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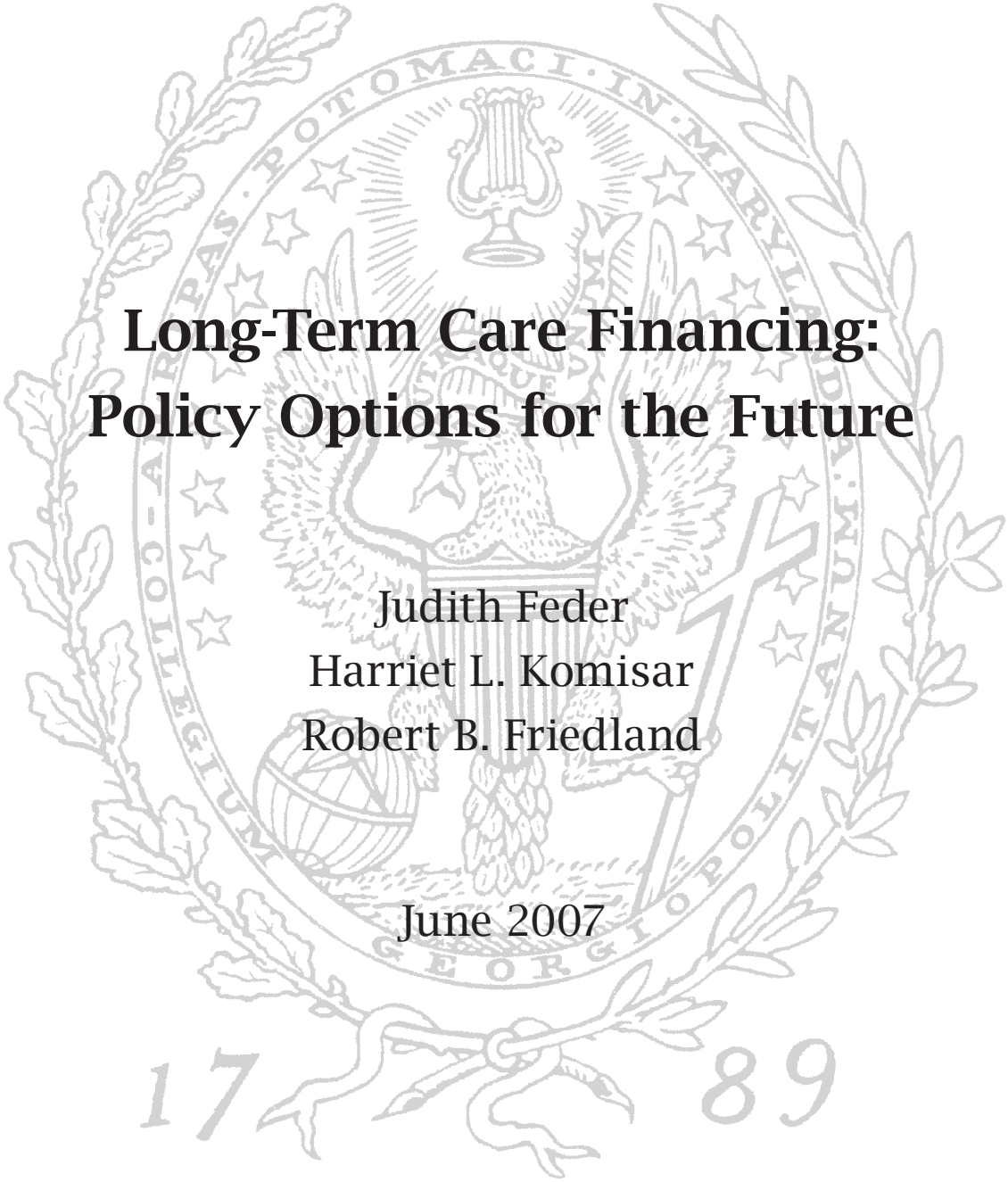

Long-Term Care Financing: Policy Options for the Future

Judith Feder
Harriet L. Komisar
Robert B. Friedland

June 2007

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Introduction

Four years from now will be 2011—the year that the first of the baby boom generation will turn age 65. For more than a decade, social scientists and policymakers have looked toward that date with alarm. As more and more Americans turn age 65, it will become harder and harder to ignore the growing conflict between the promises the nation has made to protect our seniors and the willingness of the body politic to provide the resources needed to fulfill those promises.

