



U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

AN ANALYSIS OF LONG-TERM CARE REFORM PROPOSALS

February 1993

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This report was prepared under contract between HHS's Office of Family, Community and Long-Term Care Policy (now DALTCP) and Systemetrics. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, John Drabek, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201. His e-mail address is: John.Drabek@hhs.gov.

AN ANALYSIS OF LONG-TERM CARE REFORM PROPOSALS

Brian Burwell
SysteMetrics

Mary Harahan
John Drabek

U.S. Department of Health and Human Services

David Kennell
Lisa Alecxih
Lewin-VHI

February 1993

Prepared for
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services

This report was developed in conjunction with a study of long-term care financing reform conducted by the Office of the Assistant Secretary for Planning and Evaluation. The statements and opinions expressed in the report are solely those of the authors and do not reflect the position of the Office of the Assistant Secretary for Planning and Evaluation and the Department of Health and Human Services.

"If You Don't Know Where You're Going, You Might End Up Somewhere Else..." ---Yogi Berra

TABLE OF CONTENTS

PART I. THE LONG-TERM CARE DEBATE	1
What is the Prospect for Long-Term Care Reform?	1
What's Wrong With The Current System?.....	1
A Fragmented Financing System	2
The Role of Medicaid	3
States Are Where the Action Is	5
The Shift Towards Home and Community-Based Care	7
What Will the Future Bring?	8
Other Trends May Reduce the Demand for Long-Term Care	9
The Future Affordability of Long-Term Care	9
Some Elderly Will Always Be Poor.....	10
PART II. REFORMING LONG-TERM CARE POLICY: WHAT ARE THE OPTIONS?	11
Public Insurance.....	11
Medicaid Reforms	24
New Federal-State Programs.....	29
Voluntary Insurance	35
PART III. DISCUSSION	46

LIST OF TABLES

TABLE 1: Sources of Financing for Long-Term Care for the Elderly, 1992	4
TABLE 2: State Per Capita Spending for Long-Term Care Under Medicaid: 1991	6
TABLE 3: Long-Term Care Financing Reform: Public Insurance.....	12
TABLE 4: Long-Term Care Financing Reforms: Medicaid Reforms	27
TABLE 5: Long-Term Financing Reforms: New Federal-State Programs.....	32
TABLE 6: Long-Term Care Financing Reforms: Voluntary Insurance	39

PART I. THE LONG-TERM CARE DEBATE

What is the Prospect for Long-Term Care Reform?

Though not as precipitous perhaps as the crises of the uninsured and health care costs, the problem of long-term care looms on the nation's horizon. We are an aging population, and long-term care will comprise an ever-increasing percentage of our nation's expenditures for health care. We do not have an adequate system for financing the services that people need, and many elderly live in fear that chronic illness will devastate them financially, leave them dependent on their children or welfare, and limit their ability to live where and how they want at the end of their lives. Too often, these fears become reality. While long-term care reform may not be *imminent*, it is probably fair to say that the current political climate implicitly recognizes that long-term care reform will follow soon on the heels of reform of our acute health care system. This timetable could change, however, if long-term care reform becomes a "wild card" in the crafting of a political consensus around acute health care reform.

As the long-term care debate moves forward, we certainly are not lacking for ideas. Numerous proposals for reforming both public and private financing systems have been laid on the table. Some of these ideas have been incorporated into legislative proposals by Congress, although, as yet, there has been no serious effort to enact any of these proposals into law.

The purpose of this paper is to heed the advice of our national baseball sage and take a serious look at where these various long-term care reform proposals may take us, before we end up somewhere where we don't want to be. It does not advocate any one particular route. The purpose of the paper is rather to describe the diverse strategies that have been proposed, and to present a balanced discussion of the points that have been made in support of, and in opposition to, each proposal. Like controversial calls on the baseball diamond, what we believe is "balanced" may not be perceived to be so by those who advocate a particular proposal, but so be it. Our goal is to inform the long-term care debate, so that the decisions we make as a nation about long-term care policy are ones that we will look back upon with vindication, not regret.¹

What's Wrong With The Current System?

Before describing long-term care reform strategies, we should first examine the strengths and weaknesses of our current system. One characteristic of the existing system that must be kept in mind is that most long-term care provided in the United States is informal (unpaid) care. In 1989, there were about 2.1 million disabled elderly persons living in the community receiving active help in basic Activities of Daily Living

¹ This paper is limited to a discussion of long-term care reform proposals for persons age 65 and over. New policies for financing services for non-elderly disabled are also needed, but are not discussed in this paper.

(ADLs) from other people.² Almost two-thirds of these individuals receive help from informal caregivers only.³ Only about one in twenty persons in the community receive no informal care, and rely solely on formal sources of assistance. Many more elderly receive informal help in Instrumental Activities of Daily Living (IADLs) in tasks such as meal preparation, laundry, grocery shopping, and money management. So although, in 1992, we as a country will spend about \$60 billion dollars for formal long-term care services for the elderly through public and private sources,⁴ the value of long-term care provided by family and friends exceeds this amount by far.

Do we rely too heavily on family caregivers? Are families unduly-stressed by the burdens of informal care? Should more public assistance be made available to reduce these burdens? These questions are fundamental in assessing the merits of long-term care proposals, because many proposals explicitly intend to increase the role of formal providers, so that the burden on informal caregivers may be lessened.

A system that relies primarily on unpaid, rather than paid, help has some significant advantages. One obvious strength is the commitment of family caregivers. There is no evidence that the dependent elderly are being abandoned by their families, despite the growing mobility of our society and the increased labor force participation of women. Informal care is more flexible, usually more caring, and more reciprocal. The "intangible" benefits of informal caregiving within families are self-evident, but difficult to measure. Regardless of what public long-term care policy we end up with, the care of disabled elderly people by their families will always be a foundation of our long-term care system.

The centrality of informal care is a key distinction between our long-term care system and our acute care system. Long-term care is, for the most part, not professional care; it is simply helping disabled elders with their everyday lives. Since formal care will always supplement informal care, not replace it, a challenge to the long-term care reform process is to spell out family roles and responsibilities. Where do family responsibilities end and public responsibilities begin? The reform proposals advanced to date have generally not addressed this basic issue explicitly, but they must.

A Fragmented Financing System

In the public sector, we finance long-term care services for the elderly through a multiplicity of programs. Disabled elders who are in need of services have a limited understanding of how these various programs work, who is eligible, and how services can be accessed by those who are eligible. This fragmentation creates problems in

² Basic Activities of Daily Living include bathing, dressing, toileting, transferring, and eating.

³ Source: Jackson, Beth: "Family Caregiving: Still Going Strong?" Presentation at The Changing Face of Informal Caregiving, a conference sponsored by the Office of the Assistant Secretary for Planning and Evaluation, DHHS, Berkeley Springs, West Virginia, October 15, 1992.

⁴ Source: Lewin-ICF based on results from the Brookings-ICF Long Term Care Financing Model.

coordinating services across programs, because in many cases, individuals are eligible to receive publicly-financed services from more than one source simultaneously.

Medicare provides very limited coverage of long-term care, and, in fact, is purposely designed not to assist persons who only have chronic impairments. Medicare's Skilled Nursing Facility (SNF) benefit and Home Health Care benefit are both targeted to persons recovering from acute illness episodes who are in need of skilled services, i.e. nursing and therapy services. A large number of discretionary programs, including those funded under the Older Americans Act, the Social Services Block Grant, HUD housing assistance programs, Veterans' Administration programs, and others, provide broadly-targeted resources to provide services and supports to the disabled elderly. However, the primary public funding source for long-term care is Medicaid, which covers long-term nursing home care, home health care, and non-medical home and community-based services to disabled elderly persons who meet Medicaid's financial criteria.

The Role of Medicaid

Medicaid accounts for over three-fourths of all public spending for long-term care (Table 1). Thus, our national long-term care policy is primarily based on a "welfare model" in which public assistance is made available only to those persons who do not have the financial resources to pay for their own care. The "welfare" orientation of our long-term care policy is severely criticized for the following reasons:

- People are forced to deplete all of their life savings on the private cost of long-term care before they are eligible for public assistance;
- Many people who have been financially independent all of their lives are emotionally devastated by being dependent on "welfare" at the end of their lives;
- Some people who have exhausted their resources paying for nursing home care do not return home, even when they are functionally able, because they can't afford to;
- Family caregivers often go to extraordinary lengths in providing informal care in order to avoid the catastrophic costs of formally provided care;
- Because long-term care is financed through a welfare program, it is difficult to garner political support for adequate funding; and
- The system creates perverse incentives for the non-poor elderly to 'look poor' without really being poor by sheltering or divesting their financial assets.

TABLE 1. Sources of Financing for Long-Term Care for the Elderly, 1992 (in billions of 1992 dollars)			
	Nursing Home	Home Care	Total
Medicare	\$1.9	\$2.8	\$4.7
Medicaid	\$19.8	\$2.4	\$22.2
Other Public	NA	\$2.1	\$2.1
Public	\$21.7	\$7.3	\$29.0
Out-of-Pocket	\$26.0	\$3.4	\$29.4
TOTAL	\$47.7	\$10.7	\$58.4
SOURCE: Lewin-ICF estimates based on results from the Brookings-ICF Long-Term Care Financing Model.			

At the same time, it is important to acknowledge some of the *positive* features of Medicaid as the primary funding source for long-term care. For one, it provides a relatively broad safety net for older persons who do not have the financial resources to pay for their own care. Second, it targets public resources fairly efficiently, because benefits are only provided, by and large, to the poor and near-poor. Third, the combination of Medicaid financing for the poor, and private financing for the non-poor, has helped to constrain costs and prices. We have generally not seen the type of cost inflation in the long-term care market that has occurred in the acute health care system. And fourth, the structure of the Medicaid program allows considerable flexibility for States to design long-term care systems in accordance with their own cultural, political and fiscal characteristics.

The welfare orientation of our national long-term care policy is often criticized for being too draconian. Shouldn't we allow individuals without spouses to keep more than \$2,000 in assets (the current Medicaid eligibility resource threshold in most States) before qualifying for public benefits? But even if we agree that \$2,000 is too miserly an amount, what is the appropriate amount: \$10,000...\$20,000...\$100,000? Or should long-term care services be publicly-financed without regard to financial circumstances at all? To what degree should our national long-term care policy protect inheritances for the heirs of elderly persons who need long-term care services? Having to answer these questions in the policy debate may be unsettling...but as we consider the extent to which people should be responsible for financing their own care, they need to be explicitly addressed.

It is important to note that Medicaid now makes a clear distinction between financial eligibility criteria for married couples and for single persons. Under the spousal impoverishment provisions of the Medicare Catastrophic Coverage Act of 1988, Medicaid's new financial eligibility criteria for married nursing home residents substantially enhances the financial security of spouses remaining in the community.⁵ For single persons, however, Medicaid policy takes the more restrictive position that

⁵ These financial protections are also extended to married couples who receive Medicaid home and community-based waiver services.

most all of an individual's assets should be used to pay for private care before public assistance is made available.

States Are Where the Action Is

Because Medicaid is the primary public financing source for long-term care, and because there is considerable flexibility available to States in designing their Medicaid programs, States, much more than the Federal government, are the key actors in long-term care policymaking. The flexibility available to States is manifested in the diverse nature of State long-term care systems. The publicly-financed long-term care system in Minnesota is very different from the public long-term care system in New Mexico, which in turn is very different from the public long-term care systems of New York and Florida. Levels of funding for nursing home services and home and community based services differ dramatically across States, as shown in Table 2. Financial and functional eligibility criteria under Medicaid also vary from State to State.

The degree to which States have attempted to consolidate long-term care funding sources and programs into a coordinated administrative structure also differs. Oregon and Washington are examples of two States which have made serious efforts to implement consolidated systems that address the fragmented nature of public funding sources. Four States--California, Connecticut, Indiana, and New York--are also experimenting with the development of public-private partnerships to establish stronger linkages between the private and public long-term care insurance markets.

Although States have considerable flexibility in designing their own long-term care systems, some believe that public systems need to be even more flexible than they currently are. One accepted truism of long-term care is that disabled elders have highly diverse needs. The appropriate policy response to diverse needs are financing mechanisms that can tailor services and supports to individualized needs. If what a disabled elderly person really wants is someone to transport her best friend from across town so that the friend can help her clean the apartment, wash her clothes, and provide some companionship, then our public long-term care system ought to be flexible enough to accommodate that. Too often the choice is limited to a paid home care worker for two hours per day two days a week, and that's it. In regard to 24-hour supervised care, the choice is often restricted to a nursing home or nothing. Other residential options, like assisted living facilities, shared housing, and adult foster care need to be made more available under public programs. Thus, while Medicaid provides some flexibility in eligibility criteria and service coverage, many feel it is still a too rigid financing mechanism, and still based on the medical model.

