregivers should be both properly trained and adequately compensated.*

KEY ELEMENTS OF A LONG TERM CARE PLAN

A social insurance long-term care plan should offer benefits covering all three of the key elements of long-term care: home care, respite care, and nursing-home care. All are essential in any comprehensive program that seeks to provide a continuum of care, but each poses different challenges from the standpoint of designing benefits that will meet the needs of patients and their families without at the same time making the program unduly vulnerable to the risk of incurring essentially uncontrollable costs.

■ **HOME CARE:** A nationwide long-term care program should cover a range of home-care and community-care services as well as nursing-home care. However, because these kinds of services are not broadly covered now under Medicare, Medicaid, or private insurance, they are by no means uniformly available in all parts of the country. Demand for these services and the availability of a way of paying for them will create significant new costs that must be anticipated and, to the extent possible, controlled. The process of creating a comprehensive home-care benefit will thus require careful planning and decisions about how best to allocate the resources available.

When we talk about designing a “comprehensive” long-term care program, in fact, we should acknowledge at the outset that home care, no matter how desirable, is not going to be feasible for everyone. For example, a very elderly person who lives alone and is becoming progressively incapacitated may simply be better off going to a nursing home (or to a congregate residential arrangement offering personal care services, in communities where such facilities are available), especially if children and other family members live far away and if high-quality home-care services are not

readily available. Trying to design a continuing home-care plan to cover every individual in such circumstances would be futile; the plan would be unlikely to meet their needs satisfactorily and it would almost certainly become prohibitively expensive.

A nursing home or other congregate setting may also be the best place for people living alone who, regardless of age, become so severely disabled that

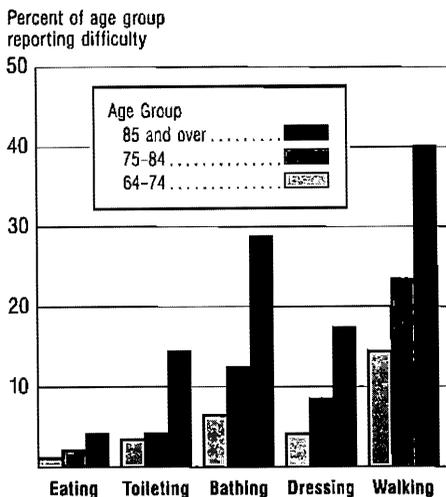
they require full-time care or monitoring. Paying for round-the-clock care at home usually costs more than providing the same kind of care in a congregate setting, and it hardly seems reasonable for the insurance program to pay the extra cost.

What about people who are perhaps only marginally impaired—people who might be able to continue living at home if only they could count on getting help from time to time with such tasks as shopping, preparing meals, doing general housework, getting to the doctor, and arranging for recreational and social activities? There are, of course, a number of social-services programs both public and private that seek to provide this kind of support in many communities, but the question here is whether this benefit should be a universal right under a social insurance plan.

Ideally, it would seem, the answer should be yes, not just as a matter of compassion but because it so obviously makes sense—and is so obviously cost-effective—to help people to continue

WHEN AN AGING POPULATION NEEDS A HELPING HAND

Relatively few Americans report difficulty performing basic daily activities at age 65, but chronic impairment is much more widespread among the oldest-old, underscoring the importance of making home-care services more broadly available.



Source: National Center for Health Statistics
(Data from 1984 National Health Interview Survey of persons 65 and older living in communities outside of nursing homes or other institutions)

living independently as long as possible. But as a practical matter we do not have the administrative experience to establish clear-cut eligibility criteria that can distinguish objectively between what beneficiaries may feel is *desirable* versus what they *need*—criteria, in short, that can be administered with sufficient fairness and consistency to withstand the challenge of appeals to a hearings process and the courts. Does Mrs. Smith, living alone, elderly and frail but otherwise fairly healthy, really need help with house-

keeping, and if she does, what about Mrs. Brown, who is not quite so frail but could certainly use some help? Objective criteria must be able to deal with such questions. But to answer affirmatively in both of these situations is to risk authorizing a benefit that may, for the time being at least, be too broad to control.

Congress, trying to address important priorities while simultaneously struggling to control costs, will be understandably reluctant to adopt long-term care legislation that could be construed as offering housekeeping services as a matter of right. For now—that is, until we have much more experience with administering long-term care benefits—we will do better to focus on providing a social insurance home-care benefit only to those who meet reasonably severe disability criteria—such as inability to perform unassisted a specified number of the activities of daily living.

In the illustration above, then, social insurance would not cover a home-care plan for either Mrs. Brown or Mrs. Smith. It would, however, if their circumstances met a more specific test—if, for example, Mrs. Smith or Mrs. Brown were caring for a spouse who met the test of disability described above and if she could no longer provide informal care unassisted because of her own deteriorating health.

At this stage the home-care component of a long-term care insurance plan should be limited to providing suitable home-based and community-based care services to those chronically impaired individuals who cannot perform a specified number of the activities of daily living unassisted but who can continue to live at home, generally because they have someone there to help (usually a spouse) or because they live with relatives or in congregate housing adaptable to the provision of home-care services. The needs of the marginally impaired, no matter how important, should be met, for now at least, through various existing (albeit usually underfunded) federal, state, and community social-service programs that are not subject to the necessarily rigorous objectivity tests of an insured right.¹

More specifically, eligibility for the home-care benefit should be based on (1) a determination that the individual requires long-term care because of (a) chronic inability to perform a specified number of the activities of daily living (ADLs) without assistance, (b) equivalent disability from a combination of several ADL limitations, or (c) the need for constant monitoring or supervision because of a mental condition such as Alzheimer's; and (2) a determination that the beneficiary need not be institutionalized if appropriate home-care services are provided.

The initial determination of eligibility should be made by a local care-coordinating agency. (The agency could be a public or private nonprofit agency, state-certified under federal guidelines.) The agency should then

conduct a comprehensive needs assessment including a detailed medical and social history and interviews with both the patient and the family caregivers to determine care requirements and personal preferences.

Based on this assessment, the agency would determine (subject to review and appeal) the scope of the care required and whether home-based or institutional care would be more appropriate. This decision would depend on such variables as the need for full-time care, the degree of availability of an informal caregiver, the availability of suitable home-care services, and the comparative cost of equivalent home-based and institutional care. Whenever possible, patient and caregiver should be offered a range of choices within overall cost limitations.

The agency would then develop an individual care plan covering the types of services needed, the required frequency of services, and the appropriate setting (home, community, institution). As a broad cost-control measure, the annual cost of any individual care plan for home-care services should not be allowed to exceed a specified percentage of the average cost of care in skilled nursing homes in the area.

Individual care plans should emphasize those services that can help someone continue functioning at the highest possible level of independence and that will help to sustain informal caregivers. Services that might be approved for an individual care plan would be drawn from a range that should include (but not necessarily be limited to) the following: personal care services, nursing care, homemaker and home health aide services, medical supplies and equipment, home modifications, electronic emergency response systems, adult day care, medically necessary transportation, physical and speech therapy, and medical social services including patient and family health counseling and training of family caregivers.

Costs should be controlled by adhering to strict disability criteria, requiring a copayment, and actively managing individual care plans in order to avoid the use of unnecessary services rather than by limiting the types of service covered by the program. There would, of course, be no prior hospitalization requirement, and the present elderly and disabled covered by Medicare would be immediately eligible for coverage. There should probably be a short waiting period after an application has been filed before coverage begins—in effect, a deductible—but there should be no limit on the duration of coverage. Medicaid would be expected to cover the copayment for low-income beneficiaries (with states required to adopt liberalized minimum eligibility criteria that are consistent nationwide, as noted in Part 4, so that low-income people can count on Medicaid to cover copayments and other costs not covered by social insurance).

Administration of the home-care program could be by the states, through

the local care-coordinating agencies, with the federal government exercising active oversight, setting minimum benefit standards, and monitoring quality. Under this approach, funds would be allocated to the states in accordance with broad measures of need—principally the size of the eligible population and the fiscal capacity of the state. If the states are to have major administrative responsibilities, it probably makes sense for them to have a fiscal stake in administering the program by requiring them to pay part of the cost. Alternatively, administrative responsibility could be retained by the federal government, with various functions contracted out, as under Medicare.

Regardless of the form of administration, however, a federal financing initiative will be needed to make home-care services widely available, because the emphasis on nursing-home care under Medicaid and most private health-care plans has had the effect of limiting the availability of high-quality home-care services in many parts of the country—a problem that will present a major obstacle to the success of any new program and may take years to overcome. But one thing is sure: these services will not magically blossom in the absence of financing. Postponing the implementation of a plan until quality services are generally available would mean a more or less permanent postponement.²

It is important to acknowledge, once again, that we can expect the public cost of long-term care to become somewhat higher if a major part of the burden is met through a social insurance program rather than by a continuation of the present hodgepodge. Obviously, some significant new costs will develop because home-care services will become more widely available to more people in more communities. Partially offsetting these new costs, however, is the opportunity to control unreasonable outlays under a unified system of long-term care. No such opportunity exists with the present patchwork of public and private programs.

It is really not enough, however, to look at costs only in terms of *public* costs. The main difference between public and private costs is that one kind is more visible than the other. Public programs carry big price tags that make headlines, and it is only natural to exclaim: “We can’t afford *that!*” In contrast, although the ultimate cost of a haphazard approach to long-term care is extremely high, it may *seem* lower because it is not so readily visible and cannot be so readily quantified. What is the cost to society as a whole when an individual is denied access to care? Or when someone is sent to a nursing home because no alternative care is available? Or when a husband and wife are both impoverished by the cost of care being provided to one of them? Or when a working woman with children to support must quit her job in order to care for a chronically ill family member?

These kinds of costs are incurred every day in households throughout the United States. They may not make headlines, but they add up just the same. And one way or another, we pay the bills—a bill for needs neglected and a bill for burdens borne unfairly by those who, with a little help, might have been able to cope but instead are forced into dependency. Regardless of how we approach the arithmetic of costs, a universal public insurance program clearly represents the best way to make manageable for each of us the cost of protecting all of us.

There are ways to keep the costs of a public program within reason. A home-care benefit need not pay *all* the costs of home care. There is no reason to substitute paid services for all of the informal services currently being provided by relatives or friends. On the contrary, a public program should be designed to encourage and support the continuation of informal services whenever possible.

One way to reduce an undesirable shift away from family caregiving is to require a copayment, so that the family can see an economic advantage in continuing to provide informal family care. There will be problems, however, in determining the optimum cost-sharing arrangement. A copayment high enough to discourage the unnecessary use of paid services may also become a barrier to the use of necessary services. And, other economic considerations aside, many older people without access to informal care would be unfairly burdened by a high copayment. Thus the level of a home-care copayment will need to be a compromise.

Probably more important than copayments in controlling the use of unnecessary home care services will be the administrative process of determining the need for and appropriate use of services. This process will be complex, requiring coordination between federal, state, local and private agencies, but there are opportunities to build on the experiences of various innovative programs that have demonstrated the feasibility of serving the needs of patients and their families while also controlling costs.³ At their best, they provide the consumer with a single access point to a range of care services, and the care coordinator's continuing involvement means that the need for services can be assessed, modifications made as needed, and unnecessary costs avoided.

■ **RESPIRE CARE:** As previously noted, most home-care plans will rely heavily on the availability of a primary caregiver—usually a spouse or other family member. We need to reduce the burden borne by such caregivers.

Someone who takes responsibility for caring for a dependent person over a long period of time needs to know that at least brief periods of respite will be available from time to time; otherwise the burden is likely to become

overwhelming, as anyone knows who has tried to take care of someone suffering from a progressively debilitating disease. Caregivers need assurance, too, that the cost of respite care will be affordable and that the dependent person will be competently cared for when the caregiver must be absent.

Society as a whole will benefit if respite care is made broadly available because people who might hesitate to take on the burden of providing home care will be more likely to do so if they can count on periods of respite—thus reducing the likelihood that the patient will have to be institutionalized because of the absence of an alternative.

Designing a respite-care benefit is a somewhat different challenge from designing an individual care plan that provides services to a patient on a continuing basis. Respite care is a time-limited concept; that is, the benefit should be specifically designed to relieve family caregivers for brief periods of time—such as when the family goes on an annual vacation or when key caregivers must attend to out-of-the-ordinary obligations that make it impossible for them to provide their usual attention to the patient. The benefit need not be open-ended, but it does need to be flexible.

In some cases, the need for a temporary respite may be handled relatively simply—for example, by paying for a home health aide for a few days. In other cases, a respite-care plan could involve arranging for the dependent person to be taken daily to a community facility such as an adult day-care center for a few days, or perhaps to a nursing home or residential facility for a short stay.