To date, discussion of this conflict has focused primarily on promises related to health care and retirement income—the provinces of two of our largest public programs, Medicare and Social Security. Despite Medicaid's investment in the personal care services that many of the same baby boomers will also require, long-term care has received considerably less attention. The reasons for that disregard and strategies to overcome it have been analyzed elsewhere.[1] The goal of this report is to put long-term care financing foursquare in the middle of the health and retirement conversation—as a critical part of deciding just what kind of society we want in years to come.

Four facts provide a foundation for that decision.

- We already have a major public and private commitment to long-term care financing—a public-private partnership. The combination of public and private spending on long-term care totaled more than $200 billion in 2005, about one-tenth of the nation's health care spending.[2] In addition to private

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and public spending is an enormous investment in family care, the primary source of long-term care for people who need it.

- The current partnership is totally unsatisfactory. Today's financing partnership consists primarily of out-of-pocket private financing and last-resort public financing. Individuals and families are dissatisfied with this partnership because it poses so great a financial risk, so overwhelming a family burden, and so little assurance that people actually receive the care they need. State governments are dissatisfied as rising long-term care costs crowd out their capacity to meet other pressing needs. And the federal government is dissatisfied with its share of the growing burden and reluctant to take on a larger share of the bill.

- Action to address dissatisfaction cannot simply aim at limiting public costs. Arbitrary limits simply shift costs to individuals and families already bearing an enormous burden. Rather, the policy challenge is to assure sufficient public and private resources to build an effective partnership that spreads risk, supports access to quality care, and shares financial responsibility fairly among taxpayers, affected individuals, and families.

- The partnership we build has to work for people of all ages, both now and in the future. About 2 in 5 of today's long-term care users are children or working-age adults, who do not have years to prepare for possible long-term care needs. And, though the demand for long-term care will grow as our population ages, more than 10 million people are today in need of long-term care. As a nation, we cannot wait years to meet these needs. The time to act is now.

The purpose of this report is to explore options for a new public-private partnership for long-term care financing All the proposals presented here try to move the partnership away from reliance on out-of-pocket financing by people needing long-term care and their families, toward insurance, through which costs are spread across a broad population at risk of needing service, users and nonusers alike. They all rely on government rules or resources to promote that move. All proposals also assume some mix of public and private financing. No proposal, no matter how focused on expanding private insurance, eliminates

public support for those without it; no proposal, no matter how public, provides benefits intended or likely to eliminate personal financial responsibility or family-provided care.

Eight of the options we present were developed by experts, whom we invited to design policies for financing long-term care that would address one or more of the problems with the current system.[3] We sought innovative ideas that would offer a range of private and public sector roles. In addition to the eight new policy proposals authored by experts, we include four proposals from other sources. Two are ideas that have been widely discussed for the past decade or so and proposed in congressional bills, one a tax benefit to individuals who purchase private long-term care insurance; the other, a Long-Term Care Partnership between private long-term care insurance and Medicaid. The Partnership was enacted into law in the Deficit Reduction Act of 2005. The third is recently introduced legislation (the Community Living Assistance Services and Supports Act, or CLASS Act), providing a voluntary federal insurance program aimed at workers. The fourth is based on the approach to long-term care financing adopted by Germany just over a decade ago.

The public-private partnerships envisioned in these proposals differ from each other primarily in the relative roles assigned to public versus private insurance—or, to be more precise, whether the proposal's primary purpose is:

- to promote growth of the private long-term care insurance market (retaining public financing as a safety net);
- to expand the long-term care safety net for people with low-to-modest incomes (with the better-off expected to rely on private financing);
- to establish public catastrophic long-term care insurance and stimulate complementary private insurance to fill in the gap (along with the safety net); or
- to establish a base of universal public long-term care insurance (to be supplemented by private financing and a publicly-financed safety net).