TABLE 2. State Per Capita Spending for Long-Term Care Under Medicaid: 1991¹				
State	Medicaid Nursing Home Expenditures 1991 (Millions)	Medicaid Home Care Expenditures 1991 (Millions)	Total Medicaid Long-Term Care Expenditures 1991 (Millions)	Spending Per State Resident 1991
New York	\$3,345.5	\$1,914.0	\$5,259.5	\$294
Connecticut	643.2	135.3	778.5	238
Massachusetts	1,150.3	236.2	1,386.5	234
D.C.	121.0	13.0	134.0	222
Rhode Island	166.2	23.8	190.0	190
Maine	206.8	28.5	235.3	190
Minnesota	600.5	156.0	756.5	173
New Hampshire	129.5	46.6	176.1	154
North Dakota	77.1	21.6	98.7	150
Wisconsin	550.5	142.2	692.7	142
New Jersey	836.2	230.4	1,066.6	137
Vermont	52.2	17.5	69.7	122
West Virginia	175.0	45.0	220.0	119
Ohio	1,241.9	29.4	1,271.3	117
South Dakota	60.6	16.9	77.5	108
Indiana	574.2	20.7	594.9	106
Nebraska	135.8	32.9	168.7	105
Pennsylvania	1,073.8	143.8	1,217.6	101
Montana	59.2	19.1	78.3	98
Washington	355.8	107.3	463.1	97
Arkansas	201.2	32.2	233.4	96
Delaware	50.7	14.9	65.6	96
Kentucky	261.1	72.4	333.5	89
Maryland	358.8	58.2	417.0	87
Hawaii	87.1	8.4	95.5	84
Mississippi	204.6	8.3	212.9	80
Oklahoma	214.1	42.0	256.1	80
North Carolina	426.5	102.5	529.0	79
Tennessee	373.6	22.5	396.1	79
Louisiana	328.7	12.1	340.8	78
Missouri	346.4	59.3	405.7	78
Oregon	132.7	86.8	219.5	78
Georgia	428.5	67.9	496.4	75
Colorado	181.7	67.9	249.6	75
Alaska	37.4	1.3	38.7	74
Iowa	193.1	11.7	204.8	73
New Mexico	84.7	18.6	103.3	67
Kansas	147.4	20.1	167.5	66
Alabama	227.7	46.5	274.2	66

TABLE 2 (continued)				
State	Medicaid Nursing Home Expenditures 1991 (Millions)	Medicaid Home Care Expenditures 1991 (Millions)	Total Medicaid Long-Term Care Expenditures 1991 (Millions)	Spending Per State Resident 1991
Florida	776.8	60.0	836.8	65
Idaho	53.7	10.2	63.9	63
Illinois	666.8	66.8	733.6	63
Michigan	417.1	158.4	575.5	62
Texas	899.6	152.1	1,051.7	62
South Carolina	170.1	36.9	207.0	58
Virginia	313.7	47.0	360.7	58
California	1,563.2	49.1	1,612.3	55
Wyoming	22.6	2.2	24.8	53
Nevada	45.0	6.8	51.8	46
Utah	19.5	23.3	42.8	25
Arizona ²	9.4	0.0	9.4	3
U.S. TOTAL	\$20,798.8	\$4,746.6	\$25,545.4	\$102
<p>1. SOURCE: HCFA 64 data, Bureau of Data Management and Strategy. Data are for Federal Fiscal Year 1991. Includes Medicaid long-term care expenditures for persons under age 65; excludes ICF-MR expenditures.</p> <p>2. Arizona provides most public long-term care coverage under a capitated demonstration program, the Arizona Long-Term Care System (ALCS). Thus, these data do not accurately reflect true publicly-financed long-term care expenditures in Arizona.</p>				

The Shift Towards Home and Community-Based Care

A final characteristic of our current long-term care system is the remarkable shift that has occurred towards home and community-based services in recent years. For example, between 1987 and 1991, Medicaid expenditures for nursing home care increased 54 percent, but expenditures for home and community-based services increased by 130 percent. Medicare home health expenditures also more than doubled over the same period, from \$1.8 billion to almost \$4.5 billion.⁶ Recent research indicates that the percentage of disabled elderly persons with ADL and/or IADL impairments who receive some type of formal home care (public and/or private) increased from 26 percent in 1982 to 33 percent in 1989.⁷ Although the "institutional bias" of our public long-term care system used to be severely criticized, this criticism is heard less frequently today. Indeed, we are more likely to hear about the difficulty people have in accessing nursing home care.

Nonetheless, access to publicly-financed home care services is highly uneven. In States that have very limited home care benefits under their Medicaid programs, many poor disabled elders receive no formal home care, no matter how disabled they are. A

⁶ Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

⁷ Source: Jackson, Beth: "Family Caregiving: Still Going Strong?"

small handful of States account for the great majority of Medicaid spending for home care services. Thus, although there has been significant growth in public financing of community-based services, the demand for additional services is still great. However, since research has shown fairly convincingly that most recipients of home care services are not at immediate risk of nursing home placement, States remain wary of the cost implications of expanding access to in-home services for their elderly Medicaid populations.

What Will the Future Bring?

In reforming long-term care policy, we should be careful not to enact solutions that address yesterday's problems. The policy challenges of the future are going to be substantially different than the policy challenges of today. Although it is not possible to predict the future with certainty, some demographic, social and economic trends *are* fairly predictable.

Over the next 40 years, the decline in mortality rates and the aging of the baby boomers will result in a doubling of the elderly population, to about 66 million people. At the same time, the number of older persons at risk of disability and in need of long-term care services will increase even more rapidly. From 1990 to 2010, the number of persons age 85 and over will increase from 3.2 to 5.9 million. By 2030, there will be 7.7 million elderly persons age 85 and over. After 2030, when the baby boom generation starts to turn age 85, this age cohort will grow even more rapidly. By 2050, there will be approximately 14.5 million persons age 85 and over.

The growth and aging of the elderly population will result in both a relative and absolute increase in the size of the disabled population, assuming disability rates remain constant.⁸ When the first birth cohorts of the baby boom generation turn 85 years old, there are likely to be over 20 million disabled elderly, almost a three-fold increase in the size of today's long-term care population.

Just as the demand for long-term care will be growing dramatically, there will be fewer working- aged adults to provide and/or pay for care. The ratio of the population 75 years of age and over to the population ages 20 to 64 will more than double over the next sixty years.⁹ However, since the baby boom generation is currently just approaching middle age, this "dependency ratio" will not begin to rise for another 20 years or so.

⁸ Manton, Kenneth, "Epidemiological, Demographic and Social Correlates of Disability Among the Elderly," The Milbank Quarterly, Vol. 67, 1989. Disability rates are defined as the ratio of the disabled population over the total population. The disabled population includes persons having IADL limitations. [<http://aspe.hhs.gov/daltcp/reports/epdemes.htm>]

⁹ Social Security Administration, Office of the Actuary, Social Security Area Population Projections: 1989, June 1989, p.44. It should be noted, though, that the overall dependency ratio (children and elderly as a percent of the working-age population) has declined significantly since 1970, from .904 to .698, and that projected dependency ratios to 2080 are not expected to exceed the 1970 high.

Most forecasters believe that labor force participation rates among women, particularly those between the ages of 35 and 54, will continue to increase in future years. If true, some believe this will lessen the ability and/or willingness of women to provide unpaid care. Thus far, however, research has been unable to document that increased labor force participation among women has had a negative effect on their provision of informal care. Many women work *and* provide informal care at the same time. In addition, it is often overlooked that about one third of all informal caregivers are themselves elderly, and often retired. Finally, mortality trends suggest that more elderly women in the future will have their husbands with them longer, and while daughters are more likely to provide informal care than sons, male spouses have been shown to be as equally committed, to caring for their wives as females spouses are committed to their husbands. Thus, while it is often stated that there will be a dwindling supply of informal caregivers, to provide assistance to the disabled elderly in future years, this effect is probably overstated.

Other Trends May Reduce the Demand for Long-Term Care

On a more optimistic note, other trends may lessen future demand for long-term care. For one, it is possible that the incidence of disability among future elderly cohorts will decrease. Reduced smoking rates, reduced incidence of heart disease through better eating habits, blood pressure and cholesterol screening programs, and more frequent exercise, may all improve the health status of future elderly cohorts and reduce the rate of disability in their later years.

The elderly of tomorrow will also be better educated than the elderly of today, and studies show that higher education levels are associated with healthier lifestyles and an increased ability to adapt to changing life situations. Clearly, a major medical breakthrough which either reduced the prevalence of Alzheimer's disease and/or improved its response to treatment would greatly affect the demand for long-term care in future years as well.

The Future Affordability of Long-Term Care

Economic trends will affect the future affordability of long-term care, and, in turn, the demand for publicly-financed care. The income of elderly Americans has increased substantially over the past twenty years, and most projections indicate that the real incomes of the elderly will continue to increase. The average annual income for elderly families is estimated to increase from less than \$20,000 in 1988 to over \$30,000 in 2018 (in constant 1988 dollars). The number of elderly living below the poverty line is estimated to decline from about 5.4 million to about 2.9 million persons over the next 30 years.¹⁰

¹⁰ Source: Lewin/ICF estimates based on the Brookings/ICF Long Term Care Financing Model.

Although financial asset levels (net worth less home equity) are difficult to project, since they are very dependent upon the overall performance of the national economy, the amount of assets held by elderly persons is also expected to increase. By 2018, the proportion of elderly persons with less than \$5,000 in financial assets is projected to decrease from 39 percent to 27 percent, while the proportion with \$25,000 or more will increase from 45 percent to 57 percent. This increased wealth of the elderly will result in part from real increases in Income over the period, and therefore increased savings.

The improving economic status of elderly Americans suggests that more elderly will be able to purchase their own care or protect themselves from catastrophic long-term care costs. With their increased wealth, the elderly will also have greater incentive to buy risk protection (assuming no expansion in public insurance). But even though many elderly may have increased financial resources, the cost of buying services from formal providers is also expected to increase. The great majority of elderly will not be able to afford long term care unless they save for their future needs well in advance of old age, and spread the risk of financing long term care by participating in risk pooling arrangements.

Savings rates (the proportion of total income saved) must increase if the future elderly are to be able to finance their own long-term care needs. It is expected that individuals will increasingly plan for retirement in two stages: (1) by saving money to cover living expenses for their active years; and (2) by purchasing insurance to pay for increased medical and long term care expenditures in their "very old" years.

Some Elderly Will Always Be Poor

Although the elderly of the future will be financially better off than the elderly of today, there will always be elders who are unable to finance their own care. These economically disadvantaged elderly are likely to be very old, widows, and people living alone--those most likely to require long term care. These persons will continue to rely on public programs for assistance with long-term care, since they will not be able to afford to purchase their own care, or buy private insurance.

PART II. REFORMING LONG-TERM CARE POLICY: WHAT ARE THE OPTIONS?

There has been no lack of proposals for reforming our nation's long-term care policy, and it is not possible in this paper to discuss them all. However, most of the proposals are variations of a smaller number of basic models, of which we will discuss four: (1) Public insurance; (2) Medicaid reforms; (3) New Federal-State programs; and (4) Voluntary risk pooling (insurance). In this section of the paper, we describe these basic models, discuss common variations of the models, and where applicable, refer to specific examples of recent legislation which reflect a particular approach.

We also present the principal arguments that have been made in support of each particular model, along with the major arguments that have been articulated in opposition. Although space limitations preclude us from including every point of view that has been made in the policy debate, we hope to summarize the major points of contention in an accurate and equitable manner.

Public Insurance

Many reform proposals argue that coverage of long-term care services should primarily be a **public** responsibility, not a **private** responsibility. These proposals offer extensive public coverage of long-term care without means-testing, meaning that *all* disabled elderly persons would qualify for benefits regardless of their economic means. Most long-term care services, other than informally provided care, would be provided by the public sector, and the cost of providing these services would be financed through a significant increase in taxes.

However, there are many variations of the public insurance model (see Table 3). On the benefits side (what will be covered) proposals range from limited expansions in public coverage (beyond what public programs presently pay for) to comprehensive public insurance, in which private payments for services would be virtually eliminated. An example of the latter is the Universal Health Care Act of 1991 (HR 1300), sponsored by Congressman Marty Russo (D-IL), which proposed universal and comprehensive coverage for medically necessary nursing home care and home care services without any copayments or deductibles. This coverage would be provided as part of a national health insurance program that covered both acute and long-term care services under a new public program.