A limited respite-care benefit is, as noted elsewhere, part of the new Medicare Catastrophic Coverage Act. Although the benefit will be available only in limited situations, it at least provides a base to build on. When eligibility requirements are met, Medicare will, under certain specified circumstances, pay for the temporary services of a home health aide and



ART / TODD DAWSON

REST FOR THE WEARY

A flexible respite-care benefit will be crucial to the success of any long-term care plan designed to rely in large part on informal caregivers. Otherwise the burden of caring for a chronically ill person can simply become overwhelming.

personal care services to provide a respite for a spouse, relative, or friend caring for a Medicare beneficiary who cannot be left alone. The benefit cannot exceed a total of 80 hours of respite-care services in a year.⁴

Under a universal long-term care plan, this benefit should be improved. To begin with, the 80-hour limit may be too restrictive in many cases. At eight hours a day, five days a week, it would cover two weeks—arguably enough for, say, an annual family vacation in a situation where friends or other unpaid caregivers can augment paid home-care services by, for example, being available during evenings and weekends. But suppose the beneficiary needs assistance during both daytime and evening and no volunteer informal caregiver is available. At 16 hours a day, an 80-hour benefit covers only five days. Moreover, the benefit as provided under the new law requires Medicare beneficiaries to have incurred major out-of-pocket expenses before paid respite care will be covered. If people are to be encouraged to provide continuing informal care, they will need to know that, within reasonable limits, periods of relief are available without having to meet unduly burdensome and expensive requirements.

■ **NURSING HOME CARE:** Designing a system to finance and deliver high-quality home-care services nationwide is clearly the biggest challenge in developing a comprehensive long-term care plan. But nursing-home care will continue to be a necessary part of long-term care—and the most expensive part.

As with home care, it makes sense to try to control part of the public cost of nursing-home care through the use of copayments. The rationale, however, is somewhat different. With home care, the main reason to have a copayment is to provide an incentive for family caregivers to continue relying as much as possible on informal care rather than turning entirely to paid services. When someone goes into a nursing home, on the other hand, income that would have been used to cover food-and-shelter costs at home becomes available and may reasonably be used to help cover the same kinds of costs in the nursing home.

Since just about everyone who is retired has Social Security benefits and many also have supplementary benefits from private or public pension plans, and since the purpose of these retirement arrangements is to meet regular expenses such as food and shelter, there is no reason for a public long-term care program to cover all of the room-and-board costs of a stay in a nursing home. Thus there is a strong argument for a cost-sharing arrangement. But, as with home care, determining the optimum copayment may be difficult.

A flat 30-percent copayment might seem reasonable, since it roughly corresponds to the percentage of nursing-home costs that are attributable to room and board.⁵ And indeed it might be entirely reasonable for large numbers of nursing-home residents who no longer have a spouse in the community and who, having no prospect of returning to the community, have sold or otherwise disposed of their homes.

A problem arises, however, in the case of a couple when one spouse goes to a nursing home and the other continues to maintain their home. In that situation, household food costs can be expected to decline, but the cost of shelter may not be reduced much, if at all. Thus a 30-percent copayment may be excessive for a nursing-home resident who has a spouse or other dependents living at home or who, even in the absence of dependents, continues to maintain a home in the expectation of being able to return there.

One way to address these varying circumstances would be to begin with a 15-percent copayment during the first six months of a nursing-home stay. Thereafter the copayment would remain at that level only if the patient has a spouse or other dependent in the community; otherwise it would be increased to 30 percent.

Analysis of unpublished data from the 1985 National Nursing Home Survey indicates that only about 1 percent of all seriously disabled nursing-home residents who have been in a nursing home for as long as six months and who do not have a spouse living in the community can be expected to return to a private or semi-private residence.⁶ Thus it would seem that increasing the copayment from 15 to 30 percent after six months when there is no spouse in the community is a reasonable adjustment to the fact that in the overwhelming majority of such situations the nursing home has become the patient's permanent residence.

The nursing-home benefit should cover personal (custodial) care as well as intermediate and skilled nursing care and should be available to anyone who meets the previously described eligibility criteria for home care. The benefit would be administered as an integral part of the individual care plan and by the same care-coordinating agency, which would determine, in consultation with the patient and family caregivers, whether institutionalization had become preferable to home care.

Private insurance could be sold to fill in the deductibles and copayments for both home care and nursing-home care and to cover whatever the social insurance plan does not. Medicaid would have to cover copayments and any other required but uncovered long-term care costs for those without private insurance and unable to pay such costs on their own.

FINANCING THE PROGRAM

Social insurance programs, both in the United States and abroad, have traditionally been financed largely by earmarked contributions from workers and employers. That is, of course, the way we finance the principal programs administered through the Social Security system: Old Age, Survivors and Disability Insurance (OASDI) and the Hospital Insurance (HI) part of Medicare.⁷ In deciding how to finance a long-term care program of social insurance, it is useful to look first at the financing of OASDI and HI and at the present and future costs of these programs.

Employees currently contribute 7.51 percent of their earnings to Social Security: 6.06 percent to OASDI and 1.45 percent to HI. These deductions from earnings are matched by employer contributions. The OASDI contribution rate is scheduled to increase to 6.2 percent in 1990, with the HI contribution rate remaining at 1.45 percent; thus the total employee contribution rate will be 7.65 percent of earnings, matched by employers. Under present law no further rate increases are scheduled for either OASDI or HI.

Although OASDI benefit payments are increasing in absolute terms, the cost of the program is more accurately measured as a percent of the covered payrolls on which program financing is largely based. Expressed that way, the cost of the program has been declining, and is expected to remain at levels below those of the recent past until well into the next century. The cost of OASDI benefits in 1989, for example, is expected to be 10.36 percent of payrolls, compared to 11.94 percent in 1982—a decline of 13 percent in seven years. The cost is projected to decline to 10.27 percent by the year 2000 before climbing moderately to 10.76 percent in the year 2010, and then continuing to climb to 12.03 percent (roughly the 1982 level) in 2015.⁸

Throughout this period, then, the combined contribution rate—12.40 percent of payrolls—will be producing income much greater than the cost of benefits.⁹ Moreover, the annual surpluses will be even larger, since the income derived from partially taxing the benefits of higher-income beneficiaries is returned to the trust funds, and interest is earned on the reserves as they build.

Although benefit payments will begin to exceed income from contributions and taxation of benefits in about the year 2020, the reserves will continue to build for another decade after that because of interest earnings. Then it will become necessary under present arrangements to start cashing in the bonds held by the trust funds. It is thus entirely correct to say that the OASDI program is in good shape, with costs that should be manageable not only in the near term but for a very long time before it may become necessary to change the contribution rates scheduled in current law.¹⁰

The cost of the hospital insurance program, on the other hand, has been rising both in absolute and relative terms. It reached 2.52 percent of payrolls in 1988 and is projected to reach 3.42 percent in the year 2000 and 3.96 percent in 2010. That is substantially higher than the combined employee-employer contribution rate—2.90 percent of payrolls—scheduled under current law. In their 1988 report, the Social Security trustees estimated that HI reserves, including interest earnings, will continue to build only until 1997 and will then decline, with the system requiring additional financing early in the next century. Exactly how much and how soon will depend on a number of variables, including the impact of research on the diseases of the elderly and the effectiveness of cost-containment efforts, but there is no question that the HI program will require additional funding. Twenty-five years from now, assuming no major savings from research and cost control and no major changes in HI benefits, the employee contribution rate needed to sustain the program could be as much as 2.2 percent of earnings, with further increases necessary thereafter.¹¹

Medicare Part B, covering mainly physicians' charges, is technically not under-financed (since close to three-fourths of the cost is funded through general revenues and it can be assumed that more of those revenues will be directed to the program as costs rise), but it is increasingly burdensome, both to taxpayers generally and to those covered by the program who must pay more and more in premiums to help cover program costs. And the Medicare program now also includes catastrophic protection, with benefits intended to be fully financed by an increased premium paid by all covered beneficiaries and by a supplementary income-related premium to be paid by about 41 percent of all beneficiaries. About 5.6 percent are expected to be paying the maximum (\$800 in 1989).¹²

As we consider the financing of a new social insurance program for long-term care, we can hardly afford to ignore the underfinancing of Medicare and the increasing costs of medical care in general. We can and should look for ways to save money. The fact that, even with great gaps in coverage, we are currently paying 11.3 percent of our gross national product for health care—more than any other nation—tells us there is fat to trim.¹³ Increased efforts to control unnecessary services are clearly worthwhile, as are efforts to prevent illness from occurring in the first place. It may be bad for some hospitals if fewer people have to go to them, but it is good for the people who don't have to go, and for the rest of us who share in the savings.

There are savings to be realized, too, from the efforts of the Department of Health and Human Services to determine which medical procedures work and which do not, so that Medicare can pay only for efficacious treatment. Limiting payments to hospitals on the basis of diagnosis has

helped control the length of hospital stays. In the offing are other attempts to control costs—such as fee schedules based on the cost of resources going into a treatment, together with controls on the volume of services provided and limits on the amount of additional fees a physician is allowed to charge (balance billing), as recommended by the Physician Payment Review Commission.¹⁴

Still other opportunities to save are further down the road, such as requiring doctors to accept the fee schedule as full payment and perhaps reimbursing primary physicians on a per-capita basis for the services they render to Medicare patients. And we can certainly save by simplifying the administration of health insurance. After a quarter of a century of experience with Medicare and Medigap, we ought to be able to overhaul many of the needlessly complex arrangements that force beneficiaries, hospitals, physicians and other providers to struggle with seemingly endless red tape.

In the long run, important savings should also accrue from efforts to accelerate research on the causes of the progressively debilitating diseases of old age. We should therefore guarantee the funding of this research as part of any health insurance program by specifying that a portion of the contribution rate is to be specifically earmarked for this purpose. (If, for example, the income from 0.05 of 1 percent of earnings covered by Social Security were dedicated to research, it would produce an average of roughly \$1.4 billion a year from 1990 through 1994.)¹⁵

Aside from humanitarian considerations, it just makes good business sense to invest in this kind of research as a way to control the cost of health insurance. Consider the implications for Alzheimer's and related diseases. With the 85-and-over population projected to reach more than 16 million by the year 2050, in the absence of research breakthroughs we will have to anticipate caring for perhaps as many as 4 million Alzheimer's patients in this age group alone—and another 3 to 4 million in the 65-to-84 group.¹⁶ Alzheimer's is a particularly good example of the importance of guaranteed funding because research on the causes of dementias is, by its nature, multi-year research. Funding cannot be switched on and off without doing great harm. When prospects for stable long-range funding are uncertain, able researchers are likely to be lost to other projects.

When all is said and done, however, it needs to be acknowledged that there is a limit to what can be accomplished by strategies to save money. In the long run Americans are going to be paying more, not less, for our health care. Costs are driven in part by our ability to do things in medicine that we couldn't do before—joint replacements, heart bypass operations, organ transplants and other manifestations of high-tech medicine—but also by doing better what we used to do less well, as in the case of cataract

operations. The increasing frequency of satisfactory outcomes justifies the increasingly widespread use of these procedures. Hardly a month passes without new discoveries that improve on existing procedures; some of them save money, but on the whole they increase our outlays for health care even though they improve the quality of that care.

Equally important, demographic and socioeconomic trends are combining now to create future costs that, if not addressed, could far exceed those we have thus far experienced. Demographic trends may be more or less inexorable, but socioeconomic trends are another matter. An aging society must, of course, anticipate major health-care cost increases. That much is unavoidable. We do not, however, have to accept as inevitable the costs associated with denying adequate health protection to millions of children in families that cannot afford health insurance. But as long as we do—as long as we are willing to tolerate broadly unmet needs such as prenatal care, preventive health services, and mental health care—we face the prospect of paying bills in the future that will be accompanied by very heavy penalties for late payment.

For all of these reasons, then, we should assume that the financing of a long-term care plan should be worked out in coordination with efforts to address other health-care financing challenges. Sooner or later (preferably sooner) we must confront the developing shortfall in Medicare Part A funding that will, unless corrected, jeopardize the hospital insurance program. And an even greater challenge is the question of what to do about the more than 40 million people under 65 who either have no health insurance at all or who are grossly underinsured.

It is important, too, to adopt an approach to financing long-term care that can be expected to provide stable and adequate funding for many years. As with other major health programs, long-term care requires long-term financing.

A good case can be made for continuing to finance our present social insurance programs primarily from deductions from workers' earnings matched by contributions from employers (frequently referred to as the payroll tax). The best argument is that this approach works so well for so many, as Social Security in its entirety has demonstrated. Nearly everyone contributes to financing benefits (either directly or as a dependent of a contributor) and thus earns the right to receive benefits.

Not everyone agrees that this is the best approach. Financing a program through earnings deductions is sometimes criticized as regressive, because the deduction represents a comparatively greater hardship for lower-paid workers, income from sources other than earnings is not taxed, and earnings income above a ceiling is exempt. (Income above \$48,000 is exempt

from taxation for Social Security in 1989; the ceiling is adjusted each year as average wages rise.) Seen as a whole, however, Social Security is quite progressive, since the benefit formula is heavily weighted to favor those with a history of lower earnings. They get back in benefits considerably more per dollar of contributions, and the very lowest wage-earners with children in the family are also eligible for an earned income tax credit that offsets not only their contributions but most of their employers' contributions as well.

The Medicare hospital insurance program is even more progressively financed, since the benefits package is the same for everyone but higher-paid earners pay more for it. Someone earning \$10,000 and someone earning \$48,000 pay the same percentage of earnings to the HI program—1.45 percent—but the lower-paid worker pays \$145 and the higher-paid worker pays \$696 for exactly the same package of benefits. And the new catastrophic plan is also financed progressively. Progressive financing is, of course, the reverse of how private insurance is financed; a flat premium represents a much greater burden for lower-income than for higher-income policyholders.