Each proposal reflects the care and creativity authors have given to this serious and complicated task. In each of the four categories, proposals vary consid-

erably. Proposals to promote private long-term care insurance vary in their focus on new marketing, new tax benefits, new tax requirements, or new product design. Safety net proposals vary in income and disability eligibility, focus on home care versus all care, and nature of the benefits. Proposals for public catastrophic protection vary in their definitions of "catastrophe" and how tightly they tie catastrophic protection to the purchase of private coverage. And proposals for universal public long-term care insurance range from basic to comprehensive benefits. In some cases, proposals, or elements of proposals, could fall into more than one of these categories. We have generally classified each proposal by its primary goal, undoubtedly oversimplifying its features in order to concentrate on common elements across proposals, rather than each proposal's unique features. We therefore urge readers to examine each proposal, as explained and analyzed by its author(s) at our website: ltc.georgetown.edu.

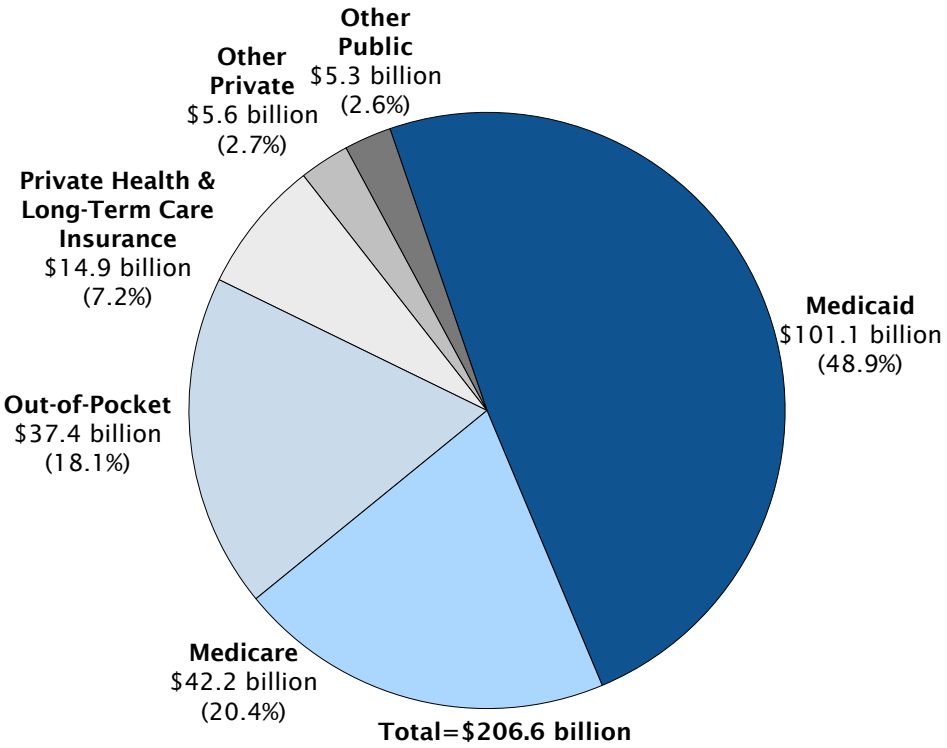
The following discussion begins with a description of our current partnership, and the reasons for so much dissatisfaction with it. We then go on to present and evaluate proposals for change, primarily in terms of their impact on how many and what kinds of people will be protected against the risk of needing expensive and extensive long-term care.

The Current Public-Private Partnership for Long-Term Care Financing

Of the $207 billion spent on long-term care in 2005, 72 percent came from public sources, primarily Medicaid (Figure 1). This public share is larger than applies in acute medical care financing.[4] However, a closer look at the current public-private partnership reveals that the public role in long-term care is smaller and the private role far larger than this snapshot of national spending suggests. Indeed, the fundamental problem with the way long-term care is financed is not its distribution between public and private sources but the lack of insurance protection—public or private—to protect individuals in the event that they need extensive, costly long-term care.

The importance of the private role in long-term care is obscured by exaggeration of the public role in expenditure data. Typically included in the data

Figure 1
National Spending for Long-Term Care, by Payer, 2005



NOTE: Components may not sum to totals because of rounding.
SOURCE: H. Komisar and L. Thompson, *National Spending for Long-Term Care* (Washington, DC: Georgetown University Long-Term Care Financing Project, February 2006).

are all Medicare expenditures for home health care and skilled nursing facility services—services that are delivered by long-term care providers but are fundamentally different from the personal assistance that constitutes the bulk of long-term care. Although Medicare may cover some of these services, its benefits focus overwhelmingly on short-term "post-acute" care—skilled nursing, rehabilitation, and therapy services associated with an acute illness or injury. During the 1990s, Medicare's home health benefit appears to have provided some long-term care (personal assistance) to enrollees who also had a qualifying need for skilled nursing or therapy services. Legislative changes in the late 1990s, however, led to a sharp decline in use of the benefit and a renewed focus on post-acute services.[5]

