

Long-Term Care Financing Reform: The Time is Here

Needed: Proposals that Promote Accessibility and Affordability

President-elect Barack Obama has proposed significant changes in the way Americans buy health insurance, but he has had little to say about the need to reform the system of paying for long-term care. Nevertheless, just below the radar, some important new ideas for financing this critical assistance are starting to attract attention in the Washington policy world.

Today, more than 10 million Americans require long-term care, which assists people with chronic conditions, traumas and illnesses that limit their ability to handle basic daily care, such as bathing, dressing and eating.¹ Most of these people are 65 years old or older and most receive this personal assistance at home, with much of the care provided by relatives or friends, who often sacrifice money and time in helping their loved ones. But many people need paid assistance. About 15 percent are cared for in skilled nursing facilities,² and with nursing home costs nearing \$80,000 annually and the price of home health aides approaching \$20 per hour, such help is far beyond the means of most Americans. As a result, hundreds of thousands of aged and disabled people are receiving poor care, or getting none at all.

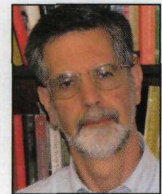
Overall, the United States already spends more than \$200 billion annually on paid long-term

care,³ a financial burden soon to become a far greater challenge as 77 million baby boomers begin to reach their 80s, the decade in which many will need high-quality care. It is estimated that nearly 70 percent of today's 65 year olds will need some long-term care before they die, and one in five will require this help for five years or more.⁴ Boomers, who have been notoriously poor savers, have little put away for healthy retirement, much less for their long-term care needs. As of Sept. 30, 2008, typical households aged 50 to 59 had only about \$95,000 in their retirement accounts.⁵ Such a modest nest egg would barely support one person in a nursing home for a year, and leave nothing for a surviving spouse. As a result, as boomers age, long-term care will increase financial pressures on government.

Today, almost half of all long-term care costs are paid by Medicaid, the welfare-like government health care program. Medicaid was created in 1965 principally to provide medical treatment to young mothers with children. Yet, more than two-thirds of Medicaid funds are spent on the frail elderly and people with disabilities; one-third of Medicaid expenses are for long-term care itself.⁶ By mid-century, federal and state governments will be spending 6.5 percent of gross domestic product on Medicaid, more than twice what they spend today.⁷

However, the elderly and those with disabilities are not eligible for Medicaid benefits until they are both extremely ill and impoverished. In practice, this means many middle-class people are forced to spend their assets on care and then apply for Medicaid once they run out of money. That is an especially cruel and inefficient system for those who have had the misfortune to be struck with chronic diseases, such as dementia.

Just as troubling, Medicaid is becoming a huge financial burden on federal and state govern-



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ments, which jointly operate the program. Medicaid has become the most costly single service states provide, except for education. When combined with the costs of providing Medicare and Social Security, the cost puts tremendous fiscal pressure on the federal budget.

At the same time, private insurance, which was intended to provide long-term care benefits to higher income seniors, covers less than 10 percent of these expenses.

Roughly 250 million people, or 85 percent of Americans, have medical insurance today — most through employer-based coverage or Medicare.⁸ A far smaller number, just 7 million, or one of every 200 of those aged 45 or older, have long-term care coverage.⁹ That is our real crisis of the uninsured.

In an attempt to make quality long-term care more available to those who need it, policy analysts are exploring ways to incorporate long-term care financing with health reform — a step which makes both good political and policy sense. Their goal: Make quality long-term care available and affordable for those Americans who will need it, while not breaking the fiscal bank.

POTENTIAL SOLUTIONS TO CONSIDER

Most of the plans for reform of long-term care are built on one of three models:

- Enhancing private long-term care insurance
- Designing a new government-operated social insurance program much like Medicare
- Creating a hybrid that includes elements of both private and government coverage

Each represents an effort to help families pre-fund the potential cost of their long-term care. And the best way to do that is to encourage them to insure against the risk of needing years of personal assistance, either at home or in a nursing home or other facility.

The trouble is, as currently structured, private long-term care insurance is far too expensive for most people. A typical annual premium for a 60 year old is about \$2,000 for a high-quality policy. The best way to get the price down is to encourage more people to buy. In other words, as with any other insurance, those people not needing care would help pay the costs of those who do.



Many potential solutions are available that could make long-term care more sustainable in the future.

Vastly expanding the number of insured offers significant benefits. To start, it could give people greater ability to design their care. Although Medicaid is beginning to pay for community care, most benefits still go to nursing homes, a setting that most frail elderly and younger people with disabilities prefer to avoid.

Second, increasing the number of insured would dramatically shrink the welfare-like Medicaid system. Most of the developed world has already taken such a step, and many policy analysts believe the United States should too. Also, replacing Medicaid would make it much easier to coordinate care for those with multiple chronic conditions. Finally, individual insurance would reduce the fiscal pressures that Medicaid is placing on federal and state budgets.

Private insurance could be made more attractive by lowering premiums. More than two dozen states are trying to achieve this goal by allowing consumers to take a tax credit or deduction to partially offset the premiums they pay for long-term care policies. The insurance industry also strongly supports adding a federal credit. However, little evidence exists to indicate that even a generous tax break would substantially expand the market for private insurance. One study concludes that a 25 percent reduction in the after-tax cost of premiums would increase sales by only about 11 percent.¹⁰

Another possible approach to increase demand for private insurance is through a program called the Partnership Act, which allows people who buy insurance to keep more of their assets when they qualify for Medicaid. This program, which is operated by states that elect to participate, is overseen by the Centers for Medicare and Medicaid Services. Experience with an early version of this program has resulted in only limited success. It is too soon to know whether an expanded model — enacted two years ago — will encourage more people to buy private insurance.