TABLE 3. Long-Term Care Financing Reforms: Public Insurance

Reform Proposal	Specific Proposals or Representative Legislation	Basic Features of Proposal	Change in Public Spending 1993 (in billions of 1992 dollars) ¹	Change in Out-of-Pocket Spending 1993 (in billions of 1992 dollars)
I. Comprehensive Public Insurance	Universal Health Care Act of 1991 (HR 1300) Rep. Russo (D-IL)	Universal (medically necessary) nursing home coverage without deductibles or copayments. Home and community-based coverage for all persons with 2 or more ADL impairments.	\$72.5	-\$28.8
	MediPlan Long-Term Care Act (HR 651) Rep. Stark (D-CA)	80% coverage of nursing home costs after 2-month deductible. 80% coverage of home care. No deductibles or copayments for persons with incomes below 200% of poverty.	\$47.0 ²	-\$12.6
II. Limited Expansions in Public Insurance A. Short-Term Nursing Home Coverage	Comprehensive Health Care for All Americans Act (HR 8), Rep. Oakar (D-OH)	Covers first 6 months of nursing home care to Medicare eligibles without deductibles or copayments.	\$6.5 ³	-\$1.1
	The Pepper Commission	Covers first 3 months of nursing home care with 20% copayment. (Other expansions in public coverage of long-term care services also proposed by Commission.)	\$5.5 ⁴	NA
B. Back-End Nursing Home Coverage	S. 2305) Sen. Mitchell (D-ME)	Public coverage of all nursing home care after an individual spends two years in a nursing home	\$12.7 ⁵	-\$15.0
C. Home Care Coverage	Commonwealth Fund Commission on Elderly People Living Alone	15 to 25 hours of in-home care or adult day care to Medicare elders with two or more ADL impairments. 20% copayment for persons above 200% poverty.	\$7.7	NA
	Pepper Commission Proposal	Coverage of home care services for Medicare elders with 3+ ADL impairments. Individual budgeting caps set for each eligible beneficiary, adjusted for level of disability. 20% copayment for persons above 200% poverty.	\$16.8	-\$0.1

1. Source of cost estimates: Brookings/ICF Long-Term Care Financing Model. Estimates cover all public costs for persons age 65 and over. Where legislation also includes benefits for persons under age 65, these costs are not included in estimates.
2. One month deductible (rather than two months) and no low income protections; home care for 2+ ADLs.
3. 20 percent copay (rather than no copays).
4. Cost of short-term nursing home coverage only. Excludes other expansions in public coverage.
5. Costs would increase in future years as more users met deductible requirements. Proposal modeled includes insurance purchase for two-year deductible.

However, most reforms which propose significant expansions in public coverage retain *some* private responsibility for long-term care in the form of deductibles, copayments or means-testing. For example, a bill submitted by Congressman Pete Stark (D-CA) in January 1991, the MediPlan Long- Term Care Act (H.R. 651) provides for 80 percent coverage of all nursing home and home care costs, as well as a two-month deductible for nursing home coverage. A proposal developed by the American Association for Retired Persons, called Health Care America, although proposing comprehensive public coverage of nursing and home care services, still retains income-related copayments, requiring nursing home recipients to contribute up to 35 percent of their income, or a maximum of \$952 per month.¹¹

Another bill, sponsored by Congressman Henry Waxman (D-CA), the Long-Term Care Security Act Of 1992, reflects many of the recommendations made by the recent Pepper Commission.¹² The bill proposes public coverage for the first 180 days of any nursing home stay, after which public coverage would be provided once nursing home users spent down their assets to \$30,000 for individuals and \$60,000 for married couples. A 20 percent copayment is also required for both nursing home and home care services.

Thus, while there are numerous proposals to provide fairly comprehensive public coverage of long- term care, most fall short of universal coverage. Deductibles, copayment requirements, and means- testing are often retained in various forms to: (1) reduce inappropriate overutilization; (2) reduce program costs; and (3) target benefits to those in most financial need.

Financing Models for Public Insurance

Expanded public financing of long-term care would entail a major shift in how the costs of formal long-term care will be shared by our society. In evaluating public insurance models, it is important to assess not only who benefits, but who pays. The distribution of the cost burden will depend upon the specific tax and financing mechanisms that are used to generate the revenues needed to pay for public benefits.

It is also important to understand how the current costs of long-term care are distributed throughout society. About 50 percent of all *formal*¹³ long-term care costs are borne privately by the individuals who use formal care (primarily private payments for nursing home care). The remaining 50 percent of formal long-term care costs is *already* borne by the public sector, 38 percent by the Medicaid program. Medicaid program

¹¹ **Health Care America.** The draft health care reform proposal of the American Association of Retired Persons as approved by the Board of Directors, March 1992.

¹² The U.S. Bipartisan Commission on Comprehensive Health Care, more commonly known as The Pepper Commission, was mandated by Congress in 1988 to recommend legislation that would ensure all Americans coverage for health care and long-term care. The Commission reports its recommendations in a report to Congress, A Call for Action, in September 1990.

¹³ Although we fully recognize the private costs of informally provided care, this discussion is limited to the cost burden of formal (paid) services.

costs, in turn, are paid out of Federal and State general revenues, primarily income taxes.

A *social insurance* approach, modeled on Social Security and Medicare, would finance benefits for current beneficiaries from payroll taxes on current workers.¹⁴ Under social insurance, workers would "pay into" the system during their working years, and draw benefits out of the system when they need long-term care during their elderly years. Like Social Security and Medicare, a social insurance approach to financing long-term care would be built upon social pacts between successive generations of workers.

If enacted today, a social insurance program for long-term care would create a "windfall" for the current generation of elderly who would have never paid into the system, but who would be eligible for publicly-financed benefits. There are also significant concerns about the burden which a social insurance program would place on future generations of workers, particularly in about 30-40 years when the aging of the baby boom generation will dramatically change the worker to beneficiary ratio.

Consequently, broader-based financing mechanisms have also been proposed to finance a public insurance program for long-term care. For example, increased taxes on unearned income, along with an increase in payroll taxes, would distribute costs more evenly across all age groups, since individuals over the age of 55 hold the vast majority of the nation's financial assets, and earn the majority of unearned income. This could include increased taxation of Social Security benefits for beneficiaries with high incomes. Another possible financing mechanism, proposed for example in the Long-Term Care Family Security Act of 1992, is to increase inheritance taxes by lowering the value of estates that are exempt from Federal tax from \$600,000 to \$200,000. This latter proposal might be termed a "buy now, pay later" approach, since the government would pay for your long-term care while you are alive, but then collect from your estate upon your death.¹⁵

In sum, how the costs of a public insurance program would be paid for is as important as what benefits would be covered, and who would be eligible to receive them. Like private insurance, a public insurance program would **reduce** the costs to most individuals who needed long-term care services (since the value of the benefits received would generally exceed their contributions to the program) and **increase** costs to those who paid into the system, but never used benefits. Unlike private insurance, however, participation in the insurance risk pool would be mandatory, not optional. In addition, a public program is likely to include an income redistribution component, in

¹⁴ Medicare Part A is financed as a social insurance program. Medicare Part B, which covers physician and ancillary services, is financed through premiums paid by beneficiaries and general Federal tax revenues.

¹⁵ Of course, individuals who never used public long-term care would "lose" under this proposal because they would still have to share in the cost of the program without receiving benefits (although they would have the benefit of being insured). This would be the "insurance" feature of a publicly-financed program. There would also be a wealth redistribution effect, since individuals with estates of less than \$200,000 would receive benefits but not pay increased taxes.

which "premium" costs are income (or wealth) related, while benefits for all eligibles would be equal.¹⁶

The Argument for Public Insurance

Many arguments have been made in support of a public insurance approach to financing our nation's long-term care system.¹⁷ These arguments include:

Universal Access. All persons who needed long-term care would be provided access to care without regard to their ability to pay. Persons with long-standing chronic conditions would not be denied access to care due to "uninsurability." Discriminatory admission policies against poorer (Medicaid) patients, in order to increase profitability, would be attenuated.¹⁸

Equity. All persons would be entitled to the same standard benefit, regardless of their economic position. The current system is two-tiered, with private pay patients often receiving a higher quality of care than Medicaid patients. Wealthier individuals could, of course, still purchase additional amenities not covered under the public program, but the basic standard of care would be raised for everyone. Also, since the program would be Federally-financed, differences in access and quality which currently exist across states would diminish.

Protection Against Catastrophic Costs. Since all persons would be covered under a public program, all individuals would be protected from the risk of being impoverished by catastrophic long-term care costs. This protection would be provided to all elderly individuals, not just those who could afford to buy risk protection in the private market.

Dedicated Financing. Since a public long-term care program is likely to be financed by dedicated taxes (taxes devoted exclusively to the purpose of financing long-term care) the financial stability of the program would be increased. The financial solvency of the long-term care "trust fund" would be ensured through long-range planning, not year-to-year fluctuations in Federal revenues and spending.

Broad-Based Insurance. All taxpayers or workers would be required to pay taxes to finance the system in return for program benefits if they became disabled. Thus, a broad (universal) insurance risk pool would be created. This means that the

¹⁶ For a more expanded discussion of financing options for a public long-term care insurance program, see Gist, J.R. Options for the Public Financing of Long-Term Care, Public Policy Institute, American Association of Retired Persons, December 1989.

¹⁷ See, for example, Wiener, J.M. and Hanley, R.J. Long-Term Care and Social Insurance: Issues and Prospects. Brookings Institution, Washington, D.C., June 1991; Harrington, C. et al: "A National Long-Term Care Program for the United States: A Caring Vision." JAMA Vol. 266(21):3023-3029, December 4, 1991; and Ball, R.M. and Bethel, T.N. Because We're All In This Together: The Case For A National Long Term Care Insurance Policy, Families USA Foundation, Washington, D.C., 1990.

¹⁸ It is reasonable to expect that even in a public insurance program that there would still be individuals willing and able to pay more than the public rate for better services and that providers would seek out such patients.

costs of long-term care would be spread across a very broad group of users, not just the disabled. Since many contributors to the system will **not** need long-term care services before they die, the cost to any single contributor is minimized.¹⁹

Administrative Efficiency. Compared to private insurance systems, public programs like Social Security and Medicare, since they are so large, have low administrative costs relative to the amount of premiums paid. This maximizes their administrative efficiency and provides a better return on premiums than small risk pools, which have higher administrative costs. For example, significant savings are achieved by not having to pay for the marketing of insurance policies, since **everyone** must participate (i.e., everyone **has** to buy a policy). Administrative efficiencies are also achieved on the supply side since providers need only bill and be regulated by a single payer.

Buying Power. Since a public insurance program creates an extremely large buyer of long-term care services (a "monopsony") substantial leverage is created in the government's ability to regulate the prices which suppliers of long-term care can charge for their services.

Protection of the Elderly Poor. Proponents argue that a broad-based public insurance program is the best political strategy for raising the public revenues needed to care for persons who cannot afford to purchase, long-term care in the private market. In the absence of a public insurance program, they claim, it will be increasingly difficult to raise the necessary taxes to pay for the long-term care of the poor elderly served by Medicaid.

The Argument Against Public Insurance

While the arguments in favor of public insurance may be compelling to many people, others believe just as strongly that it is the wrong road to take in long-term care reform. People who take issue with a broad-based public insurance program make the following counter-arguments:

Finance Long-Term Care Through Savings and Investment, Not Income Transfers. Opponents of public insurance for long-term care argue that financing long-term care is fundamentally about saving (and risk pooling) for the future. National long-term care policy should be built on a system of savings and risk pooling, and the productive investment of risk pools, to meet future needs. Each generation should be responsible for financing its own long-term care, and not shift the burden to subsequent generations. In public insurance programs, they argue, there is no real accumulation of reserves, or the productive investment of reserves, only income transfers between individuals. Even under social insurance financing models, such as Social Security and

¹⁹ It is estimated that approximately 43 percent of persons turning age 65 in 1990 will enter a nursing home at least once before they die. This estimate, however, does not assume the enactment of a social insurance program for nursing home coverage. Source: Kemper, P. and Murtaugh, C.M. "Lifetime Use of Nursing Home Care." N. Engl. J. Med. Vol 324(9):595-600, February 28, 1991.

Medicare, they argue that there is no real accumulation of reserves, only the promise of the Federal government to meet future commitments.^{20,21}

Increased Social Expenditures for Long-Term Care. Critics argue that the availability of universal insurance for long-term care will greatly increase the demand for formal services ("moral hazard" effects). By lowering price barriers to formal services, total utilization of long-term care will increase dramatically. There will be a substantial shift from informal to formal care, as families seek to maximize public benefits. In consequence, there will not just be a displacement of public spending for private spending, but an increase in total national spending for long-term care services. The cost estimates for public insurance proposals presented in Table 3 include assumptions about induced demand for formal services that would result from universal coverage.

Politicization of Price and Quality. In a single-payer system, prices and quality standards would be established primarily through public regulation, not through competition in the marketplace. Long-term care suppliers will attempt to maximize profitability through manipulation of the political process, rather than offering a superior product at the best price. Public expenditures will increase because providers will be more influential in the political process than the taxpaying public.