There are several ways of financing a new long-term care insurance plan, and a combination of several approaches is possible. Let us first examine the traditional method of adding to deductions from workers' earnings with matching contributions by employers.

It has been estimated that the net additional cost of a comprehensive social insurance long-term care plan (that is, the cost of providing protection above and beyond what is already being paid for by Medicare, Medicaid, and other public programs) would be approximately \$20 billion in 1990.¹⁷ If only the net increase were to be financed for, say, the next 60 years, it would require adding about a 0.75 percentage point increase in the Social Security contribution rate for employees, with a matching increase for employers.¹⁸

However, we need to look at more than the net additional cost of the new program, because the burden of financing long-term care would shift as the social insurance program became responsible for meeting costs currently met by other programs. Currently, to the extent that Medicaid finances long-term care, that burden is being borne jointly by the states and the federal government, but long-range cost estimates should be based on assuming that under a comprehensive social insurance plan a very large proportion of the total public cost of long-term care, estimated to be as high as \$50 billion in 1990, will eventually be met through the social insurance program, with Medicaid playing a residual role.¹⁹

If we were to set a level contribution rate adequate to finance the

program for 60 years—building a large reserve during the early years—the rate would need to be about 1.9 percent each for employees and employers. In other words, the 7.65-percent earnings contribution rate scheduled for 1990 would have to be raised to about 9.55 percent, matched by employers.

An increase of that magnitude would not have to be imposed all at once, however. It could be phased in, both because the cost of the plan would be comparatively low at first—rising as the elderly population grows—and because during a transition period part of the cost could continue to be met by Medicaid. Current nursing-home residents now being covered by Medicaid, for example, would presumably remain on the Medicaid rolls rather than being shifted to the social insurance plan, and the states and the general revenues of the federal government could for a time be required (through a maintenance-of-effort provision) to contribute to the new social insurance system.

If we adopt such a pay-as-you-go approach—as opposed to building a reserve in the early years by immediately charging a rate high enough to cover costs in later years—a contribution rate of 1 percent, matched by employers, should be sufficient for the first ten years. That rate would raise about \$50 billion in 1990.²⁰ Looking beyond the year 2000, however, with long-term care costs rising significantly and expected to continue to rise for many years, it would be necessary to adopt a schedule of increasing contribution rates. Assuming a continuation of the same maximum contribution and benefit base as in present law (increasing automatically as wages rise), such a schedule would look something like this:

2000–2010	1.2
2010–2020	1.4
2020–2030	1.8
2030–2040	2.3
2040–2050	2.7

It should be noted that if there are significant breakthroughs in research on the chronic diseases of the elderly, as may well happen, and we thus have in the long run a much lower incidence of Alzheimer's disease, osteoporosis, arthritis, and incontinence, for example, costs would be much lower. If disability rates among the very old were to decline as much as mortality rates are expected to, long-term care costs would be perhaps 25 percent less.²¹

There are, of course, ways of financing a long-term care social insurance plan in whole or in part other than by an increase in Social Security contribution rates. For example, we could:

■ *Enact dedicated personal and corporate taxes.* This retains the strength of the contributory approach by financing the program through a dedicated increase in the income tax rate (with a cap on the amount to be paid by high earners) coupled with a dedicated surtax on the corporation income tax. Over the course of a lifetime almost everyone would have contributed something through the personal income tax, and employers would have contributed through the corporate tax. Since the income tax is applied to unearned as well as earned income, it would be more progressive in its effect than the present Social Security tax. Increasing the present rates of the personal income tax from 15 to 16 percent and from 28 to 30 percent would raise \$30 billion in 1990. A 5-percent surtax on the corporation income tax would raise about \$5.7 billion.²²

■ *Remove the cap on earnings subject to Social Security taxes,* dedicating the additional revenues to financing long-term care. Raising the ceiling or removing it outright would also make the financing of Social Security more progressive. But this strategy should be approached with caution. A moderate adjustment of the cap might make sense. At some point, however, progressive financing can be overdone.

One of the key reasons why Social Security continues to enjoy broad popular support is that all earners do reasonably well under the system. But if higher-income earners had to contribute a percentage of every dollar of earnings—instead of having their income above a ceiling exempted—they could end up paying much more into the system than they would ever be likely to receive in benefits. Some redistribution of wealth is desirable in a social insurance plan, but if progressivity and redistribution are carried too far, there is a risk that the program will lose its insurance characteristics and, in so doing, will lose public support.

■ *Remove the cap on only the employer's share of the tax.* If the cap were lifted outright—that is, for both employee and employer contributions—for both OASDI and HI, income to the system would increase by about \$49 billion in 1990.²³ The income from removing the cap on only the employer's share, while in the short run raising roughly half as much, over the long run raises about as much as if the cap were lifted for both. That is because employee contributions to Social Security are linked to benefits, while employer contributions are not. If workers pay more into the system, traditionally they are entitled to receive more in benefits, but employer contributions to Social Security can be thought of as being for the general support of the program.²⁴

■ *Increase taxes at death.* Since 70 percent of all deaths in the United States occur in the 65-and-older population, and the proportion of those leaving

substantial estates is heavily concentrated at the upper end of the age spectrum, a surcharge on the estate tax dedicated to financing long-term care would represent a reasonable way for elderly people to help finance the new social insurance program without having to lower their living standard. A 10-percent surcharge on gifts and estates above \$200,000, for example, would raise about \$4 billion in 1990, with the amount increasing rather rapidly to \$5.5 billion five years later.²⁵ A similar argument can be made for taxing capital gains at death under the income tax and using the proceeds for this purpose, and such a plan would raise about \$5.5 billion in 1990. (The income from this change would remain level for several years.)²⁶ Either or both of these approaches might be especially appropriate as a way to help cover the cost of insuring those already old or disabled.

■ *Increase the taxation of Social Security benefits paid to higher-income beneficiaries*, dedicating the revenues to the long-term care program. Under present law, if a Social Security beneficiary has total income above \$25,000 a year for an individual and \$32,000 for couples, up to 50 percent of the OASDI benefit is taxable. If the benefit were taxed the same way as contributory private pension plans and government career plans—that is, taxing the part of the benefit that exceeds what was actually contributed by the pensioner while working—about 85 percent of the benefit would be taxable. Applying this formula only to those who exceed current income thresholds would produce an additional \$3.1 billion in 1990.²⁷ Lowering the thresholds to \$12,000 for individuals and \$18,000 for couples in addition to taxing 85 percent of the benefit would produce about \$9 billion in 1990.²⁸ (In both cases these are near-term figures which would increase as the number of higher-income beneficiaries rises.)



There are other possible approaches to financing. For example, changes could be made in the rules governing tax subsidies for private pension funds (principally tax-protected earnings on accumulated funds), in effect taking back some of the subsidy and then using it for another retirement purpose. Two proposals that would reduce private pension subsidies have been made. One would decrease the limits on contributions by employers for high-earning employees. At present, tax-protected contributions to qualified pension and profit-sharing plans can go high enough to produce pensions of \$128,900 a year. (This limit applies to a combination of a defined-benefit plan and a defined-contribution plan from the same employer.) Since only one half of one percent of all employees earn more than this amount when working full-time, it is doubtful, to say the least, that the taxpayers as a whole should be subsidizing pensions up to such high levels. If the dollar

funding limits for defined-benefit plans were lowered to the Social Security wage base (projected to be \$50,700 in 1990) with comparable reductions in limits for defined-contribution plans, the amount raised in 1990 would be about \$3 billion—and revenues thereafter would increase year by year, even if the limits continue to be indexed as they are today.

The other possibility is for a minimum tax on the investment income of qualified pension and profit-sharing plans, individual retirement accounts, Keogh plans, 401(k) plans, and perhaps other tax-protected retirement vehicles. For example, a 5-percent tax on the realized investment income of such plans would produce about \$6 billion in 1990 and greater amounts year by year thereafter.²⁹

It would also be possible to recapture from pensioners themselves a portion of the windfall that resulted from the dramatic tax rate reductions made by the 1981 tax changes and by the Tax Reform Act of 1986. The reduction in tax liability as a result of tax rate changes was estimated to be \$13.6 billion in fiscal year 1988, and that amount will grow in later years. These changes constitute a windfall because when, in prior years, tax-protected contributions were made to pension plans it was expected that a large part of the tax loss would later be made up by taxes on pensions when received, but the cuts in tax rates have meant that much less is being recovered than was expected. Recapturing some of this windfall would call for a special tax on pension benefits in addition to the income tax rates now applied. It might be possible to secure \$5 to \$10 billion a year from this source for many years into the future.³⁰

In discussing the cost of the program, it should be remembered that there would be some important offsets. The sharply reduced burden on Medicaid, for example, would mean that substantial federal and state resources that are now being consumed by nursing-home costs could be redirected to better serve the needs of other Medicaid-eligible population groups, particularly children in low-income families. And the most important offset, of course, would be the savings to millions of families whose resources would otherwise be at risk of being devastated by the burden of long-term care. It bears repeating that most of the costs of an insurance plan are costs that will have to be met anyway but in the absence of insurance will fall with disproportionate impact on those facing huge long-term care expenses.

ALTERNATIVE APPROACHES

The approach to universal long-term care protection described on pages 75–83 relies heavily on social insurance, leaving comparatively minor roles for private insurance, individual savings, and Medicaid. There are, of

course, other ways to assign roles so that public and private costs are distributed differently.

One alternative that greatly reduces the role of social insurance is to provide a comprehensive home-care benefit but to require a long waiting period before covering the cost of a nursing-home stay. The social insurance program might, for example, begin covering nursing-home costs only after a patient has been in a nursing home for two years or more.

Variations of this proposal have been heard from some representatives of the insurance industry and have attracted support among some policymakers. A positive way to look at this approach is to say that it controls the cost of social insurance while still protecting against the kind of cumulative and ultimately overwhelming financial burden that can be incurred when someone remains in a nursing home for a very long time. But there is no escaping the fact that this approach would leave it up to the patient and family to figure out how to cope with an extraordinarily large deductible—that is, the full cost of care for the first two years.

Based on current costs, that deductible could easily exceed \$60,000 for someone going into a nursing home in 1989, and will of course be much greater in the future as nursing-home costs continue to rise. Few people could possibly hope to cover an expense of such magnitude entirely on their own. Faced with a two-year wait before they could expect any help from social insurance, most people would presumably exhaust their own resources and would then be forced to turn to Medicaid—unless they had bought private insurance to fill the two-year gap.

That, of course, is the key to this approach. The theory behind it is that the public cost of long-term care can be greatly reduced by creating a greatly enhanced market for private insurance—and that the market will be enhanced both because there will be a strong demand for insurance to fill the two-year gap and because insurers will be able to offer much more



**'BUT WHERE WILL WE
FIND THE FUNDS TO
PAY FOR A NURSING HOME?'**

Proposals that would cover nursing-home costs under social insurance only after a long waiting period would leave patients and families struggling to cope with the impact of a very high deductible.

broadly affordable policies if they know that the maximum risk exposure for any given policy will be no more than two years.

There is no doubt that this approach would stimulate the sale of private insurance—that is, to people who are relatively well off and able to pass insurers' health screening criteria. It might even stimulate the market for private insurance enough to marginally lower the total public cost of long-term care. But it would create many problems.

To begin with, this approach would leave entirely unprotected the two groups with the most immediate need for protection: those who are already old or disabled and those whose health problems make insurers unwilling to accept them. Enhancing the market for private insurance would not help them, because even under the most optimistic assumptions they could neither afford nor qualify for coverage.

Moreover, very large numbers of lower- and moderate-income people would still have to rely entirely on Medicaid if forced into a nursing home by a long-term illness. Even if they had actively wanted to buy private insurance to fill the two-year coverage gap, in most cases they would have had to use any spare income to meet more immediate priorities. So with this approach they would have no more protection against the risk of being rapidly overwhelmed by nursing-home costs than they have now.

At the same time, however, they would in most cases have been contributing from their earnings to help finance the public part of the program. This raises a basic question about the equity of the proposal. Social insurance programs in the United States have generally been designed to serve all income levels and to offer lower-income contributors more in relation to their contributions than higher-income contributors. This proposal turns that principle on its head. Workers would have to contribute to a long-term care protection program that would not in fact protect them.³¹

Only those who could also afford private insurance or meet a two-year deductible on their own would be served by this approach. And its effectiveness, even as a device to protect relatively well-off people, depends on private insurers being able to market policies that guarantee adequate protection, getting the great majority of middle-income Americans to buy these policies, and not letting them lapse—a doubtful outcome. And even among those who buy and retain these policies, situations would inevitably develop in which some policyholders, after decades of faithfully paying premiums, would still find themselves facing major out-of-pocket expenses because of a greater than anticipated gap between benefit levels and nursing-home costs—the gap having developed either because benefit levels were too low all along or because they had not kept pace with increases in nursing-home costs.

This approach, if adopted, would be likely to create an unstable situation. The new home-care benefit would be important but would not, of course, protect those who, for whatever reason, have to go into a nursing home. The nursing-home benefit, with its two-year waiting period, would be of no use to the majority of nursing-home residents because they would need help long before two years had elapsed and would not have been able to afford private insurance. People who had been paying into a program called “long-term care insurance” would have good reason to wonder just what it was they had been paying for, and public pressure would build to reduce or eliminate the two-year waiting period.