Alongside overstatement of public financing is understatement of the private contribution. Understatement comes in part from a focus only on expenditures, ignoring the role of family or informal care as well as private financing. Most people who need long-term care live at home (and are often referred to as "community residents"), not in nursing homes (Figure 2, in Box 1). And most people who need long-term care rely solely on assistance from family and friends; among the others, most receive family support in addition to paid assistance. The overwhelming majority—85 percent—of total hours of care received by people living at home with long-term care needs are unpaid.[6] Among people with long-term care needs living at home, fewer than 10 percent rely on formal (paid) care alone (Figure 3). In 2002, among people age 65 and older who needed help with activities of daily living (ADLs), half received 65 or more hours per month of unpaid family or informal care.[7] Many nursing home residents also receive assistance from family members.

Understatement of the private burden also comes from its reliance on direct or out-of-pocket spending by long-term care users, rather than insurance. As a result, individuals with extensive long-term care needs bear enormous financial burdens for their care, while those fortunate enough not to need it spend nothing at all. Estimates are that among people turning age 65 today, half can expect to live their lives without having to spend anything on long-term care, and one-fourth will spend less than $10,000 (in present discounted value).[8] At the other end of the spectrum, 6 percent of older Americans will spend more than $100,000 (in present discounted value). The distribution of family caregiving is similarly skewed.

Box 1

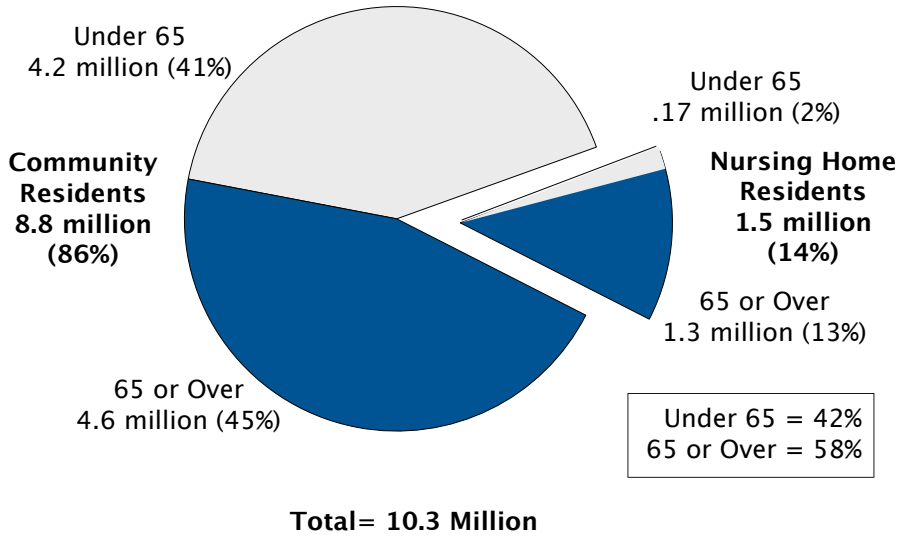
What is Long-Term Care and How Many People Need It?

Long-term care consists of personal assistance with essential, routine tasks of life—such as bathing, dressing, getting around the house, and preparing meals—for people who are unable to perform these tasks without assistance because of disabling physical or mental conditions. Because long-term care addresses these basic activities of life, it directly affects how a person lives and the quality of everyday life. People receive long-term care in a variety of settings including private homes, adult day-care centers, assisted living facilities, and nursing homes.

The need for long-term care arises from various causes, including diseases, disabling chronic conditions, injury, developmental disabilities, and severe mental illness. Of the 10 million people needing long-term care in 2005, 14 percent were nursing home residents (Figure 2).