Limited Choice. A public insurance program will have a uniform benefit package. In sum, everyone in the system will "buy" the same insurance product. Although the government could modify the benefit package over time, critics argue that the government would not be as flexible as the marketplace in being responsive to changing consumer preferences. For example, in the current long-term care market, a range of 24-hour residential care alternatives to nursing homes (e.g. Continuing Care Retirement Communities, assisted living facilities, adult foster care programs) have

²⁰ This argument is probably best articulated by Gordon Trapnell:

“The reality of public programs is that the contributions collected from current workers are used to pay for current beneficiaries. Any surplus of earmarked taxes (over benefits required) is simply used to reduce the general deficit of the federal government--in other words, to support other federal outlays. So there is no real investment of any given individual’s contributions to pay for that person’s retirement. Instead, each generation pays for the benefits of those already retired, gambling that future generations of workers will be equally generous to them when it comes their turn to retire....Therefore, the only realistic means of providing for the accumulation of the capital-based savings necessary for funding social insurance needs would appear to be private savings.” Source: Trapnell, G. “Can We Afford Public Funding for Long-Term Care?” Contingencies, July/August 1990, pp. 39-46.

²¹ In counterpoint of this argument, others point out that if the public investments of excess contributions are invested “wisely” (e.g. in education, research and development, infrastructure) that the returns to the economy (and thus the ability to finance future benefits) could be equal to those of private investment of long-term care savings.

developed in response to consumer preferences. Critics claim that these types of market innovations would be less likely to occur in a publicly-financed system.²²

Formalization of the Long-Term Care System. Most long-term care provided in the United States is informal care. Not only family members caring for each other, but neighbors, friends, and community organizations voluntarily helping the disabled members of their communities. Universal access to paid services would displace much of this informal care with formal care. Some claim this would actually lead to a less "caring" long-term care system in the long run.

Poor Targeting of Public Resources. Medicaid currently pays for about 40 percent of all long-term care costs, and these resources are targeted to the elderly poor, and those who have depleted their private resources in nursing homes. Opponents claim that the primary beneficiaries of a universal public insurance program would be middle and upper class elderly persons, most of whom can well afford to pay for their own care, or buy private insurance without public assistance.

Estate Protection Not a Public Policy Issue. One effect of a public insurance program for long-term care would be to protect inheritances. The program would protect the assets of long-term care users, rather than force the depletion of those assets to buy care in private markets. Estate protection, critics argue, particularly for persons without spouses, is not a public policy goal. This distinguishes long-term care from Social Security and Medicare, both of which have the legitimate policy goal of preserving the economic well-being of elderly people during their retirement years. In brief, opponents ask: why is the depletion of private assets for long-term care at the end of someone's life a public policy concern, as long as the government provides a safety net (i.e. Medicaid) for those who deplete all of their assets? Should taxpayers be forced to pay increased taxes so that the children of long-term care users can have their Inheritances protected?

Both sides of the policy debate clearly have formidable arguments, and these arguments should be developed further as the debate moves forward. Future debate on the relative merits of long-term care financing proposals should address the specific arguments discussed above. Proponents of public insurance argue that some of the concerns raised by opponents could be addressed through specific design features of the public program.²³ For instance, a public insurance program could still promote competition in the marketplace through preferred provider contracts with superior providers, or by encouraging the development of capitated delivery systems similar to the Social HMO model. There are also those who argue that aside from the objective merits of a public insurance program, the political reality is that the Federal government

²² In counterpoint to this argument, some analysts have proposed that public insurance benefits be paid in the form of an indemnity benefit (voucher) tied to an individual's disability level. Individual purchase decisions by long-term care consumers would then determine the nature of the long-term care marketplace, rather than the decisions of government policymakers. See Scanlon, W.J.: "Possible Reforms for Financing Long-Term Care." J. of Economic Perspectives Volume 6, Number 3:43-58, Summer 1992.

²³ See Wiener, J.M. and Hanley, R.J. Long-Term Care and Social Insurance: Issues and Prospects.

would never be able to raise the tax revenues needed to finance a national long-term care program with universal coverage. In light of that reality, they argue, incremental reforms are only the possible option for expanded public coverage.

Limited Expansions in Public Insurance

In contrast to long-term care reform proposals which provide universal access to comprehensive benefits, others have proposed more modest expansions in public benefits. Unlike comprehensive public insurance, limited expansions are less likely to be financed as a social insurance program, and are more likely to be financed out of general revenues. However, they would still provide expanded public benefits (e.g. Medicare expansions) without means-testing, meaning that benefits would be provided without regard to ability to pay. In this section, we discuss three "limited expansion" models that appear to have some support in the long-term care policy debate:

- A "short-term" nursing home benefit;
- "Catastrophic" nursing home coverage; and
- A home care benefit.

Short-Term Nursing Home Benefit

A short-term nursing home benefit was one of several expansions in publicly-financed long-term care recommended by The Pepper Commission. The Commission proposed that the Medicare SNF benefit be expanded to cover the **first three months** of a certified nursing home stay, including **both** skilled care and custodial care. Eligible beneficiaries would be required to pay a copayment equal to 20 percent of actual costs, or 20 percent of the national average cost of nursing home care, whichever was lower. Individuals could be eligible for more than one episode of coverage, although provisions would be enacted to prevent "revolving door" coverage.²⁴

A short-term nursing home benefit would provide some public coverage for the approximately one million elderly persons who are admitted to nursing homes each year. It would provide **complete** coverage for the 23 percent of these admissions who are discharged back to the community within three months. Most importantly, it would extend coverage to beneficiaries who do not currently meet Medicare's relatively strict criteria for skilled care. The estimated increased cost of this relatively modest expansion in public benefits (over current outlays) is estimated at \$5.5 billion in 1993, as shown in Table 3.

Proponents of expanded public financing for short-term nursing home care argue that it supports the original goals of the Medicare program: to provide the elderly with financial protection from acute illness. Most people who use short-term nursing home care do so during recovery from an acute illness episode, but many people feel that the current Medicare SNF benefit is too narrowly targeted to provide true coverage of post-

²⁴ "Revolving door" coverage pertains to the frequent discharge and readmission of nursing home patients by providers in order to extend coverage of benefits.

acute care recovery. By limiting coverage to short-term stays, benefits would be targeted to nursing home users with the highest probability of being discharged home. Further, a short-term nursing home benefit would promote continuity of coverage between inpatient hospital stays and post-acute nursing home care by ensuring that all admissions to post-acute care are covered by the same payment source. Presently, the discharge of patients from hospitals to nursing homes is often hindered by nursing homes' uncertainty about coverage/payment for new admissions.

A short-term nursing home benefit would help preserve the economic security of elderly persons who have a reasonable chance of recovering to an independent life style. Asset protection for those who are unlikely to ever be discharged from a nursing home *is not* a policy objective of this approach. Finally, by picking up the front end of all nursing home stays, the cost of private long term care insurance for extended nursing home care would decline somewhat, increasing the percentage of elderly persons who could afford to purchase coverage for longer stays.

It is important to note that The Pepper Commission did not propose a front-end nursing home benefit as the only expansion in public support of long-term care services, but as one of a number of expansions, including added protection for long nursing home stays and expanded public coverage of home care services. However, others have proposed front-end nursing home coverage as a relatively low cost stand-alone proposal that would restore some of the expanded nursing home benefits temporarily enacted, then repealed, under the Medicare Catastrophic Coverage Act.

Detractors of short-term nursing home coverage have generally argued that public resources would be more wisely used to provide catastrophic coverage for persons with very long nursing home stays ("catastrophic coverage"). Thus, rather than discussing specific criticisms of front-end coverage proposals, we proceed directly to a discussion of a "catastrophic" nursing home benefit.

Catastrophic Nursing Home Coverage

In contrast to expanded public coverage of short-term nursing home stays, a "catastrophic" nursing home benefit would target public coverage to persons who require extended nursing home care. For example, a bill sponsored by Senator George Mitchell (D-ME) (S. 2305) in the 100th Congress, proposed to provide public coverage after an individual had spent two years in a nursing home.

The rationale for a "catastrophic" nursing home benefit is that it would provide "stop-loss" protection for extraordinarily large nursing home costs, which proponents claim is the primary concern of the elderly, not the financial consequences of short nursing home stays. Resources would be targeted to individuals and families faced with the most debilitating chronic illnesses, such as Alzheimer's disease. Proponents argue that it is the specter of total impoverishment resulting from extended nursing home care that the elderly fear most. A short-term nursing home benefit would do little to relieve that concern.

Like a front-end nursing home benefit, a catastrophic benefit would reduce the cost of private insurance for uncovered benefits.²⁵ Some claim that catastrophic coverage would create a more stable private insurance market because the risk of private insurance plans would be limited by public "back-end" insurance. Insurers could better predict their costs, and price their products more competitively (and accurately) than in today's environment, where insurers are liable for unlimited coverage. By reducing the cost of risk protection for uncovered nursing home stays, a catastrophic public benefit would greatly encourage the purchase of insurance coverage for the deductible period.

The primary criticism of catastrophic nursing home coverage concerns who would benefit from such a program. Depending upon the length of the deductible period, a catastrophic benefit could end up providing benefits primarily to relatively wealthy elderly persons, not those who are in most need of financial help. For example, if the front-end deductible were two years, as in the Mitchell bill, only those elderly who could afford to pay for at least two years of private care (about \$60,000 on average) would benefit. Persons with fewer assets would already be impoverished by the time they were eligible for the new benefit, and would already be eligible for public assistance under Medicaid. A catastrophic coverage program would provide these persons with no increased financial protection whatsoever. Thus, by expanding public benefits to persons who can now afford to pay for their own care, a catastrophic benefit could be criticized as a regressive program which transfers tax dollars from the non-wealthy to the wealthy.

Even with a two-year deductible, a back-end benefit would still carry a high price tag--about \$13 billion in increased public outlays in 1993 (see Table 3). Public outlays would increase further in subsequent years as more nursing home users met the two-year deductible requirement. Costs are higher for catastrophic coverage because persons with long nursing home stays account for a very high proportion of total nursing home utilization.²⁶ If the program was Federally-financed, States would reap a windfall, however, since a back-end benefit would pay for many nursing home users now covered by Medicaid.

A Home Care Benefit

Another limited reform option is to expand public coverage of home care services without expanding coverage of nursing home care. It is possible to argue that the policy objectives of a home care benefit program are qualitatively different from the objectives of an expanded nursing home benefit. For one, expanded home care benefits are more akin to current Medicare benefits in that they would provide financial protection against

²⁵ Any significant expansion in public long-term care benefits will increase the affordability of private insurance for uncovered benefits by reducing the risk (cost) of uninsured events, unless "moral hazard" effects increase total utilization by more than amount of care covered under public expansions.

²⁶ Spence, D. and Wiener, J.: "Nursing Home Length of Stay Patterns: Results from the 1985 National Nursing Home Survey." *The Gerontologist* Vol. 30, No. 1:16-20, 1990.

the out-of-pocket costs of maintaining individuals at home. Home care would help individuals maintain their "quality of life" in the community, and protect them from the distress of either purchasing expensive home care services on their own, or becoming a burden on family members. Once an individual enters a nursing home, it can be argued that there is less justification for protecting an individual's financial assets, particularly if there is little likelihood that the individual will return to the community.

Examples of two home care benefit proposals include one advanced by The Commonwealth Fund Commission on Elderly People Living Alone in 1989 and another proposed by The Pepper Commission in 1990.²⁷ The Commonwealth Fund proposal is limited to disabled *elderly* persons, while the Pepper Commission proposal encompasses both elderly and non-elderly persons with disabilities.

The Commonwealth Fund proposed expanding the Medicare benefit package to include home care services for persons with chronic conditions. Elderly individuals with limitations in two more ADLs and cognitively impaired persons with comparable limitations would be entitled to between 15 and 25 hours of home care services per week, depending upon level of disability. Recipients would be required to pay 20 percent of costs as a copayment, although Medicaid would cover the full share of copayment requirements for persons with incomes below the poverty level, and would-share copayment costs with persons between 100 and 200 percent of poverty. The Commonwealth Fund estimated that approximately 1.6 million disabled elderly would be eligible for home care benefits under this proposal. The estimated cost of this expansion is about \$7.7 billion in 1993 (Table 3).

The Pepper Commission proposal used somewhat different eligibility criteria for their proposed home care benefit. It proposed that home care benefits be made available to: (a) persons who need hands-on or supervisory assistance with three or more ADLs; (b) persons who need constant supervision due to cognitive impairments; and (c) persons who need constant supervision due to difficult behaviors. Because The Pepper Commission criteria include persons who need supervisory as well as hands-on assistance with ADLs, the estimated eligible population totaled 2.0 million persons, 25 percent larger than the target population proposed by The Commonwealth Fund.

Like the Commonwealth Fund proposal, the Pepper Commission proposed imposing a 20 percent copayment requirement on home-care recipients, with comparable Medicaid coverage of copayments for persons with low incomes. The Commission also proposed that case managers be assigned the responsibility of devising a care plan for each individual eligible for services within an overall budgetary cap, which would be adjusted according to an individual's level of disability.

The estimated public cost of the Pepper Commission home care proposal is about \$16.8 billion in 1993 (Table 3). This is more than double the estimated cost of The

²⁷ Rowland, D. Help At Home: Long-Term Care Assistance For Impaired Elderly People. A Report of The Commonwealth Fund Commission on Elderly People Living Alone, Baltimore, MD, May 1989; and The Pepper Commission, A Call For Action, September 1990.