At that point, the respective roles of public and private insurance would once again become the focus of legislative debate—creating anew exactly the kind of controversy and uncertainty insurers want to avoid when they are trying to develop a stable market for their products.

The Executive Panel of the Ford Foundation’s Project on Social Welfare and the American Future has recommended federal long-term care insurance after a two- or three-year waiting period but with a federal subsidy to help lower-income households buy private insurance covering the deductible period.³² (The report does not provide details about the proposed sliding-scale subsidy, but it prices the cost of the subsidy at \$7.2 billion a year.) There are still several problems with the idea of having a long deductible period, even if a subsidy is used to encourage lower-income families to buy private insurance to fill the gap:

- In spite of the subsidy, many people will not be able to buy the private insurance they need under the plan, and still others for whom the ability to buy is a close question will decide not to buy. This approach seems to be based on the idea that most older people can afford private long-term care insurance without undue sacrifice and that therefore the subsidy can be kept relatively low and still do the job. That notion ignores the distribution of income among the elderly. For every elderly household with more than \$50,000 in income, there are seven with less than \$15,000.³³ The fact is that most retired people live mainly on their Social Security benefits and have few, if any, other resources to call upon.³⁴

- This approach is unnecessarily expensive. Built into the cost of private insurance are costs that either are not part of social insurance or are much lower on a per capita basis: the costs of promotion, sales commissions, and profits, plus the higher cost of administration.

- There is also reason to be concerned about the fact that lower-income people would have to submit to a means test in order to qualify for the subsidy. Under Medicare today, the only difference in the treatment of

lower- and higher-income people is that those at the high end of the income scale are expected to pay a higher premium as part of their income tax to help cover the cost of the new catastrophic protection plan. But the great majority of beneficiaries with modest income are not subjected to any kind of inquiry or scrutiny regarding their relative ability to pay premiums.

The panel presents its plan as if this approach represents the only alternative to a more comprehensive and therefore more expensive plan. But there is, in fact, another option that merits consideration.

A PROMISING COMPROMISE

It is possible to approach long-term care insurance in a way that addresses these concerns at relatively manageable cost. Under this approach, home care would be covered exactly as in the plans previously discussed—that is, the cost of home-care services would be covered by social insurance (except for a copayment) with no limit on the duration of the social insurance benefit. The important difference would be in coverage of nursing-home costs. Rather than cover a nursing-home stay only after a long waiting period, the social insurance benefit would begin immediately (or after only a very brief waiting period) but would extend for a limited period of time, such as a year, continuing in effect thereafter only if the patient has a spouse or other dependents in the community.

The assumption behind this approach is that a patient's income and assets should be protected as long as they are needed for the patient's spouse or other dependents or because the patient might be returning to the community, but that in the absence of these conditions the protection of assets becomes a matter of concern primarily for the patient's heirs, if any. In almost all cases, someone who remains in a nursing home for as long as a year and has no spouse or other dependent is going to become a permanent resident of the nursing home.³⁵ When that happens, it seems reasonable to use the patient's income and assets to pay for the cost of the nursing home, as long as sufficient income is set aside to provide for the patient's personal needs.

There are, of course, many people who would prefer to see their assets preserved for their heirs. That is an entirely legitimate concern for individuals, but whether it should be a high priority for a public program is arguable. This approach assumes that those who have substantial resources and are actively interested in protecting assets for heirs will buy private insurance designed to go into effect when the social insurance benefit stops. In the absence of such insurance (or after the exhaustion of insurance benefits),

however, patients will be expected to use their own assets and income to pay for care, and they will turn to Medicaid—an improved Medicaid, that is, as discussed previously—if those resources are inadequate.

This approach offers several advantages:

■ The public cost of long-term care is substantially lower under this plan than under a plan with an unrestricted nursing-home benefit because the income and assets of permanent nursing-home residents without dependents in the community are used to help cover the cost of care. This plan would cost at least a third less than a plan with an unlimited nursing-home benefit and would also be somewhat less costly than the approach discussed on page 93.³⁶ With a sustained major effort in research on the chronic illnesses of the old, it may well be possible to support such a plan more or less indefinitely for a level contribution rate of less than 1 percent of earnings for employees with matching amounts from employers. (Based on present cost projections, a level contribution rate would need to be more in the neighborhood of 1.3 percent of earnings.³⁷ But, as noted earlier, it is not unreasonable to expect that costs could be as much as 25 percent lower than projected if research into the causes of the leading diseases of old age produces significant results leading to more efficacious treatment and, even more importantly, to more successful preventive care. Thus the need to dedicate a portion of long-term care financing to such research cannot be stated too strongly.)

■ All those who contribute to financing the plan are eligible for benefits on an equitable basis, without first having to “spend down” or undergo a means test. The plan thus provides broad coverage in a manner consistent with the traditional principles of social insurance.

■ The plan protects those who are already elderly and disabled and those who cannot meet the health screening criteria of private insurance.

■ The plan is balanced, covering both home care and nursing-home care in a way that encourages home care when feasible without creating barriers to the use of a nursing home when necessary.

■ The plan promotes rehabilitation, since care is made available as soon as it is needed. Timely attention to rehabilitation can lead to a partial or full restoration of function. A plan with a long waiting period for nursing-home coverage, on the other hand, may lead to postponement of rehabilitation, resulting in higher care costs later.

■ The plan encourages individual savings because such resources can be retained to help meet household costs and to maintain a couple’s standard of living rather than being consumed by the cost of care.

■ The plan creates a logical and appropriate role for private insurance. Families wanting to protect assets for heirs will have good reason to buy private insurance, but no one needing to preserve assets for his or her own use or for a spouse or other dependent will have to rely on private insurance.

With this approach, insurance companies should be able to develop a major market among those with sizeable assets—perhaps with the cost of premiums shared in many cases by sons and daughters interested in preserving their parents' assets. But the extent of coverage achieved by private insurance will not be crucial to the success of the total plan, as would be true if social insurance were to cover nursing-home costs only after a long waiting period.

This approach provides for a stable division of responsibility between public and private insurance. With everyone protected against the cost of home care, respite care, and nursing-home stays as long as there is a personal need for the protection of income and assets, there would be no strong public pressure to extend social insurance coverage to the estates of permanent nursing-home residents without dependents in the community. The insurance industry would thus be free to develop a market among families who want such assets protected without having to worry unduly that Congress may change the rules.

Obviously this approach to long-term care insurance works properly only if accompanied by improvements in Medicaid. Although the social insurance plan becomes the first payer of nursing-home bills, Medicaid continues to have a major role in long-term care, and the risk remains that some Medicaid patients will be treated as second-class patients. It is thus imperative—as it is in any case—that Medicaid be further improved to assure that all those served by the program are properly protected.

The improvements needed include all those discussed previously in this report, especially the need for a federal requirement that all states adopt eligibility criteria guaranteeing Medicaid assistance to anyone who cannot otherwise meet nursing-home costs, coupled with more stringent enforcement of Medicaid nursing-home quality-of-care standards.³⁸ Because enactment of a social insurance plan would reduce Medicaid's share of the public long-term care cost burden, the saving to the states should be sufficient to pay for the improvements needed while also freeing their Medicaid programs to better serve other needy population groups.

There is a risk that some people will misunderstand how this plan is intended to work and will perceive it as being too limited. Someone hearing about something described in a brief news story as a "one-year nursing-

home benefit” is understandably likely to react by exclaiming: “One year? That’s not long enough!” The details are at risk of being overlooked. “One year? My grandfather was in a nursing home for five years and my grandmother went broke trying to pay the bills. In the end my husband and I had to pay the nursing home with the money we were trying to save for our daughter’s college education. How could a one-year nursing-home benefit possibly have helped us?”

The answer is that indeed the plan would have protected this family. The nursing-home resident in this example had a spouse in the community, so the benefit would *not* have been limited to one year—it would have been extended as long as the spouse continued to live in the community.

But it is quite true that this approach does not provide *total* insurance coverage. Anyone who is in a nursing home for more than a year and who does not have a spouse or other dependents in the community will be required to begin using his or her resources—including any private insurance that he or she may have bought—to pay for care. In such situations, those who do not have private insurance and whose own resources cannot cover the cost of care will have to turn to Medicaid. Assuming that Medicaid is improved, however, the question is whether this is such a bad thing, given what it will cost to provide a more totally comprehensive social insurance plan and given the high priority of other social needs. This approach, it can be argued, provides the necessary degree of protection but no more than that, while at the same time sharply limiting the circumstances under which it becomes necessary for nursing-home residents to apply for Medicaid assistance, thus restoring to Medicaid the opportunity to play a balanced role in protecting young and old alike.

THE NEXT STEP

Long-term care will continue to be a complex issue, and there is room for disagreement about how best to deal with it. But we should be beyond debating whether some federal action is needed. A public program is not an option; it is a necessity. The next challenge is to agree on a sensible plan—one that assigns logical roles to social insurance, private insurance, individual savings, and Medicaid—and then to implement it.

NOTES

PART 1

LONG TERM CARE: WHERE WE ARE NOW

- 1 U.S. Bureau of the Census, *Current Population Reports*, Series P-70, No. 8 and unpublished data.

In addition to the estimated 31.1 million Americans who have no health insurance protection at all, there are an estimated 10 million or more for whom protection is very inadequate—adding up to nearly 20 percent of the total population that is either uninsured or grossly underinsured. The view is put forward by some that this problem will be handled more or less automatically by a combination of employment-related group health insurance and Medicaid for low-income and unemployed people. This is not the case. Although group health insurance for workers is widespread, many people in low-paying or part-time jobs or working for small employers are not covered, and the situation is getting worse, not better. Between 1975 and 1985, for example, the percentage of the population with hospitalization insurance declined from 82 to 74 percent, according to the Health Insurance Association of America.

During the recession of 1981-82, when the unemployment rate rose to 9.5 percent, the number of uninsured Americans increased quickly. This was not surprising, since having private health insurance protection depends in most cases on having a job. What is striking is that the situation has not improved much if at all during the recovery years. The characteristics of employment are changing, and, as many economists have noted, recovery can mean returning to previous levels of employment quantitatively but not qualitatively—that is, fewer jobs are accompanied by equivalent benefits. Thus the relationship between employment and insurance is increasingly tenuous, and in fact the great majority of those without health insurance today live in households where there is at least one worker. This situation suggests that if we go through another recession in the next few years, the number of uninsured could easily exceed 50 million.

Meanwhile, the vaunted “safety net” provided by the means-tested Medicaid program is full of holes—not just for the elderly but for people of all ages. According to the Congressional Research Service (in its *Medicaid Source Book: Background Data and Analysis*, prepared for the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce, November 1988), the Medicaid program, because of various barriers to eligibility, currently offers protection to only about 41 percent of the poor.

We are the only industrialized nation other than South Africa that has no system to assure health care for all. Consequences are unforgivably harsh. When high-risk pregnant women go without even basic prenatal care, infant mortality rates remain comparatively high and children are born burdened by the risk of having suffered permanent damage. We are getting farther from rather than closer to the goal of providing all of our citizens with the essentials of adequate health care regardless of individual ability to pay.

- 2 Estimates of “the long-term care population”—the number of Americans of all ages in need of long-term care services—are necessarily imprecise, mainly because of the limited data available on the number of people in the non-institutionalized population who currently receive only informal care but might be eligible for formal, paid-for care services under a national long-term care program. Estimates also vary considerably depending on the degree of disability used as a standard. For the purposes of this report, it may be said that the long-term care population essentially consists of persons of any age who are chronically unable to perform two or more of the basic activities of daily living (ADLs) unassisted, or are equivalently disabled by partial inability to perform three or more such activities, or require on-going monitoring or supervision because of mental impairment. (The basic activities of daily living include eating, transferring from bed to chair, toileting, bathing, dressing, and moving about.) Using these criteria, the long-term care population can be estimated as including approx-

imately 2,800,000 persons aged 65 and older, a figure which includes the estimated 80 percent of the elderly nursing-home population who meet this disability test. Estimates for the under-65 population are more difficult to arrive at because of the absence of reliable data for this population on specific numbers of ADL limitations; a less precise standard—those with one or more ADL limitations—must therefore be used. Using this standard, it can be estimated that roughly 263,000 children under 16 and roughly 2,645,000 persons aged 16-64 should be included in the long-term care population. Accordingly, for the purposes of this report the total long-term care population is estimated to be approximately 5,708,000.

LONG TERM CARE POPULATION	UNDER 16	16-64	65 AND OLDER
In institutions	63,000	445,000	1,200,000
Not in institutions	200,000	2,200,000	1,600,000
TOTAL	263,000	2,645,000	2,800,000

(Estimates are for 1989 and were supplied by the Lewin/ICF division of Health and Sciences Research Incorporated, Washington, D.C. Estimates for those 65 and older are based upon results from the 1982-84 National Long Term Care Survey conducted by the Health Care Financing Administration and the 1985 National Nursing Home Survey conducted by the National Center for Health Statistics.)