Figure 2

People with Long-Term Care Needs, 2005

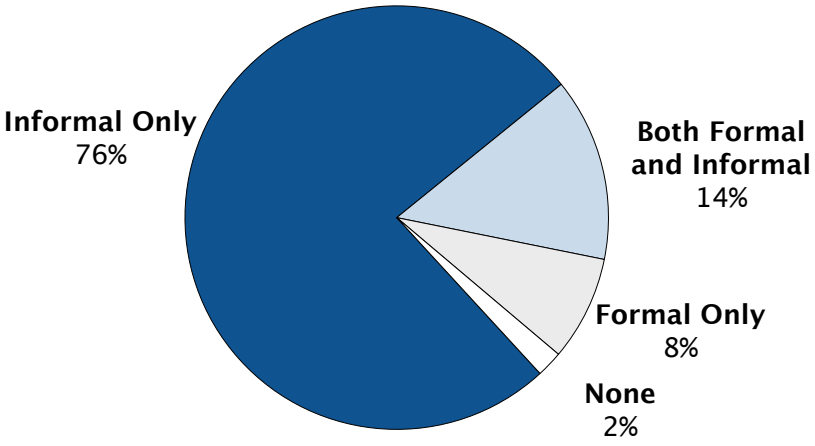


Total= 10.3 Million

NOTE: Components may not sum to totals because of rounding. Community residents with long-term care needs are defined as people who need another person's assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs). ADLs include: bathing, dressing, eating, using the toilet, getting in and out of bed or chairs, and getting around the house. IADL need is based on a single question asking if the person needs help with routine activities such as everyday household chores, doing routine business, shopping, or getting around for other purposes.
SOURCES: Health Policy Institute, Georgetown University, analysis of data from the 2005 National Health Interview Survey and the 2004 National Nursing Home Survey.

The absence of insurance—which spreads costs across many people to prevent catastrophic burdens on a few—creates this skewed distribution that is so troubling in the current public-private financing partnership. Evidence tells us that because the need for long-term care is an unpredictable and variable risk—not the certainty that is sometimes assumed—it would be beneficial to spread the risk of needing long-term care, just as we spread other costly risks. That needing long-term care is a risk and not a certainty is obvious among the population under age 65. Despite the fact that younger people account for about 40 percent of all those who need long-term care, the risk that any one individual in

Figure 3
Distribution of Community Adults Who Need Long-Term Care, by Type of Care Received



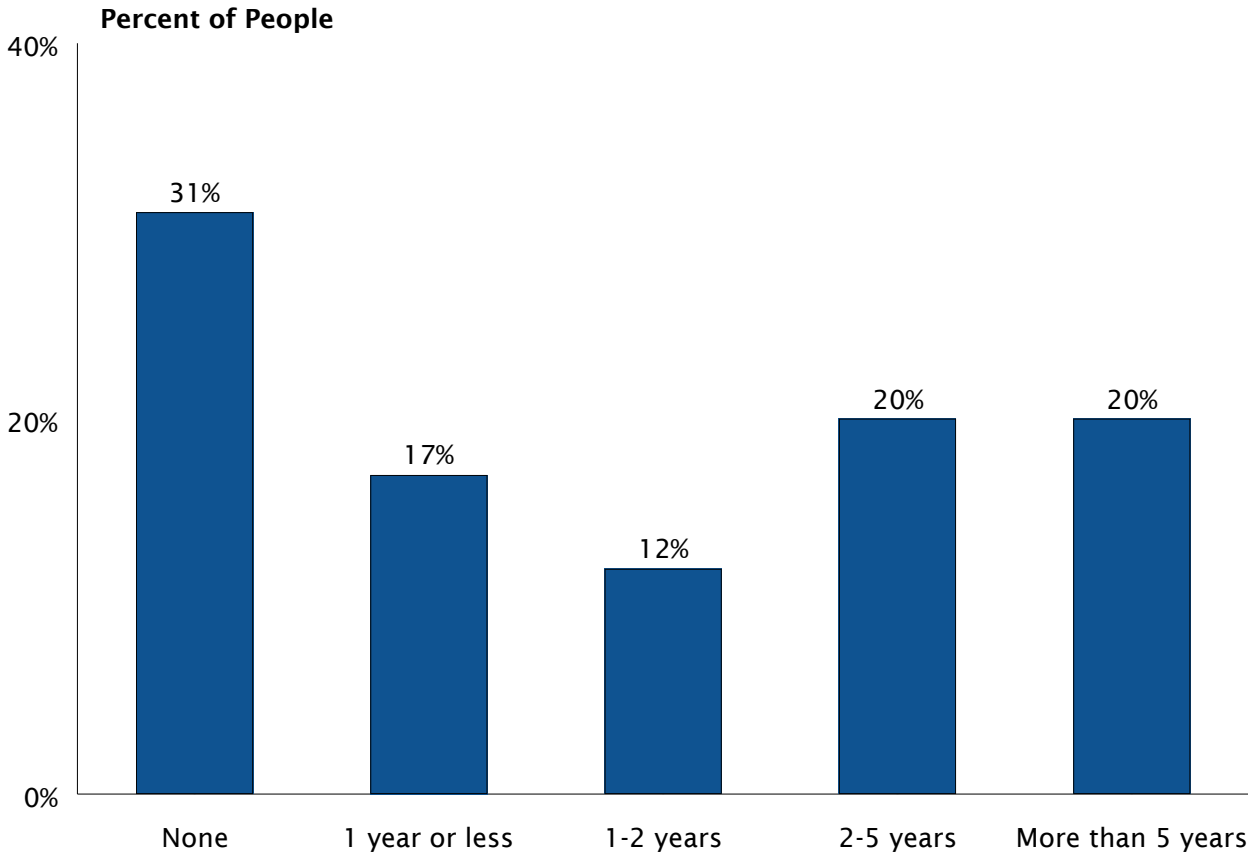
SOURCE: Health Policy Institute, Georgetown University, analysis of data from the National Health Interview Survey on Disability, Phase II, 1994-1997.