Commonwealth Fund proposal. In addition to targeting a somewhat broader population, The Pepper Commission proposal assumes higher utilization levels, since It does not cap the number of hours of service any particular individual can receive, and somewhat higher costs per home care visit.

These differences in the estimated costs of a home care benefit underscore the difficulty of making accurate projections of participation and utilization in an expanded public home care program. The number of persons potentially eligible for home care services can vary substantially with only slight changes in the disability criteria used to determine eligibility.²⁸ Second, it is difficult to estimate what proportion of persons eligible for benefits would actually use services, since some individuals and family members will prefer to retain informal caregiving arrangements, without formal help. Third, program costs will also be extremely dependent upon utilization controls imposed on the program, as well as reimbursement rates paid to formal home care providers. Existing public home care programs range from using volunteers for certain non-skilled services (e.g., Meals-on-Wheels programs) to using highly skilled nurses to provide care to persons with serious medical and chronic conditions.

While there is considerable political support for the expansion of publicly-financed home care benefits, there has not been extensive debate regarding the policy objectives of such an expansion. For example, public funding of new home care benefits should be based upon empirical information about persons who are **not** being served adequately under existing policy. Before we enact a new public home care program, we should ask: "What is the magnitude of 'unmet needs' among the current disabled elderly, and what groups are being underserved by both the formal and informal care system? What groups of informal caregivers experience the greatest emotional, physical, and financial distress as a result of their caregiving responsibilities? What types of people experience the greatest financial stress from having to purchase formal home care services out of private income?" *Although the data to address these questions have many limitations, there is no strong evidence to date that show large numbers of disabled elderly living at home have unmet needs, that most informal caregivers feel overly burdened, or that more than a small number of people are experiencing high out-of-pocket costs for formal home care services.*

Another concern that has been expressed about expansions in public home care benefits is that they do not come to grips with the issue of family roles and responsibilities versus public responsibilities. Most home care reform proposals have failed to take into account the presence or absence of family caregivers in allocating public home care benefits. There is some concern that a significant expansion in public home care benefits will "substitute" for care that has been traditionally provided by families. This could lead, critics argue, to an erosion of traditional family relationships; a less caring, more formalized, long-term care system; and increased societal costs for

²⁸ See Jackson, M.E., Burwell, B., Clark, R.F., and Harahan, M.: "Eligibility for publicly-financed home care." [<http://aspe.hhs.gov/daltcp/reports/pubfhces.htm>] *American Journal of Public Health*, Vol. 82, No. 6:853-856, June 1992, and Stone, R. and Murtaugh, C.: "The elderly population with chronic functional disability: implication for home care eligibility." *Gerontologist*, Vol. 30:491-496, 1990.

the production of long-term care services (since informal care is less costly). However, research conducted to date provides little empirical support for these concerns, since the addition of formal home care services into households has been shown to have little impact on the quality of informal care provided.²⁹ Rather, it appears that informal caregivers are more likely to rearrange their informal caregiving hours, without reducing their total effort, such that care recipients end up getting *more* care overall.³⁰ It must be recognized, however, that the results of small-scale lied conditions may *not* hold true in a dramatic policy change in the public financing of home care services.

Medicaid Reforms

Our current long-term care system allocates the great majority of public benefits through means-testing. (i.e. the Medicaid program). Long-term care reform options which propose to retain the principle of means-testing in allocating public benefits are **fundamentally** different from reforms which propose to establish coverage of long-term care benefits without regard to financial need. They differ not only in terms of who qualifies for benefits, but in terms of how benefits are financed, who administers benefits, and how resources are allocated to eligible recipients. For example, since most means-tested programs are administered by State governments, not the Federal government, it is likely that a means-tested long-term care program would retain a significant State role in the policy process, with resulting State-to-State variation in eligibility criteria and benefit packages.

In considering alternative long-term care reform strategies, the decision of whether to extend long-term care benefits to *all* disabled elderly persons without regard to financial need, or whether to target resources only to those who meet financial need criteria is a critical one. It should precede discussions about benefit packages or disability criteria. A means-tested approach affirms that persons of adequate financial means are responsible for financing their own long-term care needs in private markets. A public insurance approach, in contrast, adopts the principles of the Medicare program--that all disabled elderly should be entitled to benefits without means-testing.

While affirming that public resources should be allocated according to financial need, reform proposals which retain means-testing nonetheless maintain that current Medicaid policy is inadequate.³¹ In brief, they reflect a desire to make Medicaid policy more generous than it now is, at least in most States.

²⁹ Hanley, R.J., Wiener, J.M. and Harris, K.M. "Will Paid Home Care Erode Informal Support? Journal of Health Politics, Policy and Law Vol. 16(3):507-521, Fall 1991.

³⁰ At the same time, several recent studies indicate that the introduction of formal services into a caregiving household is not effective in sustaining informal caregivers over time when caregiving burdens are severe. See Doty, P. "Informal Caregiver 'Burnout': Predictors and Prevention." ASPE Research Notes, January 1993. [<http://aspe.hhs.gov/daltcp/reports/rn05.htm>]

³¹ See, for example, HIAA Research Bulletin. **Long-Term Care Financing Proposals: Their Costs, Benefits, and Impact on Private Insurance**. Washington, D.C., January 1991.

While maintaining that private markets should continue to serve elderly persons with financial means, means-tested reforms acknowledge that many elderly, not eligible for Medicaid coverage, cannot afford to participate in the private long-term care market. A common goal of Medicaid reform is to narrow the gap between the public and private long-term care systems, so that fewer people are caught "in-between," i.e., they can neither afford to purchase their own long-term care (or buy insurance), nor are they eligible for public assistance.

This section discusses proposed reforms to expand Medicaid coverage of nursing home care and home and community-based services. *It is important to note that States already have considerable discretion to enact these kind of reforms, without new Federal legislation.* In recent years, States have been accorded increased flexibility by Congress in eligibility criteria and benefit design for long-term care coverage under Medicaid, and several States have taken advantage of this increased flexibility to enact reforms. But while States may have the legislative authority to implement significant Medicaid reforms, they may not have the political will or fiscal capacity to do so. Moreover, the flexibility offered States under Medicaid creates a dichotomy: the same flexibility which allows States to implement significant reforms on their own also leads to ever-larger discrepancies in public long-term care coverage across the 50 States. This variation in public coverage, in turn, leads to ever-more vociferous criticisms that the existing system is inequitable, and should be made more uniform across the nation.

Reforms to Medicaid Coverage of Nursing Home Care

A variety of incremental Medicaid reforms could improve financial protections for Medicaid recipients in nursing homes. Presently, single individuals generally must have less than \$2,000 in countable assets before they can qualify for Medicaid coverage in nursing homes.³² Once eligible for Medicaid, they must also contribute almost all of their income to the cost of their care, except for a small personal needs allowance. Possible reform options include:

Raise Medicaid resource levels for nursing home coverage. This provision would increase the amount of countable assets a nursing home recipient could retain and still receive Medicaid coverage. The elderly would not have to totally impoverish themselves before qualifying for Medicaid coverage, thereby reducing the welfare stigma of the program somewhat. Medicaid recipients would retain a small level of wealth that they could still pass on as an inheritance to heirs. For example, raising the Medicaid resource level to \$12,000 in all States would cost an additional \$1.0 billion in total Federal/State spending in 1993 (see Table 4).

Provide full asset protection under Medicaid for the first six months of a nursing home stay. This provision would waive Medicaid resource criteria for the first six months of a nursing home stay, while retaining income criteria. In brief, if an elderly nursing home recipient could not afford to purchase private nursing home care from their income alone, they could receive Medicaid assistance for the difference between

³² Medicaid financial criteria for nursing home coverage vary slightly from State to State.

their available income and the private cost of care. They would not have to supplement their income by spending down assets. This provision is intended to provide asset protection for short nursing home stays, but differs from a public insurance program in its requirement that recipients contribute most of their income to the cost of care. After six months, Medicaid resource criteria would be applied, and recipients with excess resources would become ineligible, and have to begin drawing down their assets. Because most persons who are discharged to the community have short nursing home stays, this provision would provide asset protection only for those persons who are most likely to return home. It is estimated that this Medicaid reform would cost about \$700 million annually in total Federal/State spending in 1993 (Table 4).

Raise the Federal personal needs allowance from \$30 to \$100 per month.

This provision would allow Medicaid recipients to retain a higher amount of discretionary income for expenses such as haircuts, personal items, gifts, and room furnishings. This proposal would cost about \$1.2 billion in 1993, some of which would be reflected in higher SSI costs, since SSI pays for the personal needs allowance for Medicaid nursing home recipients with no income.

Require all States to provide medically needy coverage of nursing home care. This proposal would affect the 19 so-called "income cap" States which limit Medicaid eligibility to persons with incomes below 300 percent of the Federal SSI benefit level (\$1,422 per month in 1992). In these States, persons with incomes above the Medicaid eligibility level but below the private cost of nursing home care (which now averages about \$2,500 per month) are caught in-between, even if they have depleted all of their assets. This reform would increase Medicaid costs in these 19 States by some \$500 million annually.

Improve spousal impoverishment protections. Although the Medicare Catastrophic Coverage Act substantially increased financial protections for the community spouses of Medicaid recipients in nursing homes, some believe these financial protections should be enhanced even further. In July 1992, protected income levels for community spouses rose to 150 percent of the poverty level. Raising protected income levels to 200 percent of poverty would cost about \$1.2 billion in new Federal/State Medicaid spending in 1993.

TABLE 4. Long-Term Care Financing Reforms: Medicaid Reforms			
Reform Proposal	Specific Proposals	Change in Public Spending 1993 (in billions of 1992 dollars)	Change in Out-of-Pocket Spending 1993 (in billions of 1992 dollars)
A. Expanded Medicaid Coverage of Nursing Home Care	1. Raise Medicaid resource levels for nursing home coverage to \$12,000 for unmarried persons.	\$1.0	-\$1.0
	2. Waive Medicaid asset criteria for first six months of a nursing home stay.	\$0.7	-\$0.3
	3. Raise Federal personal needs allowance to \$100.	\$1.2	-\$1.0
	4. Eliminate "Income cap" States. Require all States to provide medically needy coverage of nursing home care.	\$0.5	-\$0.5
	5. Raise protected income levels for community spouses of Medicaid recipients in nursing homes to 200% of poverty.	\$1.2	-\$1.3
B. Tighten Medicaid Eligibility Coverage of Nursing Home Care	1. Require all States to count home equity of primary residence as countable resource after a six-month stay for unmarried recipients.	-\$1.9	\$2.9
	2. Tighten eligibility loopholes to prevent transfer of assets and income solely for the purpose of qualifying for Medicaid.	-\$2.3	\$3.2
C. Expanded Medicaid Coverage of Home Care Services	1. Allow States to cover a broad range of home and community-based services under Medicaid, without Federal restrictions.	? ¹	? ¹
	2. Raise Medicaid financial criteria for home care services. For example, raise income criteria to poverty level and asset level to \$5,000.	\$2.0	-\$0.2
1. Not able to estimate State response to lifting of benefit coverage restrictions on home and community-based services.			

While some proposals would broaden Medicaid coverage of nursing home care, others propose to tighten eligibility criteria for certain recipients. These proposals would reduce net Medicaid spending, which could be used to finance expansions for other groups. One proposal is to require that all States include home equity as a countable resource for Medicaid eligibility under certain circumstances. For example, home equity might no longer be excluded after a non-married recipient had been in a nursing home for six months, and is unlikely to be discharged home.³³ At this point, the recipient's

³³ This provision is presently optional to some State Medicaid programs (those which are not so-called "1634" States). However, in most States, equity in a primary residence remains an "exempt" resource regardless of how long a Medicaid recipient has been in a nursing home, and regardless of their chances of being discharged home.

home would become a countable asset, and the recipient would be forced to sell the home, and deplete home equity assets before reapplying for Medicaid assistance.³⁴ As shown in Table 4, this policy change would yield an estimated \$1.9 billion in Medicaid program savings in 1993. Alternatively, Medicaid recipients' private residences could remain an "exempt" resource, but States could be required to place liens on residential property and to recover Medicaid costs after the death of a recipient through estate recovery programs (this is presently an option).