- 3 The “activities of daily living” (ADLs) are ordinarily defined as eating, transferring from bed to chair, toileting, bathing, dressing, and moving about. Services provided to help people perform these activities are known as “personal care services.” These activities and services are to be distinguished from measures of ability to perform certain tasks necessary for independent living, sometimes referred to as “instrumental activities of daily living” (IADLs)—such as shopping, preparing food, and doing housework—and the services that help people perform such activities. From a policy standpoint, the difference between ADLs and IADLs is important. Objectively assessing someone’s ability to perform IADLs is considerably more difficult than assessing someone’s ability to perform the basic activities of daily living.
- 4 National Academy of Sciences, Institute of Medicine, *Improving the Quality of Care in Nursing Homes*, 1986.
The Nursing Home Quality Reform Act, enacted in 1987, requires a number of improvements (some effective immediately, others to be phased in by October 1990) in staffing, protection of resident rights (including strengthening of the long-term care ombudsman program), handling of complaints, state certification procedures, and sanctions for failure to comply with regulations. See Robert N. Brown, *The Rights of Older Persons: A Basic Guide to the Legal Rights of Older Persons under Current Law, An American Civil Liberties Union Handbook*, 1989, pp. 287-323. (Appendix D, pp. 393-401, includes a state-by-state directory of long-term care ombudsmen.) For additional information on enforcement of nursing home quality-of-care regulations, contact the National Citizens Coalition for Nursing Home Reform, Washington, D.C.
- 5 Alice M. Rivlin and Joshua M. Weiner, *Caring for the Disabled Elderly: Who Will Pay?* The Brookings Institution, Washington, D.C., 1988, Technical Appendix, p. 265, updated to 1988 using the Consumer Price Index (Medical Care, Hospital and Related Services).
- 6 U.S. Congress, House Select Committee on Aging, *Long Term Care and Personal Impoverishment: Seven in Ten Elderly Living Alone Are at Risk*, Committee Print, Washington, D.C., July 1985.

A study conducted for the House Select Committee on Aging by Massachusetts Blue Cross-Blue Shield in 1985 found that as many as 70 percent of the elderly living alone would be at risk of impoverishment after as little as 13 weeks in a nursing home. It should be noted, however, that there is a shortage of reliable data on the percentage of nursing-home residents who become impoverished and on the speed with which impoverishment takes place. Many variables have not been adequately quantified, including the extent to which private-pay patients avoid the stigma of having to apply for Medicaid by receiving financial help from

relatives. See Denise A. Spence and Joshua M. Weiner, Economic Studies Program, The Brookings Institution, Washington, D.C., *Medicaid Spend-Down in Nursing Homes: Estimates from the 1985 National Nursing Home Survey* (forthcoming publication).

- 7 See U.S. Department of Health and Human Services, Health Care Financing Administration, *The Medicare Handbook*, 1989, HCFA Publication No. 10050, Washington, D.C., 1989, esp. pp. 10-12 and p. 22.
- 8 Basically, the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) seeks to protect Medicare beneficiaries against the risk of incurring certain kinds of catastrophic health-care costs by limiting the out-of-pocket expenses that can be incurred for hospitalization, doctors' services, prescription drugs, and covered stays in skilled nursing facilities. The Act also improves Medicare coverage of skilled nursing care and home health services, but does not extend coverage to long-term intermediate or custodial nursing-home care. The Act establishes a limited respite-care benefit for those caring for Medicare beneficiaries at home, extends coverage of hospice care for the terminally ill, and improves Medicaid by protecting more of the income and assets that may be retained by the spouse of a Medicaid-eligible nursing-home resident. The Act does not, however, extend Medicare coverage to most long-term care situations, i.e., those requiring mainly personal-care services to provide assistance in performing the basic activities of daily living. (The Medicare Catastrophic Coverage Act is discussed in greater detail in Parts 3 and 6 of this report, and is summarized in the *Medicare Handbook*, cited above. As this report was going to press, Congress was considering a major revision of the Act. See Note 12 to Part 6.)
- 9 U.S. Congress, Congressional Research Service, *Medicaid Source Book: Background Data and Analysis*, A Report Prepared for the Use of the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, U.S. House of Representatives, Washington, D.C., November 1988, Chapter V, pp. 149-166.

Historically, Medicaid has had a built-in bias toward paying for nursing-home care. Although Medicaid law allows the states to seek statutory waivers permitting them to use alternative methods to deliver Medicaid services—thus encouraging them, in theory, to avoid over-reliance on institutions—in practice they have been constrained by complex waiver requirements that have limited their ability to reimburse adequately for home- and community-based care services. Recently these requirements have been eased, to some extent, by various provisions of the Omnibus Budget Reconciliation Act of 1987 and the Medicare Catastrophic Coverage Act of 1988. See Chapter V of the *Medicaid Source Book*, cited above (see Note 1), for a discussion of the complexities of alternative delivery options and waiver programs. (The impact of the Medicaid program on long-term care is discussed in greater detail in Part 4 of this report.)

NOTES PART 2

LONG TERM CARE IN PERSPECTIVE: WHEN A PROBLEM BECOMES A CRISIS

- 1 U.S. Bureau of the Census, *Statistical Abstract of the United States: 1988*, Washington, D.C., 1987, Table 107, p. 71.
- 2 U.S. Bureau of the Census, Current Population Reports, Series P-23, No. 128, *America in Transition: An Aging Society*, Washington, D.C., 1983, and *Current Population Reports*, Series P-25, forthcoming report.
- 3 *Ibid.*
- 4 *Ibid.*
- 5 *Ibid.*
- 6 For a discussion of this problem, see The Villers Foundation, *On the Other Side of Easy Street: Myths and Facts About the Economics of Old Age*, Washington, D.C., January 1987, esp. pp. 5, 31. Representative newspaper and magazine articles include: Paul S. Hewitt, "Who Says We're Rich?", *Washington Post*, January 3, 1989; Phillip Longman, "Justice Between Generations", *Atlantic Monthly*, June 1985; Peter G. Peterson, "Why Subsidize the Moneyed Classes?", *New York Times*, July 18, 1985; Samuel H. Preston, "Children and the Elderly in the U.S.", *Scientific American*, December 1984; Paul Taylor, "The Coming Conflict As We Soak the Young to Enrich the Old", *Washington Post*, January 5, 1986; Michael Whinihan, "The Coming Collapse of Social Security", *Detroit News*, February 1, 1989. A representative recent book on the old-versus-young theme is Peter G. Peterson and Neil Howe, *On Borrowed Time: How the Growth in Entitlement Spending Threatens America's Future*, Institute for Contemporary Studies, San Francisco, Calif., 1988.
- 7 U.S. General Accounting Office, *Long-Term Care for the Elderly: Issues of Need, Access, and Costs*, GAO Report No. HRD-89-4, Washington, D.C., February 1989; and U.S. Congress, House of Representatives, Committee on Ways and Means, *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, Washington, D.C., March 1989, Table 16, p. 230. (Note that this is an inclusive estimate in that it is not adjusted for degrees of disability. See Note 2 to Part 1 of this report.)
- 8 U.S. Congress, Office of Technology Assessment, *Losing a Million Minds: Confronting the Tragedy of Alzheimer's Disease and Other Dementias*, Washington, D.C., 1987, pp. 5, 9.
- 9 U.S. Bureau of the Census, *Statistical Abstract of the United States: 1988*, Washington, D.C., 1987, Tables 622 and 623, p. 373; and U.S. Department of Labor, *Monthly Labor Review*, March 1988, pp. 3-8, and March 1989, Table 5, p. 66.
- 10 U.S. Bureau of the Census, *Current Population Reports*, Series P-25, No. 1000.
- 11 *Losing a Million Minds* (cited above), pp. 26-29.
- 12 *Losing a Million Minds*, p. 22. A broad range of estimates is possible, depending on assumptions about longevity and other variables.

- 13** Respite-care services are available in many communities. Even where available, however, when a caregiver hires a home health aide to provide short-term, temporary respite-care services when the caregiver must be away, the charges must usually be paid out of pocket, because neither private nor public health insurance will ordinarily cover the cost. Relatively few of the private long-term care insurance policies currently in force cover respite care. The Medicare Catastrophic Coverage Act of 1988 does include a respite-care benefit, effective January 1, 1990, to pay for the temporary services of a home health aide to provide relief to an individual who lives with and normally helps a Medicare beneficiary who chronically requires assistance with essential daily personal care. The benefit will be available, however, only in a small minority of long-term care situations. To be eligible, a Medicare participant must first have incurred substantial out-of-pocket costs—meeting either the supplementary medical insurance catastrophic limit for the year (\$1,370 in 1990) or the annual deductible for outpatient prescription drugs (\$550 in 1990). Only when these conditions are met will Medicare pay for up to 80 hours per year of home health aide care, nursing care provided by a licensed professional nurse, and personal care services. (See Part 3 of this report; and see Health Care Financing Administration, *Medicare Handbook*, 1989, cited above.)
- 14** *Losing a Million Minds* (cited above), p. 64; and Office of Technology Assessment estimate as reported in “Nursing Homes Try New Approach in Caring for Alzheimer’s Victims,” *Wall Street Journal*, September 26, 1986.
- 15** For a useful discussion of continuing-care retirement communities, see Alice M. Rivlin and Joshua M. Weiner, *Caring for the Disabled Elderly: Who Will Pay?* The Brookings Institution, Washington, D.C., 1988, Chapter 5, pp. 83-95, and pp. 146-151.

NOTES

PART 3

MEDICARE: A HOLE IN THE UMBRELLA

- 1 U.S. Department of Health and Human Services, Health Care Financing Administration, Division of Budget, January 1989.
- 2 Note that the \$31.90 monthly premium includes the new add-on specified under the 1988 Medicare Catastrophic Coverage Act to help fund new catastrophic illness and prescription drug benefits. The additional premium is \$4 per month in 1989, with phased increases annually thereafter to \$10.20 in 1993. The Medicare Catastrophic Coverage Act also includes a new supplemental premium to be administered through the federal income tax system. Individuals eligible for Medicare Part A will have to pay the supplemental premium if their adjusted federal income tax liability is at least \$150. The premium for 1989 is \$22.50 for every \$150 of tax liability; the maximum premium is \$800 for individuals and \$1,600 for couples (if both spouses are Medicare beneficiaries). (See Health Care Financing Administration, *Medicare Handbook*, 1989, pp. 2-3.)
- 3 Health Care Financing Administration, Division of Budget, March 1989. About 96 percent of all eligible aged and disabled beneficiaries have chosen to enroll in Part B.
- 4 The Medicare Catastrophic Coverage Act broadens this protection by phasing in, over a four-year period, a requirement that state Medicaid programs must pay all Medicare premiums, deductibles, and copayments for Medicare participants whose incomes are below the federal poverty line but too high to qualify for Medicaid coverage. In 1989, states are required to make such payments for all those with incomes below 85 percent of the poverty line; each year the income threshold rises by 5 percent until by 1992 all those below 100 percent of the poverty line are covered. (See U.S. House of Representatives, Conference Report, *Medicare Catastrophic Coverage Act of 1988*, May 31, 1988; and see Part 4 of this report.)
- 5 U.S. Department of Health and Human Services, Health Care Financing Administration, *Medicare Handbook*, 1989, esp. pp. 10-12. Personal ("custodial") care, the level of care required in most long-term care situations, is explicitly excluded. Moreover, only Medicare-certified skilled nursing facilities are approved for coverage, a restriction that precludes coverage of individuals in other nursing facilities, regardless of the level of care they are receiving. (Medicare-certified skilled nursing facilities account for only about a fourth of the nursing homes and residential facilities in the United States.) Prior hospitalization, formerly a requirement for coverage, is no longer required, but coverage is still limited to situations requiring skilled nursing care on a daily basis.
- 6 George Schieber, Joshua M. Weiner, Korbin Liu, and Pamela Doty, "Prospective Payment for Medicare Skilled Nursing Facilities: Background and Issues," *Health Care Financing Review*, vol. 8 (1986), pp. 79-85.
- 7 *Medicare Handbook*, 1989 (cited above), esp. pp. 11-12.
- 8 *Medicare Handbook*, pp. 1-2.

NOTES
PART 4

**MEDICAID:
A LONG TERM CARE POLICY BY DEFAULT**

- 1 Joel W. Cohen and John F. Holahan, *Medicaid: The Trade-off Between Cost Containment and Access to Care*, Urban Institute Press, Washington, D.C., 1986, p. 78.
- 2 Social Security Administration, *Social Security Bulletin: Annual Statistical Supplement*, Baltimore, Md., 1987, table 169.
- 3 U.S. Congress, Congressional Research Service, *Medicaid Source Book: Background Data and Analysis*, A Report for the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, U.S. House of Representatives, Washington, D.C., November 1988, pp. 17-19. Long-term care is defined to include spending for services in skilled nursing facilities and intermediate care facilities, but not intermediate care services for the mentally retarded.
- 4 *Medicaid Source Book* (cited above), Chapter VII, p. 197.
- 5 U.S. Department of Health and Human Services, Health Care Financing Administration, 2082 Report, September 25, 1987.
- 6 *Ibid.*
- 7 *Ibid.*
- 8 *Ibid.*
- 9 U.S. Congress, Congressional Research Service, *Medicaid Eligibility for the Elderly in Need of Long-Term Care*, CRS Report for Congress No. 87-986 EPW, by Edward Neuschler with the assistance of Claire Gill, Center for Health Policy Studies, National Governors' Association, Washington, D.C., September 1987.
- 10 *Ibid.*
- 11 *Medicaid Source Book* (cited above), pp. 80-81.
- 12 *Medicaid Eligibility for the Elderly in Need of Long-Term Care* (cited above), pp. 48-49.
- 13 National Academy of Sciences, Institute of Medicine, *Improving the Quality of Care in Nursing Homes*, Washington, D.C., 1986; National Citizens Coalition for Nursing Home Reform, *Consumer Statement of Principles for the Nursing Home Regulatory System, State Licensure and Federal Certification Programs*, Washington, D.C., 1983; Robert N. Brown, *The Rights of Older Persons: A Basic Guide to the Legal Rights of Older Persons under Current Law*, An American Civil Liberties Union Handbook, Washington, D.C., 1989, p. 291.