this very large population will need care is quite small. Contrary to popular belief, the need for long-term care is also uncertain among older people. Estimates indicate that about 3 in 10 people turning age 65 today will die without needing any long-term care. At the other extreme 1 in 5 will need more than five years of care (Figure 4). Clearly, we could spread risk here as well.

The value of spreading risk through insurance goes beyond mitigating catastrophic financial burdens. It is critical to assuring that people get the care they need. In the last national survey to explore the issue of unmet long-term care needs among people of all ages, one of every five individuals at home and in need of long-term care reported going without care they needed (Figure 5).[9] And the lack of needed care increased likelihood that they would experience serious consequences—like falling, being unable to eat, bathe, or dress, or soiling themselves.[10] Although lack of financing is not the only barrier to meeting care needs, reducing financial barriers through insurance can certainly help.

The importance of policies to improve our public-private partnership increases as we look to the future. As the population ages, the number and proportion of people needing care will increase. Between 2010 and 2050, the population over age 65 is projected to increase from 39 million to 80 million, growing from 13 percent to 21 percent of the overall population (Figure 6).[11] The proportion aged 85 or over—among whom the likelihood of needing long-term care is greatest—

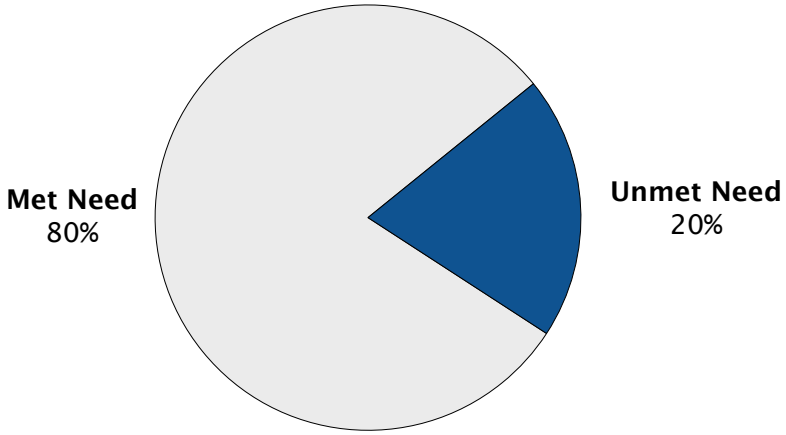
Figure 4
Estimated Years of Long-Term Care Need After Turning Age 65



NOTE: Based on projections for people turning 65 in 2005.
SOURCE: P. Kemper, H.L. Komisar, and L. Alecxih, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?" *Inquiry* 42, no. 2 (Winter 2005/2006): 335-350.