Another savings option is to tighten eligibility "loopholes" that are used by some elderly persons, their children, and their attorneys to shelter or divest assets that would otherwise disqualify these persons from Medicaid coverage.³⁵ These loopholes include the use of trusts and other financial Instruments that render income and/or assets of a nursing home recipient "unavailable" and therefore, not countable, in determining eligibility for Medicaid. While little empirical data exist on how much "Medicaid estate planning" is going on, and what effect it has on Medicaid long-term care spending, many state Medicaid officials view it as a growing problem with a large potential impact on future Medicaid costs.³⁶

Reforms to Medicaid Coverage of Home Care

Access to home care services varies markedly across State Medicaid programs. For example, a few States (New York, Michigan, Oklahoma, Texas) support broad in-home service programs for the elderly under the Medicaid personal care services option. Other states have expanded home and community-based services under the Section 2176 Medicaid waiver program.³⁷ A few States (e.g. Massachusetts and California) also support means-tested home care programs outside the rubric of the Medicaid program. However, access to home care services by poor elderly persons with functional impairments is highly uneven across States, and Federal law still restricts Medicaid coverage of non-skilled home care. Targeted expansions could include:

Allow States to cover a broad range of home and community-based services under Medicaid, without restriction. This reform would lift the restrictions currently placed on States regarding whom they may serve (only persons who meet nursing home criteria) and how many (a complicated formula) under their Section 2176 waiver programs. The "optional" Medicaid benefit package would be expanded to

³⁴ To avoid forcing recipients into "fire sales" of their homes, States could allow recipients to retain Medicaid coverage while making bona fide efforts to sell their homes at a fair market value. Once sold, home equity assets could be used to retrospectively reimburse Medicaid for costs incurred during the period of ineligibility. This practice is already followed in a small number of States.

³⁵ For a discussion of common strategies used to divest or shelter assets, see Burwell, B.: **Middle-Class Welfare: Medicaid Estates Planning for Long-Term Care Coverage**. Study conducted by SysteMetrics for HIAA, Lexington, MA, September 1991.

³⁶ Burwell, B. **State Responses to Medicaid Estate Planning**. Report prepared by SysteMetrics under contract to the Office of Research and Demonstrations, HCFA, January 1993 (draft).

³⁷ Estimated Medicaid expenditures for personal care services for persons over the age of 65 were \$1.3 billion in 1991. Estimated expenditures under the Section 2176 waiver program in 1991 were about \$500 million. Source: HCFA 64 data, Office of State Agency Financial Management.

include a broader range of non-medical community-based services such as case management, homemaker, home health aide, adult day care, assistive technology, non-medical transportation, and in-home meals that help to maintain functionally dependent elderly persons in non-institutional settings. Cost estimates of this reform are confounded by not knowing how many States would elect this option and increase funding beyond their current programs. Net increased expenditures would probably not exceed \$100-\$300 million over the short term, but could increase significantly over the longer term with improved State fiscal capacity.

Raise Medicaid financial criteria for home care services. Only about six percent of the elderly living in the community are enrolled in the Medicaid program at any one time.³⁸ Broadening the Medicaid benefit package will therefore do little to assist functionally disabled elderly persons who are poor, but not poor enough to qualify for Medicaid. An expansion of means-tested home care benefits could be enacted by raising Medicaid eligibility criteria for persons with functional disabilities.³⁹ For example, a program which covered home care services for persons with three or more ADL impairments (and/or equivalent cognitive impairments), incomes below the poverty level, and assets of less than \$5,000 is estimated to cost about \$2 billion in 1993 dollars (over and above current Medicaid spending and assuming all States participated in such a program). Raising financial eligibility criteria to 200 percent of poverty, with no asset test, would increase costs to about \$7 billion annually.

As discussed above, any expansion in means-tested coverage of long-term care services enacted under the existing structure of Medicaid would have to address whether States have the fiscal capacity to support such expansions. States already claim that recent Federal mandates to expand Medicaid have exceeded the ability of States to generate the revenues needed to finance new Medicaid spending. Thus, long-term care reform options which intend to expand coverage through means-tested program may have to consider financing strategies other than those which presently apply under Medicaid. For example, the Federal government could finance a higher percentage of new long-term care expansions than in the mainstream Medicaid program, or even fund the entire cost of new benefits.

New Federal-State Programs

An alternative to Medicaid reforms is to replace Medicaid with an entirely new Federal-State arrangement for financing long-term care. This is not as remote a possibility as many might think. For example, should there be a dramatic restructuring of the Medicaid program as part of a broad- sweeping national health care reform initiative, or the replacement of Medicaid with a broader public insurance program for acute care, the question will remain about what to do with the residual "long-term care component"

³⁸ Ries, P. "Characteristics of persons with and without health care coverage: United States, 1989." Advance Data From Vital and Health Statistics; No. 201. Hyattsville, Maryland: National Center for Health Statistics, 1991.

³⁹ Decisions would have to be made about whether these persons would also be eligible for the full Medicaid benefit package (e.g. physician services, prescription drugs) or just home care services.

of Medicaid. The opportunity would arise to create a new program, or institute a major revamping of the current program, specifically designed to meet the needs of persons with chronic disabilities.

A new Federal-State partnership for financing long-term care is likely to possess a number of features that would not be present in a comprehensive public insurance program:

- The program would remain jointly financed by States and the Federal government, although formulas for determining the Federal share of total program costs could be totally revised.
- Like Medicaid, the program would probably be financed through current operating revenues, not through earmarked taxes or a Trust Fund reserve.
- Unlike a national public insurance program, a Federal-State program is likely to accord greater authority to States over program design and resource allocation decisions, although, as in Medicaid, the Federal government is likely to establish minimal criteria for Federal financial participation.
- A joint Federal-State program would probably permit experimentation with a range of long-term care financing and delivery systems that could evolve along different paths, in contrast to the "single model" approach that would be enacted under a uniform Federal program.

Although the types of program models that could be conceptualized in an entirely new Federal-State program are almost limitless, we will discuss a few possibilities:

Secure Choice: A Restructured Medicaid Program with a Public-Private Partnership

One suggested approach is to divorce the long-term care component of Medicaid from the current program, and create an entirely new Federal/State program for the financing of long-term care. An example of this approach is "Secure Choice" (S. 1668), a bill introduced by Senator Packwood of Oregon, in August of 1991. "Secure Choice" would add a new Title to the Social Security Act, specifically to finance long-term care services for low-income elderly.

Secure Choice has two parts. Part I provides public coverage for nursing home and home care services for elderly persons over the age of 55 with incomes up to 100% of the poverty level, although States would have the option of extending coverage to persons up to 240% of the poverty level. Eligibility for nursing home services would be limited to persons with less than \$2,000 in countable assets (as in the current Medicaid program) but persons receiving home and community-based care could retain up to \$5,000 in countable assets.

Secure Choice also establishes minimal functional criteria for benefit eligibility. Criteria for home and community based services coverage are less restrictive than for nursing home coverage. States would have the option of establishing copayment requirements for both nursing home and home care services, within Federal guidelines.

The second part of Secure Choice establishes a public-private partnership program for the coverage of long-term care services for the elderly middle class, although participation in this component of the program would be optional to States. Long-term care insurance benefit subsidies would be made available to elderly persons with incomes between 240% of poverty and 400% of poverty. Individuals in this income category would be offered the opportunity to purchase a private, but subsidized, long-term care insurance policy that would cover the same benefits covered under the first part of the program. Benefits would be subsidized according to a sliding income scale. For example, for persons at or below 240% of the poverty level, the public program would pay for 75% of covered benefits, and the private insurer would pay 25%. The share paid by the private insurer would increase gradually in accordance with the income level of the covered beneficiary.⁴⁰ Since the public program would pay a greater share of covered benefits for beneficiaries with lower incomes, the premium costs of policies sold to lower income persons would be concomitantly lower as well. Premium costs would be lowered further by establishing a maximum lifetime benefit for these subsidized policies, after which all costs would be paid by the public program. "Secure Choice" establishes minimum standards for insurance policies sold under the public/private partnership program as well as for policies sold in the unsubsidized private market.

"Secure Choice" has not been the subject of much discussion in the policy arena to date. Although it is likely to be criticized for its administrative complexity,⁴¹ the unique feature of this bill is its consolidation of a publicly-financed long-term care program for the elderly poor, with a public/private partnership program designed to lower the costs of private long-term care insurance policies for the elderly middle class.

The Canadian Model

An even more radical reform of Federal/State long-term care policy would be to eliminate Medicaid coverage of long-term care services altogether, and provide Federal financial support for long-term care to the States through a Long-Term Care Block Grant. Two primary objectives of a long-term care block grant would be: (1) to provide States with increased flexibility and authority over the allocation of public resources; and (2) to consolidate a fragmented long-term care financing system into a unified financing system.

⁴⁰ Operationally, the insurer would pay a provider the full cost of an approved claim, and then bill the public program for the subsidized share of the benefit.

⁴¹ For example, since public subsidies of covered benefits would change in accordance with the income level of beneficiaries, tracking systems would have to be put into place to track beneficiary income levels on a periodic basis and make adjustments in subsidized benefits in accordance with income fluctuations.

A fundamental precept of the block grant approach is that long-term care policy and resource allocation decisions should be **decentralized**. Since the needs of persons with functional impairments are so diverse, some argue that long-term care financing mechanisms should be almost infinitely flexible in providing long-term care supports. States should be free to serve who they believe is most deserving of public assistance. This includes the ability to integrate formal services with the availability and willingness of informal caregivers to provide care. States should also be free to do or buy "whatever is necessary" to assist individuals with long-term care needs, be it housing assistance, direct care, supporting informal caregivers, or purchasing assistive devices.⁴²

TABLE 5. Long-Term Care Financing Reforms: New Federal-State Programs			
Reform Proposal	Specific Proposals	Change in Public Spending 1993 (in billions of 1992 dollars)	Change in Out-of-Pocket Spending 1993 (in billions of 1992 dollars)
Secure Choice (S 1668) Packwood (R-OR)	Establish new title under Social Security Act to provide long-term care coverage to low-income elderly. Also provides benefit subsidies for private long-term care insurance purchasers with incomes below 400% of poverty.	NA	NA
Canadian Model (Block Grant)	Consolidate Federal financing sources for long-term care into block grant to States. States have very wide discretion over use of Federal funds. Federal funds indexed to increases in long-term care demand.	NA	NA
Capitated Long-Term Care Program	Federal government would pay States a capitated amount for each enrollee in a new long-term care program. States have wide discretion over use of funds. Capitation amounts could be adjusted by financial status and disability level of enrollees.	NA	NA

A financing mechanism that allows for total flexibility in the use of Federal resources would encourage experimentation with new service delivery models, innovation in the use of assistive devices as a substitute for human assistance, and the testing of new methods for contracting with long-term care providers. In brief, a block grant endorses a "no strings attached" approach to the use of Federal long-term care resources. Moreover, consolidation of multiple funding streams under Medicaid, Title XX, the Older Americans Act, and other Federal programs into a single long-term care financing stream would help to reduce administrative inefficiencies in the current delivery of publicly-financed services.

Contrary to popular belief, Canada *does not* have a "national long-term care insurance program."⁴³ Since 1977, the Federal Canadian government has provided a per capita long-term care block grant to the ten Canadian provinces. These grants are

⁴² An example of this approach is the state-funded Community Options Program in Wisconsin which allows case managers to spend public funds in whatever manner they believe is of greatest assistance to the consumer. For example, funds can be used to hire someone to milk the cows of a disabled dairy farmer.

⁴³ Kane, R.A. and Kane, R.L. Lessons from In-Home and Community-Based Care in Canada: Toward Home Care for People Living Alone in the United States. A Background Paper prepared for The Commonwealth Fund Commission on Elderly People Living Alone. Background Paper Series: No. 19. Baltimore, Maryland, July 1989.

annually indexed for inflation and, within very broad guidelines, provinces are free to use these funds at their own discretion, adding in local sources of revenue to support both facility-based and home-based services. Most of the provinces do provide nursing home coverage to their citizens without means-testing (i.e. there are no "asset criteria") although copayments are required to cover room and board costs. The provinces have similar discretion in regard to their support of home care programs, and there is considerable variation from province to province in the manner in which they have decided to finance and administer home care programs.

A United States variation of the Canadian approach could conceivably consolidate the 80 or more current Federal funding sources for long-term care into a single capitated block grant to the individual States, allocated according to State elderly population, with possible adjustments for State per capita income. States could be given considerable latitude in regard to disability criteria, financial eligibility criteria, benefit packages, quality assurance systems, and reimbursement methods.

One feature of the Canadian system that could be incorporated into a long-term care block grant in the United States is the separation of "room and board" costs in nursing homes from "service" costs. The public system could be responsible for service-related costs, while individuals could retain responsibility for room and board costs.⁴⁴ Thus, persons with the financial means to do so could purchase more and better amenities through higher "hotel" costs, while ensuring that all persons in the system were treated equitably in regard to direct care services.

No legislative proposals have been submitted in Congress which endorse the block grant approach, and this approach would have many critics.⁴⁵ Perhaps the largest fear among States and advocacy organizations is that a block grant provides little protection against future growth in the demand for long-term care services. Even if Federal allocations are indexed annually, the rise in public long-term care costs may increase at an even greater rate than the indexing factor, leaving States with an ever-increasing share of the long-term care financing burden. Fiscal pressures on the Federal government could lead to reductions in the index to meet budgetary constraints. Without mandated matching of Federal allocations, many people fear that State contributions to long-term care financing would decline as well, leading to overall reductions in long-term care funding. In brief, without the entitlement features of Medicaid financing, public funding of long-term care services might become a more vulnerable target to annual budgetary contingencies. Consequently, the long-term care provider industry is also likely to be opposed to a block grant approach. In any case, unless some type of assurances could be built into a long-term care block grant program that Federal and State funding of long-term care services would increase in accordance with the demand for care, this approach would probably generate little political support for enactment.