NOTES PART 5

PRIVATE INSURANCE

- 1 U.S. Bureau of the Census, *Current Population Reports*, Series P-60, No. 161, *Money Income and Poverty Status in the United States: 1987*, Washington, D.C., March 1988, Table 14.
- 2 Health Insurance Association of America, *Long-Term Care Insurance: Market Trends*, Research Bulletin, March 1989, p. 5.
References throughout this section to specific insurance companies and the policies they offer are intended only as illustrations and are not intended to imply that these policies are necessarily superior or inferior to policies available from other companies.
- 3 Based on author's analysis of representative long-term care policies available from major insurance companies as of May 1989; Health Insurance Association of America, *Long-Term Care Insurance: Market Trends*, Research Bulletin, March 1989 (survey of 30 companies); Consumers Union, *Consumer Reports*, May 1988, pp. 300-311 (analysis of 53 long-term care policies); and U.S. General Accounting Office, *Long-Term Care Insurance: Coverage Varies Widely in a Developing Market*, GAO Report No. HRD-87-80, Washington, D.C., May 1987 (analysis of 33 long-term care policies).
- 4 Census Bureau, *Money Income and Poverty Status in the United States: 1987* (cited above).
The poverty threshold for an individual aged 65 or older in 1987 was \$5,447; for an elderly couple the threshold was \$6,872. The poverty thresholds in 1988 as estimated by the Congressional Budget Office were \$5,671 for an elderly individual and \$7,154 for an elderly couple. About 45 percent of the elderly have incomes below twice the poverty level. (See U.S. Congress, House Committee on Ways and Means, *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, 1989 Edition, March 1989, Appendix I, Table 8, p. 919; Villers Foundation, *On the Other Side of Easy Street: Myths and Facts About the Economics of Old Age*, January 1987, esp. pp. 23-25). The Bureau of Labor Statistics calculated that an elderly couple with a pre-tax income of \$18,000 in 1985 could expect to spend \$17,000 on food, shelter, clothing, transportation, taxes, and other basic expenditures (not including nonprescription drugs, household supplies, and personal care items). (See U.S. Bureau of Labor Statistics, *Consumer Expenditure Survey: Interview Survey*, 1985.) It seems very doubtful that a couple with a net "surplus" disposable income of \$1,000 a year—less than \$85 a month—could conceivably be expected to commit it to paying for a long-term care policy (even if premiums were as low as \$85 a month for a couple), given the need to spend funds on more immediate needs and to save for other contingencies. It should be kept in mind, too, that elderly households with substantial surplus income are distinctly in the minority. For every household with more than \$50,000 a year in income, there are seven with less than \$15,000. (See Social Security Administration, Office of Research and Statistics, *Income of the Population 55 or Older*, 1986, Washington, D.C., June 1988, Table 10, p. 23.)
- 5 Fredric L. Bodner, "Long Term Care Insurance: The Regulator's Perspective" in *The PRIDE Institute Journal of Long Term Home Health Care*, PRIDE Institute, Department of Community Medicine, St. Vincent's Hospital and Medical Center, New York, N.Y., Volume 7, Number 3, Summer 1988, pp. 8-14. The author is chief of the Health and Life Policy Bureau of the New York State Insurance Department.
- 6 *Ibid.*
- 7 See Note 4 above.

- 8 *Consumer Reports*, May 1988 (cited above), p. 308; Paul S. Entmacher and James B. Weil, "Long Term Care Insurance: An Industry Perspective" in *The PRIDE Institute Journal* (cited above), p. 28.
- 9 A policyholder might be inclined to interpret this simply as a form of consumer protection—the assumption being that a Medicare-certified nursing home is likely to be of comparatively high quality—but in fact the existence of this restriction in a policy suggests that the policy may not pay benefits in many long-term care situations, if the care required is primarily personal (or "custodial"). Policies which closely track Medicare's coverage restrictions are likely to pay benefits only if the patient requires skilled nursing care and only if that care is provided in a Medicare-certified skilled nursing facility. If the language of a policy implies that personal care services are covered but still specifies that benefits are payable only when care is provided in a Medicare-certified facility, the restriction could severely limit a policyholder's choices. Only about a third of all nursing facilities are Medicare-certified and, since Medicare-certified nursing homes tend to be among the most expensive, this restriction could also result in incurring costs that could have been avoided if the only reason for choosing such a facility is to qualify for insurance benefits. And in some parts of the country, this clause could prove to be extraordinarily restrictive. In Mississippi, for example, only 12 out of 173 nursing homes were Medicare-certified in 1988, according to the Health Care Financing Administration. That does not necessarily imply that all the rest were substandard—technically it means only that they were not currently participating in Medicare—but a Mississippian with a policy limited to Medicare-certified facilities could have a very hard time collecting benefits, even if the policy nominally covers the kind of care being provided to the policyholder.
- 10 As a general rule, private policies tend to track Medicare's restrictions. Medicare, with its emphasis on paying for services required in connection with recovery from an episode of acute illness rather than for chronic illness, historically has paid for nursing-home care only following a period of hospitalization. This limitation was eliminated by the Medicare Catastrophic Coverage Act of 1988, and it can be assumed that most private policies will follow suit. It should be noted, however, that Medicare still restricts nursing-home coverage to situations in which a doctor certifies that the patient needs and is actually receiving skilled nursing or skilled rehabilitation services on a daily basis. Medicare will not pay for the stay if the patient needs skilled nursing or rehabilitation services only intermittently or if the patient mainly needs personal care services (e.g., "custodial" care). (See Health Care Financing Administration, *Medicare Handbook*, 1989, pp. 10-11.)
- 11 E. S. Sekscenski, "Discharges from Nursing Homes: Preliminary Data from the 1985 National Nursing Home Survey," U.S. Department of Health and Human Resources, National Center for Health Statistics, *Vital and Health Statistics*, No. 142, September 1987, p. 10.
- 12 James P. Firman, *Private Long Term Care Insurance: How Well Is It Meeting Consumer Needs and Public Policy Concerns?* United Seniors Health Cooperative, Washington, D.C., September 1988. See also U.S. General Accounting Office, *Long-Term Care Insurance: State Regulatory Requirements Provide Inconsistent Consumer Protection*, GAO Report No. HRD-89-67, Washington, D.C., April 1989.
- 13 In 1988, 10 Blue Cross and Blue Shield plans were selling long-term care insurance (covering about 8,000 policyholders). About half of the plans paid a fixed percentage of charges up to a maximum of \$95 for a day in a nursing home. Because of the maximum, as charges rise with inflation these plans take on more and more of the characteristics of an indemnity plan. (The special nature of coverage offered by Blue Cross and Blue Shield of Rochester, N.Y., is discussed in Note 16.) See Health Insurance Association of America, *Long-Term Care Insurance: Market Trends*, Research Bulletin, March 1989, pp. 14-17 and Appendix C.
- 14 Office for the Aging, New York State Executive Department, Albany, N.Y.; and Legal Counsel for the Elderly, Washington, D.C. (telephone conversations, March 1989). In these cities, nursing-home costs in 1988 were reported as typically ranging from about \$35,000 to more

than \$50,000 a year. These estimates may be understated because they are based in part on Medicaid reimbursement rates, which generally equal about 80 percent of the average private-pay rate. (See U.S. Congress, Congressional Research Service, *Medicaid Source Book: Background Data and Analysis*, A Report Prepared for the Use of the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce, November 1988, p. 475.)

- 15 Total expenditures on nursing-home care rose from \$10 billion in 1975 to \$20 billion in 1980 and \$35 billion in 1985. The average increase in the Consumer Price Index for medical care during this period was 9 percent per year. (See U.S. Department of Health and Human Services, National Center for Health Statistics, *Health, United States, 1988*, December 1988.) Over the 23-year period from 1965 through 1987, the medical care component of the CPI increased at an average annual rate of 7.6 percent. It seems reasonable, even conservative, to assume that nursing-home costs will increase in the future at the rate of 5 percent a year. An argument can be made that the cost of nursing-home care may tend to increase more gradually than in the past if policies are adopted to encourage more alternatives to institutionalization. Given the many other variables that affect the cost of health care in general and nursing-home care in particular, however, it seems safe to assume that costs will continue to rise more or less steadily in the near future and under any circumstances will keep pace with general increases in wages, which may well rise at an average rate of 5 percent a year. (See the 1988 Annual Report of the Board of Trustees of the Federal Old Age and Survivors Insurance and Disability Insurance Trust Funds, p. 96.) Regulatory pressures are forcing nursing homes to hire better-qualified personnel and to pay them higher wages and benefits—costs that will be passed on to consumers. (See, for example, “This Nursing Home Giant [Beverly Enterprises] May Need Intensive Care”, *Business Week*, November 7, 1988, pp. 124-126.)
- 16 Through a subsidiary (Finger Lakes Long Term Care Insurance Company), Blue Cross and Blue Shield of the Rochester area in New York offers long-term care insurance with a service benefit (on a cost-sharing basis, with the subscriber paying 25 percent of charges) in a plan that is largely protected against long-range inflation. To cover the anticipated cost of this protection, premiums are automatically increased 8 percent a year and the insurer retains the right to make additional across-the-board increases if deemed necessary, although policies are guaranteed renewable. (The New York State Department of Insurance has approved the rates for five years.) Reimbursement arrangements with nursing homes are on a year-to-year basis, automatically renewable but open to negotiation.

Subscribers may elect to pay for lifetime protection over a 20-year period if under age 50 or over a 10-year period if over age 50. After the subscriber pays the required premiums for the required number of years, the policy is paid up, no further premiums are charged, and the subscriber is entitled to a lifetime service benefit. Although the rates for lifetime protection are, of course, much higher than for continuing premiums (a 7¾-percent-per-year inflation assumption over remaining life expectancy is built into the rates), this offer of a lifetime service benefit fully paid up at a relatively young age does seem to represent true inflation protection for the subscriber—and true risk for the plan.

The plan covers home care, day care, and respite care without a deductible, and covers custodial nursing-home care with lifetime deductibles (20 or 90 days at the subscriber's option) and maximum benefit durations of three, four, or five years (again at the subscriber's option). The plan can be purchased individually and is offered at lower rates through groups. Active workers in groups of 100 or more are enrolled without medical screening; other subscribers are carefully screened. In policies sold through employers, coverage is offered to workers, retirees, and family members related by blood or marriage.

Blue Cross of Rochester is now offering two other long-term care products, but during 1988 only this plan was available.

The only health maintenance organization offering extensive long-term coverage, Group Health of Puget Sound in Washington, does so on a service basis, but long-range rates are not guaranteed. No commercial insurance company or Blue Cross plan other than Blue Cross of Rochester is believed to be offering a service benefit without a dollar cap.

Typical rates for the most liberal version of this Rochester plan—a 20-day deductible with a 5-year benefit maximum—are:

INDIVIDUAL		GROUP	
Age	Annual Premium	Age	Annual Premium
21	\$ 145.56	21–25	\$ 137.52
40	296.28	36–40	240.60
50	474.24	46–50	383.64
60	816.72	56–60	669.36
70	1,347.36	66–70	1,063.44
80	2,385.24	76–80	1,747.20
85	2,879.04	81–85	2,049.00

- 17** See Note 15 regarding reasons to assume that nursing-home costs will rise at a rate of at least 5 percent a year. The point of this discussion would, of course, remain valid even if costs were to rise at a more modest rate—say, 2.5 percent a year. If that were the case, the policy would still cover less than a third of the cost of care.
- 18** This is based on extrapolating from the rate chart of the Travelers Independent Care Long Term Care Policy marketed by the Travelers Insurance Company, with a 20-day waiting period and adjusting for the estimated administrative load for a \$350 daily benefit. The Travelers Corporation has not reviewed this calculation, and the use of this hypothetical illustration is not intended to imply that either Travelers or any other company is offering such a benefit or would propose to charge such a premium if they were.
- 19** At age 40 the annual premium for the Travelers policy paying a \$50 daily benefit with a 20-day waiting period is \$262. Note that this is a policy with broad home-care coverage. The initial premium for a policy with similar nursing-home coverage but more limited home-care coverage should be lower.
- 20** This example is based on the Travelers rate chart (see Note 18) adjusted for a 5-percent annual inflation rate in benefit costs, assuming purchase of add-on coverage at attained-age rates, and using an interest rate of 7 percent (a rate 2 percentage points above the assumed 5-percent-per-year increase in the cost of benefits). The maximum benefit is the daily rate times five years. It should be noted that, as in all these calculations, Travelers has not reviewed these calculations and there is no implication that Travelers would sell such a benefit or use such a premium schedule if it did.