will more than double from 2.0 percent in 2010 to 5.0 percent in 2050, as this group expands from 6 million to 21 million people.[12] The number of people age 65 and older needing long term care is estimated to grow from 6 million in 2005 to an estimated 10 million in 2045-2049.[13] The number of younger people needing long-term care is also expected to grow as the population expands. If there were no change in the proportion of people under age 65 needing long-term care, population growth would mean that the number would grow from 4 million in 2005 to about 13 million in 2050.[14] Estimates focusing on the elderly population indicate that simply sustaining our current partnership—with all its inadequacies—for a growing population in need will require roughly a doubling of public alongside private expenditures between 2010 and 2030.[15] To improve, not merely sustain, our partnership will require even greater investment to assure adequate access to appropriate care of good quality. Other nations are today adopting poli-

Figure 5
Prevalence of Unmet Need Among Community-Based Adults Who Need Long-Term Care



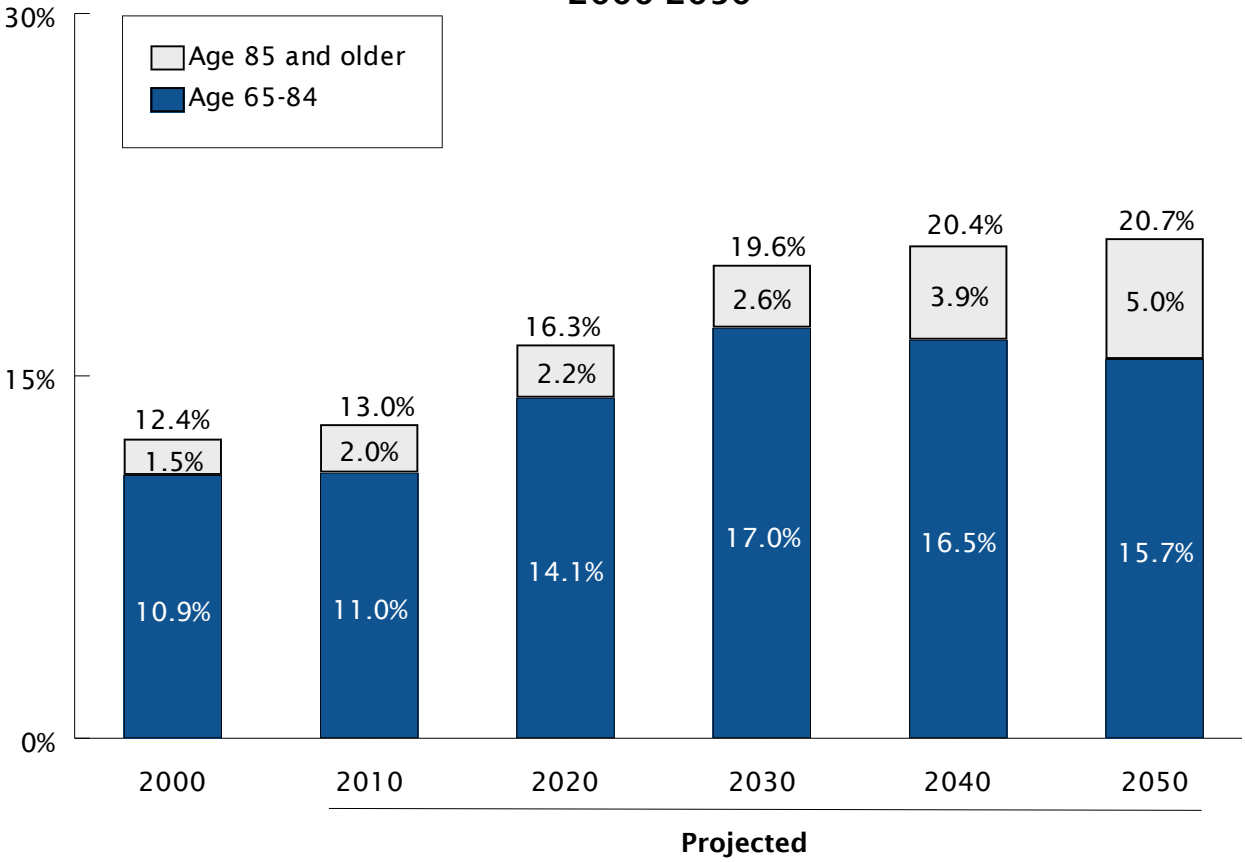
SOURCE: Health Policy Institute, Georgetown University, analysis of data from the National Health Interview Survey on Disability, Phase II, 1994-1997.

cies to address older populations and service needs quite similar to those we will face in the future.[16] There is no reason that we too cannot do better.