⁴⁴ Room and board costs for individuals without income or assets could be paid for by SSI.

⁴⁵ However, the Managed Competition Act of 1992 (HR 5936), a proposal of the Conservative Democratic Forum's Task Force on Health Care Reform, does propose to give long-term care "back to the States" in return for a new Federal program that would cover all acute care for persons below the poverty level.

A Capitated Long-Term Care Program

In response to the problematic financing structures of a block grant program, an alternative would be to design a program which combined features of a block grant model (local discretion over resource allocation) with some of the entitlement features of Medicaid (open-ended Federal financing). Instead of a formula grant program to the states, the Federal government could make capitation payments to States based upon actual program enrollment. Program features could include:

- The Federal government would establish a mandatory eligible population based on income and disability level (e.g. all persons with 2+ ADLs with incomes below the poverty level).
- The Federal government would pay States a capitation amount for each eligible disabled individual enrolled in the long-term care system and receiving services. Capitation payments would be made for each month of service receipt for each enrollee.
- Persons who met basic disability and financial criteria would be entitled to a minimum benefit package, including residential services and home care. The Federal government would monitor States to ensure that services were not being denied to the "entitled" group.
- The Federal capitation payment amount would not necessarily equal the total average cost of serving the mandatory population; States would be expected to pay a percentage of total costs, as under Medicaid. Like Medicaid, Federal capitation payments could also be adjusted according to State per capita income.
- There would be no limit on the total Federal contribution. Capitation payments to States would be open-ended, as under Medicaid.
- States, at their option, could elect to serve less disabled populations and/or higher income groups, but the Federal contribution for these "optional" groups would be at a lower percentage of average costs. Alternatively, a Federal cap could be placed on spending for optional groups.
- The Federal government could specify minimal criteria for State quality assurance systems, conduct quality of care reviews for enrolled clients, and levy financial penalties on States for noncompliance.
- Importantly, there would be no restrictions on the program benefit package. States could use Federal capitation payments in any manner they chose to, as long as they met the quality assurance criteria established under Federal law.

While a capitated benefit program would still provide States with broad flexibility in meeting the diverse needs of disabled elders, it would establish a stronger Federal role in ensuring access to services, and quality assurance. An "open-ended" financing structure would also provide guarantees that Federal and State contributions to the service system rose in proportion to the demand for care. This approach would also provide incentives for States to serve the most disabled and most needy, although they could elect to serve the less disabled and less financially needy if they chose to, albeit at a lower Federal matching rate.

Another possibility is that instead of making capitation payments to States, could also be made available to individuals as a disability allowance. This approach embodies the objective of maximizing individual choice in deciding how public resources are used to purchase long-term care services. For example, instead of purchasing care from formal long-term care providers, individuals could elect instead to pay family members to provide care. (They may also elect **not** to use their allowance to buy long-term care services, but to buy something else altogether). Although there would be many risks associated with this "voucher" approach to financing long-term care services (e.g. increased potential for elder abuse by family members), its attractiveness lies in the increased control it places in the hands of the consumers of publicly-financed services. Critics are likely to have reservations about whether very old and disabled people, often with cognitive impairments, could effectively negotiate for services in a private market. The potential for fraud and abuse might be high.

Voluntary Insurance

Regardless of whether people support expanded public benefits or an expanded private insurance market, one deficit of the existing system that most people agree on is the lack of opportunity for people to insure themselves against catastrophic long-term care costs.

Even those who believe that long-term care should primarily be a private responsibility acknowledge the drawbacks of a system in which a family's entire life savings can be wiped out simply because one family member needs extended care. Our societal values may reflect a belief that families have the primary responsibility for caring for their aged kin, but most people also believe that families should not be forced to suffer the financial and emotional consequences of becoming totally impoverished by long-term care costs.

Financial structures need to be created which allow families to share these risks. Whether we share these risks by creating voluntary risk pools (private insurance) or mandatory risk pools (public insurance) is a matter of debate, but most everyone agrees that more mechanisms are needed for spreading the risks of catastrophic long-term care among large groups. The failure of our society to spread the financial risk of long-term care distinguishes it markedly from the way in which we finance acute care, where

one person's risk of incurring a catastrophic event is spread across both users and non-users of services through various types of health insurance arrangements.

Why, in spite of consensus that we need more long-term care risk pools, haven't they developed, even among those who can well afford to buy risk protection? Analysts have identified a number of, obstacles that have impeded the development of a viable private long-term care insurance market:

- A successful market requires educated consumers. Many elderly persons are poorly informed about the risk of needing long-term care or still mistakenly believe that it is covered by Medicare and Medigap insurance. Others wait too long to plan for their long-term care needs and find themselves priced out of the market or disqualified because they are too disabled.
- Even for people who are knowledgeable, it is hard to know whether a particular long-term care insurance product is a good value. The lack of standard terminology, ambiguous terms governing eligibility for benefits, uncertainty about the impact of inflation over a long period on the value of benefits, and rapid changes in product lines, all make it difficult for consumers to compare products or to know whether a particular product is worth the premium cost.⁴⁶
- Many believe that opportunities for the elderly to shelter or divest their assets and still qualify for Medicaid--thereby allowing them to receive public coverage without true impoverishment--serves to reduce the demand for private insurance. Why buy insurance if one can preserve assets and still receive public coverage?
- Inadequate enforcement of insurance regulations has contributed to a lack of consumer confidence in the integrity of insurers and their products. Congressional hearings and investigations by consumer organizations have highlighted cases of fraudulent and misleading marketing practices, post-claims underwriting, and a failure to pay legitimate claims. While most insurers recognize the need for an adequate regulatory structure to protect consumers and build confidence in the marketplace, consumer protections in many States remain inadequate due to poor enforcement of regulations.
- There is little actuarial data on which to project future long-term care claims, and therefore to price products accurately. If insurers are forced to raise premiums to meet future costs (i.e. if financial reserves are insufficient to cover claims) many policyholders may be forced to lapse their policies, leaving them with no coverage and nothing to show for their "savings" (cumulative premium payments). Temporary reductions in income (e.g. after the death of the spouse) may also force people to lapse policies, leaving them with no coverage, and little possibility for buying another policy in the future (if they are too old to afford the increased premium cost).

⁴⁶ Health Insurance Association of America. Who Buys Long-Term Care Insurance? Washington, D.C., 1992.

- The financial solvency of the insurance industry in general is also cause for concern. If private insurers become insolvent, some policyholders may lose their protection.
- There is considerable debate about the proportion of the elderly who can afford private insurance. A typical premium for a four-year nursing home policy costs about \$1,400 a year at age 65, and increases substantially as the age at purchase increases. Estimates of the number of people who can afford to purchase private insurance vary substantially. One estimate by Lewin-ICF projects that about 37% of single persons and 59% of families could afford these premium costs at age 65 if they were willing to forego all other types of savings.
- The tax status of private long-term care insurance premiums and benefits remains uncertain.
- Unlike health care, long-term care insurance lacks a significant group market that would reduce premium costs and increase the affordability of products, although there are indications that a small number of firms are adding long-term care insurance (for both employees and their parents) as an optional benefit.⁴⁷ Until companies are assured that contributions to long-term care premiums are a deductible business expense, however, most are unlikely to contribute to premium costs.
- Current regulatory requirements, which differ from State to State, force insurers to tailor products to meet different regulatory perceptions of what constitutes adequate consumer protection.

Should the Federal Government Help the Private Insurance Market?

Given these obstacles to the development of a private long-term care insurance market, some policy analysts believe that government needs to take a more activist approach to stabilize and encourage this market. The 102nd Congress saw the introduction of numerous legislative proposals to change public policy in the private long-term care insurance market. These proposals generally fell into two categories: (1) legislation designed to stimulate the private long-term care insurance market; and (2) legislation that would establish a Federal role in the regulation of private long-term care insurance. For example, in August 1991, Senator Bentsen (D-TX) introduced the Private Long-Term Care Insurance Act of 1991 (S. 1693), which propose to change Federal policy to both stimulate the private insurance market and regulate it more forcefully. The following sections discuss a variety of strategies that have been proposed to encourage the development of private risk pools for long-term care, and to ensure that sellers of private insurance policies adhere to certain public standards in how they conduct their business.

⁴⁷ Barocas, V. Long Term Care: A New Employee Benefit? Prepared for The Conference Board, Report Number 981, 1991.

Clarify Tax Treatment of Long-Term Care Insurance Premiums and Benefits

At present, the Internal Revenue Code does not clearly specify whether premiums paid for private long-term care insurance, or benefits received, are subject to the same tax treatment as health and accident insurance. In other words, the tax code does not clarify whether individuals and employers can deduct long-term care insurance premiums from taxable income in the same manner in which they are allowed to deduct health insurance premiums, nor does it clarify whether benefits received, including indemnity payments, are exempt from taxable income.

Insurers and employers have been reluctant to offer long term care insurance in group markets, largely because of the uncertainty of the tax laws concerning long term care insurance reserves and the deductibility of premiums. The insurance industry believes that if long term care insurance was treated in the same manner as other accident and health insurance products, it would encourage employers to make long term care benefits more available to their employees as part of their compensation packages. The annual loss in tax expenditures which would result from these clarifications in the tax code are estimated at between \$200 and \$500 million annually (Table 6).

Incentives to Purchase Long-Term Care Insurance

The Federal government could increase the affordability of private long-term care insurance by providing a tax credit to persons who purchased Federally-qualified policies. Such a tax credit could be structured to provide higher subsidies to elderly persons of low income and lower subsidies to persons with higher incomes. Supporters of public subsidies of private insurance feel that these strategies are more cost-effective than proposals to simply expand public coverage, since tax subsidies would leverage additional private dollars into the market. Also, they believe that limited public resources should be targeted towards helping individuals plan and protect against their future long-term care needs rather than simply providing public assistance after they have been impoverished by long-term care costs. Finally, they argue that the private insurance market will develop much more rapidly if public policies are enacted to help stimulate the market, particularly if they are accompanied by a Federal role in the improved regulation of the marketplace. For example, the enactment of a Federal tax credit would greatly increase awareness among the elderly about the need to plan for their future long-term care needs.

A principal argument against tax subsidies for private insurance is that they will divert public resources away from the truly poor elderly to more wealthy elderly persons. Why should public subsidies be provided to elderly persons who can well afford private insurance without subsidies? Tax subsidies will only be cost-effective if they truly stimulate the market beyond what would occur in the absence of subsidies (i.e., the number of people who would buy a policy with the subsidy who would otherwise not have bought policy). Further, they argue that there is little likelihood that these

strategies will reduce Medicaid expenditures either over the short or long term, because the vast majority of Medicaid costs are attributable to people who will never participate in the private market, with or without subsidies. If so, public resources will just end up being used to reduce the private costs of long-term care to elderly persons who would otherwise never receive public assistance.

TABLE 6. Long-Term Care Financing Reforms: Voluntary Insurance				
Reform Proposal	Specific Proposals or Representative Legislation	Basic Features of Proposal	Change in Public Spending 1993 (in billions of 1992 dollars)	Change in Out-of-Pocket Spending 1993 (in billions of 1992 dollars)
A. Encourage Purchase of Private Long-Term Care Insurance	Private Long-Term Care Insurance Act of 1991 (HR 1693) Gradison (R-OH)	Amends tax code to allow LTC insurance plans that meet Federal standards to be treated as health insurance plans.	\$0.2 to \$0.5 (tax loss)	\$0.0
	Comprehensive LTC Incentives Act (HR 415) Rhodes (R-AZ)	Provides tax incentives for LTC insurance coverage and LTC health benefits	\$0.2 to \$0.4	-\$0.6
	IRA Payment for Long Term Care Premiums (HR 704) Slaughter (R-VA)	Allows distributions from IRAs and other tax-deferred retirement plans to pay for qualified long-term care insurance premiums.	\$0.0 1	\$0.0
	Public-Private Partnerships for Long Term Care (Currently being implemented in Connecticut, New York and Indiana; other States may follow).	Raise Medicaid asset level for individuals who purchase qualified long-term care insurance plans and utilize full benefits.	<\$0.1	\$0.4
B. Voluntary Public Insurance	Pepper Commission Minority Proposal 2	Allow new Medicare enrollees to buy "basic" (one-year) nursing home coverage at age 65. Coverage includes \$2,000 deductible and 20% copayment requirement. No underwriting criteria applied.	\$0.0 3	\$0.0
C. Federal Regulation of Private Long-Term Care	Numerous bills submitted in both houses of 102nd Congress.	Establish Federal standards for private long-term care products, including minimum benefit standards, consumer protection provisions, restrictions on sales and marketing practices, regulation of premium increases, standards for financial reserves, and other provisions.	NA	NA
1. Assumes use of existing IRAs or pension funds. 2. Proposed by Pepper Commission member John Cogan. 3. No impact in the short-run because purchase is assumed to occur at age 65 and benefits are not paid until age 75.				