If a \$50-a-day policy were purchased at age 50, with a 100-day waiting period, the cost illustrated for an inflation-proof policy, also extrapolated from the Travelers rate chart for an individually sold policy, would show premiums of \$355.50 at age 50; \$552.00 at age 60; \$1,383.00 at age 70; \$5,628.00 at age 80; and \$12,502.00 at age 85. Premiums paid over 36 years would amount to \$91,800. The total accumulation at 7-percent interest would be \$178,000.

A \$50-a-day plan sold on a group basis at age 50 through the American Association of Retired Persons (AARP) by Prudential in 1988 (with many differences from the Travelers plan) had a rate structure which, if extrapolated in the same manner, would have produced premium rates of \$240 at age 50; \$397 at age 60; \$1,029 at age 70; \$3,533 at age 80; and \$6,341 at age 85. Total premiums would have been \$57,000 over the 36 years and would have accumulated to something over \$117,000 at a 7-percent interest rate.

These various plans are used for illustration, not for purposes of comparison against each other nor with any implication that they are being offered on the bases described. Prudential, like Travelers, has not reviewed these calculations and does not offer such a policy. The point here is rather to show the general order of magnitude of the cost of long-term care insurance if bought first at ages 40 or 50 and then kept up to date by purchasing additional protection without limit to keep up with costs assumed to rise at 5 percent a year. In actual practice it is likely that medical screening would prevent many policyholders from being able to make all of the additional purchases needed to keep up with inflation, particularly as they reach older ages.

- 21 According to the Health Insurance Association of America, five plans covering some 14,000 workers and their spouses were in effect in 1988. Generally, about 7 percent of active workers had elected coverage, although the range was from 1 percent to 14.6 percent. The average age of those electing coverage was 40 as compared to 70 for those purchasing policies individually, and premiums at age 40 averaged about \$175 a year. Note that additional employer-sponsored plans have gone into effect since this survey was conducted. See Health Insurance Association of America, *Long-Term Care Insurance: Market Trends*, Research Bulletin, March 1989, p. 21.
- 22 People who are currently caring for a chronically ill family member while simultaneously trying to manage a full-time job may be attracted to policies that may seem (based on imprecise promotional terminology and inexact news coverage) to offer multi-generational coverage at a single low rate. They will be deterred, however, when they find that premiums are, of course, based on the number of applicants and their age. (See also Note 30 below.)
- 23 Health Insurance Association of America, *Long-Term Care Insurance: Market Trends*, Research Bulletin, March 1989, p. 5.
- 24 Such a plan, marketed by Aetna, is discussed elsewhere in this report. It is a disability income policy that operates in a similar way to long-term disability policies, which have been marketed for many years. Such a policy pays a benefit every day (or week, or month) that the claimant meets the insurer's criteria for needing long-term care, without regard to whether the claimant actually receives and pays for services or not. Although disability income policies are currently the exception rather than the rule in long-term care insurance, they are likely to become more commonplace as the market evolves. (See Paul S. Entmacher and James B. Weil, "Long Term Care Insurance: An Industry Perspective" in *The PRIDE Institute Journal* (cited above), pp. 25-28.)
- 25 Rashi Fein, *Medical Care, Medical Costs: The Search for a Health Insurance Policy*, Harvard University Press, Cambridge, Mass., 1986, Chapter 2, pp. 10-32.
- 26 The Travelers Insurance Company, Hartford, Ct., 1988. The policy is marketed as "The Travelers Independent Care Long-Term Care Policy."
- 27 In the case of a couple, the premium for each spouse is discounted 15 percent when both spouses purchase coverage (assuming, of course, that both spouses are able to pass the company's health screening criteria). Thus, in this example the annual cost of coverage for a 70-year-old husband and wife would be \$4,916.
- 28 This does not necessarily mean, however, that the benefit keeps pace, dollar-for-dollar, with inflation. The adjustment is not made if the Consumer Price Index rises by only a percentage point or so in any given year. Bear in mind, too, that adjusting for changes in the CPI overall does not necessarily keep the benefit current with increases in the cost of nursing-home care. As noted previously, the medical care component of the CPI has been rising about one and a half times as fast as the CPI as a whole. Benefit payments adjusted only for increases in the CPI overall may thus fail to cover much of the increase in the cost of nursing-home care.
- 29 Health Insurance Association of America, *Long-Term Care Insurance: Market Trends*, Research Bulletin, March 1989, p. 22.
- 30 News release from Ford Motor Company and the United Auto Workers, March 16, 1989, and letter (with accompanying documents) to the author from John R. Collings, UAW Social Security Department, May 4, 1989.

The program is expected to cost approximately \$183,000 in its first year and \$201,000 in its second year. The full cost of the program is to be met by deducting 2.5 cents per hour from the total package of wages and benefits payable to UAW-represented hourly employees at Ford's Louisville Assembly and Kentucky Truck Plants from October 3, 1988, through September 30, 1990, and the UAW and Ford have agreed that the pilot program will cease when funds thus accrued are exhausted.

- 31** Here again, however, it pays to read the policy, because promotional literature may be confusing. For example, the brochure for a Travelers policy offered to employees of the state of Maryland says “Consider the advantages . . . Parents and parents-in-law (under the age of 80) of active employees are eligible for coverage at the same group rates.” This could be misunderstood as implying that an employee could cover herself and her parents with a single application (hers) and a single premium—which, if she enrolls at, say, 40, is only \$151 a year for a \$70-a-day benefit. In fact, however, if she wants to cover her parents, they will have to enroll separately, paying the group rates applicable at their age upon enrollment (assuming they pass the insurer’s health screening), and the cost of the policy will, of course, be much higher. If, for example, her father is 75 and her mother is 70, the combined cost of covering both the 40-year-old employee and her parents under this policy will be about \$4,500 a year.
- 32** One example of this form of vesting is offered by Travelers. If the policyholder stops paying premiums after ten years, a benefit, reduced as described, is still payable. (Travelers press release, “Harnischfiger Industries Offers Employees Travelers Group Long-Term Care Plan,” December 15, 1988.)
- 33** The specified activities of daily living are eating, dressing, toileting, transferring from bed to chair, and mobility. Various versions of this policy are being marketed to employees of General Foods, the Army and Air Force Exchange Service, and the South Carolina Retirement Systems. General Foods employees are offered a return-of-contribution feature, but no inflation protection; AAFES employees are offered an inflation adjustment, but no forfeiture protection; South Carolina employees are offered both. Each of the various versions of this policy contains lifetime limits on benefits payable; limits vary from version to version.
- 34** This plan was not in final form at the time of writing, but the general approach was discussed in March 1989 with Susanne Bowman, Manager, Group Health Insurance Program, American Association of Retired Persons. The description of the 1988 plan is taken from the Certificate of Insurance, Prudential Insurance Company of America, “AARP Group Health Insurance Program / AARP’s Long Term Care Plan”, January 1988, and the rates for the 1988 plan are contained in a March 8, 1989, letter to the author from Ms. Bowman.
- 35** *Ibid.*
- 36** Paul S. Entmacher and James B. Weil, “Long-Term Care Insurance: An Industry Perspective” in *The PRIDE Institute Journal* (cited above), p. 28. Dr. Entmacher is medical director and Mr. Weil is vice-president for group senior policies at Metropolitan Life.
- 37** A major recommendation of Health and Human Services Secretary Otis R. Bowen to President Reagan was for “. . . a tax-favored Individual Medical Account (IMA) combined with insurance, and [an amendment] to Individual Retirement Account (IRA) provisions to permit tax-free withdrawal of funds for any long-term care expense.” See U.S. Department of Health and Human Services, *Catastrophic Illness Expenses, Report to the President*, November 1986, pp. 107-109.
- 38** *Ibid.*, pp. 109-111. Secretary Bowen recommended “. . . a 50 percent refundable tax credit for long-term care insurance premiums for persons over age 55 (up to an annual maximum of \$100).”
- 39** U.S. Congress, House Committee on Ways and Means, *Background Material on Programs Within the Jurisdiction of the Committee on Ways and Means*, 1989 Edition, March 1989, p. 781.
- 40** Contributions to an IRA of up to \$2,000 per year for a couple (\$2,250 for an individual with a non-working spouse) are now tax deductible only if the taxpayer is not covered by an employer pension plan or has adjusted gross income of less than \$35,000 (for individuals) or \$50,000 (for couples). The Ways and Means Committee notes: “As is the case with all [tax] exclusions, upper income taxpayers with high marginal tax rates receive more benefit per dollar of IRA contribution than lower income taxpayers with low marginal tax rates.” (*Background Material*

(cited above), p. 781.) While there is nothing inherently wrong with encouraging Americans to save, no broad public purpose is served by giving special tax preferences to those who are most well off and thus most able to use their own resources to purchase health insurance.

- 41** University of Maryland, Center on Aging, National Program Office, *Robert Wood Johnson Foundation Program to Promote Long-Term Care Insurance for the Elderly: Program Summary*, College Park, Md., January 1989.

As part of its program to promote long-term care insurance for the elderly, the Robert Wood Johnson Foundation provides planning grants to investigate the potential role of public-private partnerships at the state level. The foundation is supporting experimental projects in eight states: California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon, and Wisconsin.

The states chosen for the planning grants have in common a commitment to the use of case management as a means of determining the long-term care services to be provided to the elderly and a commitment to promote broader use of private long-term care insurance. They differ considerably in how they would go about it, however. The most common approach is to give preferred status under Medicaid to those who have bought private insurance. Separately or in combination with other approaches, states are also considering publicly financed subsidies, which would vary according to income and assets, to help people buy improved insurance products. Stop-loss provisions are also being explored, with the state governments or reinsurance pools paying for care after private insurance is exhausted. One state is exploring a stop-loss provision for individuals who buy the amount of insurance that the state determines is affordable for them based on their financial status. Another state is exploring a reinsurance pool financed by a combination of funding sources: a surcharge on private insurance premiums, continuing premium payments by persons in beneficiary status, and a direct state subsidy. Some states are exploring more than one strategy and are designing demonstration projects intended to serve as a means of developing a data base, in some instances working with a cross-section of the elderly population and in others focusing on state employees and retirees. Mandatory inflation protection is also being explored.

- 42** In the case of Medigap insurance, only about 60 cents of every dollar collected in premiums is paid out in benefits; the rest goes to the cost of advertising, agents' fees, administrative overhead, and profit. The overhead costs of Medigap insurance have remained high even though marketing is not particularly difficult (because elderly consumers are relatively accessible through retirement associations and other membership groups and tend to be fearful about gaps in Medicare coverage) and even though the industry has had nearly a quarter of a century to improve its policies. It is true that individual Medigap claims tend to be relatively small and thus the ratio of administrative costs to benefit payments is relatively high, but there is no reason to believe that individually marketed long-term care policies will return more than 70 to 75 cents on the dollar. Any public plan should be able to do better; Medicare's administrative costs are routinely reported to be about 3 percent of program outlays. (See U.S. General Accounting Office, *Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies*, GAO Report No. HRD-87-8, October 1986; U.S. Congress, House Committee on Ways and Means, *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, March 1989, p. 136.)

GAO has recently updated its data on Medigap loss ratios (the percentage of premiums paid out in benefits) in connection with testimony to Congress on the anticipated impact on Medigap policies of the 1988 Medicare Catastrophic Coverage Act. Most Medigap insurers were found to have paid out less than 60 cents in benefits for every dollar collected in premiums in 1987. However, there was considerable range in the loss ratios. Some major insurers paid out less than 40 cents on the dollar. At the other extreme, Prudential Insurance, the single largest marketer of Medigap policies (to members of the American Association of Retired Persons), had a loss ratio of 83 percent in 1987, and six Blue Cross policies that had paid out an average of 87 cents on the dollar in 1984 were found to have paid out \$1.04 in benefits for every \$1 in premiums collected in 1987. (U.S. General Accounting Office, "Medigap Insurance: Effects of the Catastrophic Coverage Act of 1988 on Benefits and Premiums", Statement of Michael Zimmerman, Director, Medicare and Medicaid Issues, Human Re-

sources Division, Before the U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Commerce, Consumer Protection, and Competitiveness, Washington, D.C., April 6, 1989.)

- 43** Alice M. Rivlin and Joshua M. Weiner, *Caring for the Disabled Elderly: Who Will Pay?* The Brookings Institution, Washington, D.C., 1988, pp. 75-82.

It is, of course, very difficult to estimate what percentage of all long-term care costs might be met by private insurance many years from now. Looking ahead to the years 2016-2020, the Brookings study estimates that private insurance will be covering only 7 to 18 percent of all nursing-home charges—and that estimate, it should be noted, is based on the very optimistic assumption that anyone with \$10,000 in assets to protect will buy insurance if premiums do not exceed 5 percent of income. The Brookings forecast could, on the other hand, understate the potential for private insurance to the extent that employer-sponsored policies are being sold to younger buyers—because the effect of such sales would not show up until about 2030 (when those who are now 40-45 will be 80-85). But it seems safe to say that, until then, even allowing for significant changes in the design of policies (with broader home-care benefits as the most important), private insurance cannot be expected to meet more than about a fourth of all long-term care costs.

NOTES PART 6

WHERE DO WE GO FROM HERE?