A third option would take advantage of Medicare's powerful marketing ability. It would allow consumers to buy private long-term care insurance through the senior's health program, much as they purchase Medicare Supplement Insurance (Medigap) today. Participation would be voluntary and companies could deny coverage to those with pre-existing medical conditions. However, the government could create a high-risk pool for those who are otherwise uninsurable.¹¹



More than 10 million Americans require long-term care, and the numbers will increase as baby boomers get older.

The advantage to such a system is that benefit packages would be simplified, as they are with Medigap. In addition, coverage would be integrated with Medicare's nursing home and home health benefits. Insurers would bear the risk of any cost increases, and program savings would be passed back to consumers. However, premiums may still remain too high for many.

The second model for a new long-term care program is social insurance. Two basic versions are possible, one funded through new taxes, the other with premiums. Economists argue that little difference exists between a mandatory insurance premium and a tax, but the way the issue is framed may turn out to be important politically.

Tax-funded designs vary mostly by the kind of

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levy used to pay for the new benefits: an income tax surcharge, a higher payroll tax, or a new European-style value-added tax, which is much like a sales tax. The difference is that the value-added tax is collected at each stage of a product's production, and not just imposed on retail sales. Nearly all industrialized countries, except the United States, have a value-added tax. It is not likely that the United States would create a value-added tax just to pay for personal assistance, but if such a levy were to be adopted to finance health reform, long-term care could be easily added.

For example, an income tax surcharge of 1 percent would raise about \$55 billion annually, which would pay for 100 hours of home care monthly with a \$500 deductible and a 20 percent co-payment. Such a lifetime benefit will be available to all who needed assistance with two activities of daily living (such as bathing and eating). This system would be quite progressive. A middle-income individual would pay an additional \$147 a year in taxes, while someone earning more than \$600,000 would pay \$10,196.¹²

Another option would be to add a payroll tax surcharge to the current Social Security and Medicare taxes. Germany, for instance, provides a solid long-term care benefit by adding 2 percent-age points to its payroll tax.

The second version of social insurance could be funded by a premium rather than a tax. The idea is that everyone would purchase a policy at a young age, creating an expanded pool of buyers that would keep premium costs low. For example, Sen. Edward Kennedy, D-Mass., and three senators have proposed the Community Living Assistance Services and Supports Act, which would create an insurance program for adults who become functionally disabled.¹³ The proposed bill would allow everyone to purchase such a policy starting at age 21. Monthly premiums would start at about \$30, and benefits would be \$50 or \$100 per day for life, depending on level of need, although both benefits and premiums would gradually rise with inflation. The Kennedy plan anticipates that many consumers would buy private insurance to supplement their government benefit.

A similar plan has been developed by the American Association of Homes and Services for the Aging, which represents not-for-profit, long-term care providers.¹⁴ This design also contemplates broad participation with no underwriting, and provides a daily lifetime benefit of \$75, with

initial premiums of a bit less than \$100 per month. Both premiums and benefits would increase with wage growth. Such coverage could be mandatory or, as in the Kennedy plan, people could be allowed to opt-out. Consumers could also buy extra private insurance to supplement their coverage.

Regardless of the funding mechanism, a social insurance system would be universal, or nearly so, and could be run more cheaply than private insurance, since it would require lower administrative costs. It is not known how many Americans will willingly pay either premiums or taxes for a benefit they may not receive for 50 years, although it is likely many would be more receptive to a premium-based system.

Finally, several policy experts have proposed hybrid plans that would explicitly meld private insurance with federal catastrophic coverage. The idea: Individuals would be responsible for their care through a high deductible — say \$100,000 or, alternatively, for the first three or five years of assistance. In some cases, the deductible would be covered with mandatory insurance. In others, families could choose to pay through savings, home equity or other assets.

For instance, William Galston, Ph.D., a senior fellow at the Brookings Institution, proposes that everyone buy a mandatory five-year, \$150-per-day private policy starting at age 40.¹⁵ Under his



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plan, all care after five years would be paid by the government. Christine Bishop, Ph.D., health economist and professor at Brandeis University, has proposed a three-year deductible with full Medicaid coverage afterwards.¹⁶ Anne Tumlinson of Avalere Health and Jeanne Lambrew, Ph.D., health care expert and professor at the University of Texas, would mandate private coverage up to \$100,000 (depending on the buyer's income). Medicare would provide any additional care.¹⁷

QUESTIONS TO CONTEMPLATE

All of these ideas raise some questions worth pondering about long-term care:

- Is it better to have a benefit structure that provides a modest daily benefit for life or a more generous benefit for just a few years?
- Should insurance be mandatory or allow for individuals to opt-out if they choose?
- Should benefits cover all costs, or should families be responsible for room and board, as they are in Germany and many other countries?
- Will any kind of voluntary private insurance be viable if a high-quality genetic test is developed for diseases such as Alzheimer's? With such knowledge, those who are predisposed to the disease would want to buy insurance, and those who are not would avoid purchasing, thus driving premiums to unaffordable levels.

No reform is perfect, but many are an improvement compared to what is currently available. After a decade of near silence on the issue of long-term care, it appears that policy experts are once again thinking about how to reform our nation's currently unsustainable system. ■



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