Support Public-Private Partnerships for Long-Term Care

Another strategy for encouraging private long-term care insurance is to support public-private partnerships for long-term care. This approach was initially developed under a Robert Wood Johnson Foundation demonstration program and is now being implemented in four States: California, Connecticut, Indiana and New York.

In December 1991, Connecticut was the first State to announce the implementation of such a program--The Connecticut Partnership for Long Term Care. Under the program, Connecticut is encouraging individuals to buy private insurance products by offering guaranteed asset protection under the State Medicaid program. For example, if someone buys a \$50,000 private policy, and then later receives the full \$50,000 in benefits, the State will also raise the Medicaid asset level by \$50,000. Instead of having to "spend-down" to the usual Medicaid eligibility asset level of \$1,600, the individual would become eligible for Medicaid once their assets reached \$51,600.⁴⁸ Without guaranteed asset protection, private insurance purchasers could still be impoverished by long-term care costs incurred after their insurance benefits ran out.

Since Connecticut only extends this protection to individuals who buy qualified products, the program has also allowed the state to have more than the usual regulatory input on the types of insurance products being sold in the marketplace, as well as marketing and sales practices. By encouraging the elderly to purchase long-term care insurance in this manner, the Connecticut Partnership for Long Term Care hopes to reduce the number of elderly persons who spend down to Medicaid. However, there is debate regarding whether the guaranteed asset protection that Connecticut is offering to insurance purchasers will end up costing or saving money over the long term.

At the time of this writing, California, Indiana, and New York are planning to implement similar public-private partnerships. New York's program has an important variation of the guaranteed asset protection provision--in New York, if purchasers buy a policy that covers up to three years of nursing home care or six years of home care, the State will waive all asset requirements for Medicaid coverage once a policyholder has utilized their maximum benefit amount.

It is important to note that these public-private partnerships for long-term care require no change in Federal policy, since States can presently implement these types of programs under current Medicaid statute. However, neither the Federal government nor Congress has taken a position on this policy approach, to either encourage or discourage similar partnerships in other States. If it desired, Congress could certainly enact guaranteed asset protection provisions for private long-term care insurance purchasers into Federal law, requiring all States to adopt this approach, or it can keep a "hands off" approach and let States decide for themselves whether they would like to encourage the private long-term care insurance market in this manner.

⁴⁸ Connecticut's asset level for Medicaid coverage in nursing homes is presently \$1,600, somewhat lower than most other States. Connecticut is one of the so-called "209(b)" States.

Federal Regulation of Private Long-Term Care Insurance

The regulation of private long-term care insurance, like most insurance products, is presently the responsibility of State governments, through their 50 State insurance commissions. State governments decide on minimum standards for insurance products, approve or disapprove specific products for sale in the marketplace, regulate premium increases, and monitor and enforce State laws and regulation regarding fraudulent or abusive marketing practices.

Many feel that the current system for regulating private long-term care insurance is inadequate, that too many purchasers of private products are being victimized by unscrupulous marketing and sales practices, and that many of the products being sold are of dubious value. These persons believe the Federal government should take a more forceful role in regulating this market, similar to the manner in which the Federal government regulates Medicare supplemental Insurance (Medi-gap).⁴⁹ A number of bills were introduced in the 102nd Congress which had the intent of protecting consumers through one or more of the following provisions:

- Require standardized use of terminology in policies approved for sale;
- Establish minimum Federal standards for all long-term care insurance products or providing a seal of approval for only those products which met Federal standards;
- Prohibit certain marketing, sales and underwriting practices, limiting agent commissions, and setting minimum penalties for noncompliance with these provisions;
- Specify rights of purchasers to cancel policies, appeal claim denials, and report abusive sales practices;
- Limit annual or-aggregate premium increases;
- Establish solvency standards for the financial reserves of insurers, specifying minimum loss ratios, and requiring insurers to submit periodic financial reports on their long-term care insurance lines.
- Establish minimum standards for State enforcement of long-term care insurance regulations and/or providing technical assistance resources to States to improve enforcement capacities.

⁴⁹ Alexcih, L. and Kennell, D. The Federal Role in Consumer Protection and Regulation of Long Term Care Insurance. Report prepared for the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, June 1991. [<http://aspe.hhs.gov/daltcp/reports/fedroles.htm>]

While there is general agreement that there needs to be effective regulation of the private long-term care insurance market, there is disagreement on the degree of control which States and/or the Federal government should have. Proponents argue that strong government regulation is absolutely necessary to maintain consumer confidence in the market and to ensure that the products sold will provide real protection from future long-term care costs. Critics argue that government regulation will unduly stifle the market; lead to less flexibility, competition, and innovation; and result in pricing many middle-class elderly persons out of the market entirely by allowing only "Cadillac" policies to be sold.

Implement Educational Campaigns

The Federal government could also support educational programs to help elderly persons make more informed judgements about their purchases of private long-term care insurance. If consumers are more informed about what to look for in a long-term care insurance product, the private market will become more competitive in both quality and price. Given the intricacies involved in evaluating various features of insurance products, such as inflation protection and benefit criteria, many feel that a major educational campaign is absolutely essential in preventing fraudulent and abusive marketing practices in the industry.

Many also feel that the Federal government still needs to make it more explicit that Medicare does not cover custodial long-term care. Increased awareness among consumers about their future risk of needing long-term care would encourage them to prepare for that possibility. Further, many elderly may not be buying insurance because they are under the impression that even though the government doesn't provide coverage of long-term care now, that a national public insurance program will soon be enacted. Thus, although there is considerable disagreement in the policy arena about whether there should be a public insurance program for long-term care, a clearer articulation of current policy might help individuals decide whether buying an insurance product is a worthwhile investment.

Other Private Market Strategies

Insurance is not the only means used in the private market to protect individuals from the costs of long term care. A number of other options are also available. Other ways in which the Federal government could encourage the use of private resources include:

Home Equity Conversion (HEC) Plans. Home equity conversion plans enable elderly homeowners to use their home equity assets without principal or interest payments until the house is sold or until they die. There are two distinct types of reverse mortgages: (1) fixed-term loans which generally make payments from 5 to 15 years; and (2) open-ended loans which make payments until death, institutionalization, or the resident moves out of the home. The government could expand current efforts to

stimulate the market for HECs by guaranteeing an increased number of loans from banks or by sponsoring such programs directly.

Use of Pension Assets. Almost 60 percent of workers over age 45 have vested pensions and many of these workers have significant levels of vested funds available. Current law limits the use of these funds by workers. Allowing persons to use qualified retirement plans for the purchase of long term care insurance, both before and after retirement, in exchange for lower pension benefits in retirement may be a wise method for encouraging Americans to prepare for potential long term care needs in retirement. Workers would not have to sacrifice current consumption and they would gain the advantage of lower premium prices by purchasing insurance at earlier ages.

Tax Free Savings Vehicles. Tax free savings vehicles similar to Individual Retirement Accounts (IRAs) could be permitted to accumulate funds to either pay directly for long term care services in retirement or to purchase long term care insurance.

Tax Free Accelerated Death Benefits. Some insurers permit policyholders to convert existing universal or whole life insurance policies into long term care coverage through a lump sum payment of accelerated death benefits in the event of terminal illness, a specific disease, or confinement to a nursing home. Under current IRS regulations, these accelerated payments are potentially taxable, whereas if they were paid out upon death, amounts up to \$600,000 would not be subject to tax. Congress or the IRS could specify that payments through such vehicles be treated the same as life insurance payments for tax purposes.

Voluntary Public Insurance

A long-term care financing strategy that has not received much attention in the policy arena is the idea of voluntary **public** insurance. Under this option, new Medicare enrollees would be offered the opportunity to purchase long-term care coverage from the Medicare program. In essence, Medicare would get into the long-term care insurance business, but only on a voluntary basis.

Under a voluntary public insurance program new Medicare beneficiaries, at the point they originally enroll in Medicare at age 65, would be offered the opportunity to purchase a relatively low-cost policy that would cover one year of nursing home care. Although this policy would not provide complete protection against the risk of long-term care, it would reduce the risk of a catastrophic loss, since it is estimated that less than one in four persons turning age 65 in 1990 will use more than one year of nursing home care during their remaining lifetimes.⁵⁰

⁵⁰ Kemper, P. and Murtaugh, C. "Lifetime Use of Nursing Home Care."

The public costs of a voluntary public insurance program would depend on the extent of coverage being "sold" in the program.⁵¹ If the policy objective was to sell risk protection to individuals who could not afford to buy protection in the private market, then a relatively low-cost package would be developed. For example, if persons bought \$30,000 worth of coverage for long term care services (indexed to inflation) at age 65 and did not become eligible to receive benefits until they reached age 75, the initial monthly premium would be in the range of \$60 per month.⁵² Premium costs would be indexed to Social Security cost-of-living adjustments, and there would be a \$2,000 deductible, and a 20 percent copayment for all covered services. A beneficiary who exhausted his or her \$30,000 in covered benefits would also be credited a \$10,000 increase in the amount of protected assets for Medicaid eligibility (e.g., a single individual would qualify for Medicaid coverage when their countable assets reached \$12,000 instead of \$2,000).

If the private long-term care insurance market is unable to fulfill the needs of elderly persons with moderate incomes, a voluntary Medicare insurance program may be a worthy complement to the private market. Persons would not be provided complete protection, because the program would not pay for extended nursing home stays over one year, but the program would protect the financial well-being of a large segment of the elderly population who could not afford to buy private insurance. Premium subsidies could also be offered to lower income participants at a relatively low public cost. A voluntary public insurance program could also potentially include persons who could not otherwise buy insurance in the private market, such as persons who already had functional limitations at age 65, although this easing of underwriting criteria would raise premiums for non-disabled purchasers.⁵³

Proponents of a voluntary public insurance program argue that the government would not be competing with the private market, only selling to individuals who could not participate in the private market. Persons with relatively small estates would be given the opportunity to reduce the risk that their entire estate would be wiped out by even a short nursing home stay. Linking the program with Medicare would also increase consumer confidence, minimize administrative costs, and ensure the long-run stability of the risk pool.

Detractors of a voluntary public insurance program, who are likely to include the private insurance industry, may claim that allowing the Federal government to sell long-term care insurance would introduce unfair competition into the market place. Private companies could not compete with the marketing advantages inherent in selling insurance as an additional Medicare benefit.

⁵¹ Although these services would be funded by participant premiums, the cost of the services would show up as government expenditures for budgetary purposes.

⁵² An alternative is to allow purchasers to pay long-term care insurance premiums through higher deductibles and premiums for Medicare Part A and Part B coverage.

⁵³ Note that instead of applying underwriting criteria on new Medicare enrollees, this approach addresses the adverse selection issue by delaying eligibility for benefits to age 75.

There may also be skepticism about whether the Federal government could operate a long-term care insurance benefit that was truly self-financed. Like Social Security and Medicare, would the Federal government truly put premium payments into "reserves" or would the program simply increase claims against future tax receipts? Second, critics may argue that political realities would create pressures on the government to hold down premium costs while raising benefit levels, such that the program would eventually become actuarially out of balance. Third, those who are opposed to public insurance for long-term care might be concerned that a "limited" and "voluntary" public insurance program would, over time, eventually be transformed into a comprehensive, mandatory insurance program.

PART III. DISCUSSION

Within the not too distant future, Americans are likely to make some important decisions about how we finance long-term care services for disabled elders. Dissatisfaction with current policy seems to be widespread and growing.

These will not be easy decisions to make. One fundamental decision is whether we should enact a public insurance program for long-term care. This will lead to a significant increase in public spending for health care services at a time when we are already dealing with exorbitant increases in public health care expenditures under Medicare and Medicaid. The enactment of a public insurance program for long-term care will require a substantial increase in tax revenue to finance the program, and many people are skeptical of the Federal government's ability to hold the lid on program outlays in order to keep the program in actuarial balance.

If we elect not to enact a comprehensive public insurance program, we will still face the issue of how to finance care for those elderly who cannot afford to purchase their own care, or buy risk protection in the private market. What level of public assistance do we consider fair public policy? Should the Federal government make this decision or should we let States decide what level of public assistance is appropriate and how resources should be allocated? And finally, should the public sector take a "hands off" approach to the development of the private long-term care insurance market, or should it take a more activist role in encouraging and regulating this market, including the support of public/private partnerships for long-term care financing?

The intention of this paper has been to identify a range of long-term care reform strategies that have surfaced in the policy debate, to sort them into a logical typology, and to present the major arguments that have been advanced in support and in opposition to each approach. Hopefully, this paper will make a contribution to the policy debate by more clearly articulating the choices that the American public, and its representatives in Congress, could make. The more informed we can make the debate, the better chance we have of ending up where we want to be, and not somewhere else.