- 1 The point bears emphasizing that such programs are neither universally available nor adequately funded. For the marginally impaired, as for millions of other Americans, the social safety net is in dire need of strengthening. See, generally, U.S. Department of Health and Human Services, Office of Human Development Services, Administration on Aging, *Where to Turn for Help for Older Persons: A Guide for Action on Behalf of An Older Person*, Washington, D.C., for information on state and area agencies on aging and the kinds of household assistance services available under the Older Americans Act and other public programs.
- 2 For a general discussion of the availability of home-care services and cost projections associated with increased availability, see Alice M. Rivlin and Joshua M. Wiener, *Caring for the Disabled Elderly: Who Will Pay?* The Brookings Institution, Washington, D.C., 1988, Chapter 14, pp. 190-202.
- 3 Diane Justice, *State Long Term Care Reform: Development of Community Care Systems in Six States*, Health Policy Studies, Center for Policy Research, National Governors' Association, Washington, D.C., April 1988, esp. Chapter V, pp. 95-114.
- 4 Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360); U.S. Department of Health and Human Services, Health Care Financing Administration, *Medicare Handbook*, 1989, pp. 1-2, 11-12; see also Note 13 to Part 2 of this report.
- 5 National Academy of Sciences, Institute of Medicine, *Improving the Quality of Care in Nursing Homes*, Washington, D.C., 1986.
- 6 U.S. Department of Health and Human Services, National Center for Health Statistics, 1985 National Nursing Home Survey, unpublished data.

During the 12-month period covered by the 1985 National Nursing Home Survey, there were 877,000 live discharges from nursing homes. Of these, 284,900 had been in a nursing home for six months or more; and of this group, 249,200 (87 percent) were discharged to hospitals or other health facilities. It can be assumed with considerable confidence that those in this group who had the degree of severe disability required for nursing-home coverage under the plan and who did not have a spouse in the community (in which case they would retain the 15-percent copayment) either died soon after being discharged to a hospital or lived out the rest of their lives in a nursing home or other health facility. Very few of this group would have returned to a private or semi-private residence. Of the 35,700 discharged to private or semi-private homes after six months or more in a nursing home, 9,800 were married (and the copayment for them would have remained at 15 percent). Of the remaining 25,900, only 10,600 were either incontinent or needed help with mobility; it can be assumed that few if any of the others would have met the disability criteria that would have made them eligible for a nursing-home benefit in the first place. Thus of the 877,000 live discharges, only 10,000 to 11,000—or a little over 1 percent—would have met the criteria for a copayment increase without necessarily being permanent nursing-home residents.

It should be noted that while discharge data are the best data now available for estimating the proportion of nursing-home residents likely to fall into the categories described, more precise data would be yielded by following a representative sample of admissions throughout a nursing-home stay, and work has begun on constructing such a sample.

- 7 Unlike OASDI and HI, physician coverage under Medicare (Part B) is financed by a combination of general revenues and premiums paid by the elderly and disabled who are protected by the program. The new catastrophic protection program is financed by a combination of flat premiums—that is, premiums that are the same for all enrollees, as with physician coverage—plus an income-related premium to be collected through the income tax. (See also Note 2 to Part 3 of this report.)
- 8 The Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, *1989 Annual Report*, Washington, D.C., Table 17, Past Experience, p. 51, and Table 26, Alternative II-B, p. 69.
- 9 The Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, *1989 Annual Report*, Washington, D.C., Table 16, Alternative II-B, p. 69.
In comparing OASDI costs and contribution rates, bear in mind that program income equals more than the employee's contribution rate times two. In addition to the matching contribution by the employer, income is also derived from taxing benefits paid to higher-income beneficiaries and from interest earned on reserves. In 1989, for example, the combined contribution rate is 12.12 percent of payrolls; income is expected to equal 12.30 percent. In the year 2015, when the combined contribution rate scheduled under current law will be 12.40 percent of payrolls, income is expected to be 12.88 percent.
- 10 Financing is estimated to be fully adequate for more than 50 years, albeit based on a big buildup and then a dissipation of that buildup. For a more detailed discussion of this point, see Robert M. Ball, "Social Security Across the Generations," in *Social Security and Economic Well-Being Across Generations*, Public Policy Institute, American Association of Retired Persons, Washington, D.C., December 1988, esp. pp. 23-26.
- 11 The Board of Trustees of the Federal Health Insurance Trust Fund, *1988 Annual Report*, Washington, D.C., Table 9, Alternative II-B, p.47.
- 12 U.S. Congress, Joint Committee on Taxation, *Overview of Present Law and Estimated Budget Effects of the Medicare Catastrophic Insurance Program and Description of Possible Premium Options*, Staff Paper, May 25, 1989, Table 3, p. 14. As this report was going to press in July 1989, Congress was considering a revision of the financing design. Under a plan adopted by the House Ways and Means Committee, the income-based surtax would be cut in half, and participation in the catastrophic protection program would be made optional. To help make up revenues lost from cutting the surtax, the basic premium paid by all enrollees in the program would be increased from \$4 a month to \$7.50, and the ceiling on out-of-pocket payments for prescription drugs would be increased from \$600 to \$800 a year.
- 13 U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, Washington, D.C., Winter 1989.
- 14 Philip R. Lee, M.D., Statement of the Physician Payment Review Commission Before the Committee on Finance, United States Senate, Washington, D.C., March 17, 1989.
- 15 Payrolls subject to the Hospital Insurance tax for 1990 are estimated by the actuaries of the Social Security Administration to be \$2.4 trillion; for 1991, \$2.5 trillion; for 1992, \$2.7 trillion; for 1993, \$2.9 trillion; for 1994, \$3.1 trillion.
- 16 U.S. Congress, Office of Technology Assessment, *Losing a Million Minds: Confronting the Tragedy of Alzheimer's Disease and Other Dementias*, Washington, D.C., 1987, p. 22.
- 17 Estimate supplied by the Lewin/ICF division of Health and Sciences Research Incorporated, Washington, D.C., July 1989, based in part upon results from the Brookings-ICF Long-Term Care Financing Model. (For a discussion of the data and assumptions used initially in the model, see Alice M. Rivlin and Joshua M. Wiener, *Caring for the Disabled Elderly: Who Will*

Pay? The Brookings Institution, Washington, D.C., 1988, esp. pp. 30-50 and Technical Appendix, pp. 251-269.)

- 18 *Ibid.*
- 19 *Ibid.*
- 20 See Note 15. A combined employer-employee rate of 2 percent applied to a \$2.4 trillion payroll would raise about \$50 billion in 1990.
- 21 *Caring for the Disabled Elderly* (cited above), Chapter 2, pp. 47- 48.
- 22 U.S. Congress, Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options*, Washington, D.C., February 1989, Table REV-01, p. 309, adjusted to match the assumption that 1990 would be the first full year of added revenues.
- 23 Social Security Administration, Office of the Actuary, April 1989, based on the assumptions in the President's Fiscal Year 1990 Budget.
- 24 This is not intended to suggest that lifting the cap on the employer's contribution would be without risk of negative consequences for workers, particularly the 6 percent earning above the cap. Obviously, contributions to Social Security are taken into account when employers make decisions about total compensation to be offered to employees. Some employers, when faced with the prospect of having to pay substantially more into the Social Security system, would seek to reduce other commitments to employees, and the effect on an employee's net earnings could be similar to the effect of having the cap on taxable earnings lifted.
- 25 Author's estimate; assumes that 1990 is the first full year during which the surcharge is in effect.
- 26 *Reducing the Deficit* (see Note 22), Table REV-09, p. 331, and assuming 1990 as the first full year of added revenues.
- 27 *Ibid.*, Table REV-14, p. 343, adjusted to match the assumption that 1990 would be the first full year of added revenues.
- 28 U.S. Congress, Congressional Budget Office, *An Analysis of Alternatives for Taxing Social Security As A Private Pension*, Staff Working Paper, Washington, D.C., March 1988.
- 29 Private pension plans are explicitly encouraged by tax policy. Plans that meet Employee Retirement Income Security Act (ERISA) requirements are tax-favored since employer contributions and earnings on the accumulating funds are exempt from taxation for both employer and employee. Employees may also gain because they pay taxes on benefits at the time of receipt when their income and tax rates may be lower. (*Reducing the Deficit* (see note 22), Table REV-07 and Table REV-08, pp. 326-330, using 1990 as the first full year of added revenues.)
- 30 U.S. Congress, Congressional Budget Office, *A Tax Policy for Pensions and Other Retirement Savings*, Washington, D.C., April 1987, p. 14.
One way to move in the direction of recovering part of the windfall would be to increase the 15-percent tax currently assessed on any part of a pension exceeding \$150,000 a year—and the \$150,000 figure could be lowered. This tax now applies only to recently awarded pensions, and in light of the windfalls described, the grandfather provisions should be reconsidered.
- 31 Some versions of this proposal would finance the public long-term care program primarily by eliminating the cap on earnings taxable for Social Security purposes (\$48,000 in 1989), and thus it can be argued that the program would be financed in large part by the 6 percent of

earners who earn more than \$48,000, and that it is thus incorrect to state that average workers would be contributing to a long-term care protection program that would not in fact protect them. Perhaps. But people do not, as a rule, make distinctions about where their Social Security contributions go; they do not think in terms of so many dollars going to OASDI, so many to HI, etc. Thus there is little question that this approach would be *perceived* as highly inequitable: "Why am I paying to support a program that won't support me when I need help?" It seems likely that sooner or later, public opposition would grow to the point where this approach would have to be considerably modified.

- 32** Ford Foundation, Project on Social Welfare and the American Future, *The Common Good, Policy Recommendations of the Executive Panel*, New York, N.Y., 1989, pp. 75-79.
- 33** Social Security Administration, Office of Research and Statistics, *Income of the Population 55 or Older*, 1986, Washington, D.C., June 1988, Table 10, p. 23.
- 34** Social Security Administration, Office of Research and Statistics, *Facts and Figures About Social Security*, August 1988, p. 6. Social Security is the major source of income (providing at least 50 percent of total income) for 62 percent of elderly beneficiary units, contributes almost all of the income (90 percent or more) for 26 percent, and is the only source of income for 15 percent.
- 35** U.S. Department of Health and Human Services, National Center for Health Statistics, 1985 National Nursing Home Survey, unpublished data (see Note 6).
In fact, analysis of 1985 National Nursing Home Survey data indicates that a six-month benefit, extended for those with dependents in the community, would in most cases be sufficient to distinguish between permanent nursing-home residents and those with some possibility of returning to the community. Obviously, the public cost of the program could be mitigated if patients were expected to begin contributing to the cost of their care after six months rather than after a year. But a one-year benefit seems preferable, for several reasons: to allow for a margin of error in the data, to reduce to the minimum the number of persons who might be left unprotected by the plan although not deemed to be permanent nursing-home residents, and to allow for the possibility that advances in rehabilitation may make it feasible for more people to return to the community even after being in a nursing home for a relatively long time.
- 36** Estimate supplied by the Lewin/ICF division of Health and Sciences Research Incorporated, Washington, D.C., July 1989, based in part upon results from the Brookings-ICF Long-Term Care Financing Model.
- 37** *Ibid.*
- 38** For an overview of nursing-home quality-of-care issues, see: National Academy of Sciences, Institute of Medicine, *Improving the Quality of Care in Nursing Homes*, Washington, D.C., 1986; U.S. Congress, Congressional Research Service, *Medicaid Source Book: Background Data and Analysis*, A Report Prepared for the Use of the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce, esp. Chapter VI, pp. 181-189; Chapter VIII, pp. 226-228; and Appendix C, pp. 371-372.



THIS REPORT DESERVES CLOSE SCRUTINY by anyone concerned with the problem of long-term care—which means it merits widespread attention indeed. Because we're all in this together, exactly as the title says.

Probably the single most important fact to understand about the long-term care issue is that it is not by any means a problem exclusively of the frail elderly, even though they are the most likely to experience chronic illness. *Long-term care is a family concern*—a problem both for those who need continuing care and for those who must struggle to provide it while at the same time trying to cope with responsibilities such as earning a living, financing the education of children, and meeting other family needs.

Most people who become chronically dependent would of course prefer to remain at home—their own or that of a family member or friend—if at all possible. But the burden of providing continuing care informally at home can exhaust caregivers' physical and emotional resources. On the other hand, the burden of paying for formal long-term care services—whether at home or in a nursing home—can rapidly devastate the financial resources of even a moderately well-to-do family.

Until quite recently, however, the long-term care problem did not command broad public attention. Generally, families tried to deal with it privately, in isolation and frustration, often plagued with guilt at what they perceived as their particular inability to care for a loved one. In fact, however, the failure was not personal but societal. We simply have not yet come to terms with the significance of basic changes altering America—changes that have created an urgent need to develop a systematic national approach to financing and delivering long-term care services.

—*from the Introduction*

PHOTO / JACQUELINE BALL SMITH



Robert M. Ball is unusually well qualified to assess the pros and cons of various approaches to long-term care insurance. He joined the staff of the Social Security Administration (then the Social Security Board) in 1939 and has played a key role ever since in guiding the evolution of Social Security and Medicare, America's principal social insurance programs. Social Security Commissioner under Presidents Kennedy, Johnson, and Nixon, he was the Carter administration's chief informal advisor on Social Security issues, and during the Reagan years he played a leading role on the bipartisan commission that reformed Social Security funding. He continues to consult widely on Social Security and health policy matters. In preparing this report he was assisted by Washington writer-editor Thomas N. Bethell.