Having more people living longer is a major accomplishment for our society. But the challenge is to assure we match that accomplishment with policies that enhance the quality as well as the duration of life. Meeting that challenge requires us to shift our existing public-private partnership to one that spreads risks and invests sufficiently to address care needs. The remainder of this report explores options for achieving this goal.

In recent years, public action to alter the current public-private partnership has focused primarily on specific measures aimed at expanding the number of people with private long-term care insurance—partly aimed at reducing burdens on individuals who finance their own long-term care by spreading risk, and partly aimed at reducing the number of people unable to pay for their own long-term care who rely on Medicaid (that is, reducing public spending).[17] Understanding the proposed interventions requires first, that we assess why they are necessary—why is the purchase of private long-term care so limited?—and second that we understand how much and for whom interventions will effectively spread risk.

Figure 6
Percentage of the Population Age 65 and Older, 2000-2050



SOURCES: F. Hobbs and N. Stoops, *Demographic Trends in the 20th Century,* U.S. Census Bureau, Census 2000 Special Reports, Series CENSR-4 (Washington, DC: Government Printing Office, 2002); and U.S. Census Bureau, "Table 2a. Projected Population of the United States, by Age and Sex: 2000 to 2050," March 2004, http://www.census.gov/ipc/www/usinterimproj/natprojtab02a.xls.

Proposals to Promote Private Long-Term Care Insurance

Why is intervention needed?

Private insurance for long-term care began to emerge in the 1970s, and first began to attract significant interest among consumers and policymakers in the mid-1980s as a strategy for retirement planning (see Box 2).[18] Despite more than thirty years of experience—during which policies have become more comprehensive in their benefits and interest in, as well as actual purchase, has increased, the reach of private insurance remains quite modest. Under current public policies, it is quite unlikely that private long-term care insurance will play a large role in long-term care financing.

Currently, only a small proportion of people has private long-term care insurance. In 2005, about 7 million people—or about 3 percent of the adult population—had private long-term care insurance policies (Figure 7). Younger people are much less likely to buy long-term care insurance than older working-age

Figure 7

Number and Percentage of Adults with Long-Term Care Insurance, 2005

	Total Population (in millions)	With Long-Term Care Insurance *Number* (in millions)	*Percent*
Total (age 20 and over)	214.7	7.0	3.3%
Age 50 and over	87.1	6.8	7.8%
Age 20–49	127.5	0.2	0.2%
50–64	50.4	3.1	6.2%
65 and over	36.8	3.7	10.0%

SOURCE: Health Policy Institute, Georgetown University, estimate based on the following information and sources: (1) Total number of people with long-term care insurance from Lifeplans, Inc., *Who Buys Long-Term Care Insurance? A 15-Year Study of Buyers and Non-Buyers, 1990-2005* (Washington, DC: America's Health Insurance Plans, 2007). (2) Population by age from U.S. Census Bureau, Table 1. Annual Estimates of the Population by Sex and Five-Year Age Groups fore the United States: April 1, 2000 to July 1, 2005, http://www.census.gov/popest/national/asrh/NC-EST2006-sa.html. (3) Percentage of people age 65 and over with long-term care insurance (10%) from Andrew Melnyk, *Long-Term Care Insurance or Medicaid: Who Will Pay for Baby Boomers' Long-Term Care?* (Washington DC: American Council of Life Insurers, 2005). (4) Assumes 3% of policyholders under age 50, based on 7% of new buyers in 2005 being under age 50 and average age of buyers declining over time (Lifeplans, Inc., *Who Buys Long-Term Care Insurance?*).

Box 2

What is Long-Term Care Insurance?

Private long-term care insurance policies pay for personal care and other services needed by people who need assistance with basic activities of living. These services may include personal care to assist with bathing, dressing, or other fundamental activities; therapies to maintain or restore functioning; homemaker services such as shopping and meal preparation; and respite care to relieve family caregivers. Policies differ in the types and amount of services they will pay for. Although some policies pay only for nursing home care or only for home-based care, most policies that people have bought in recent years pay for nursing home services and home-based care; policies may also cover assisted living and other services.

The price of long-term care insurance varies widely depending on the policy design—the level of benefits purchased and other features—and the age of the buyer. Most long-term care insurance policies have restrictions on when they pay benefits and cap the total amount of benefits. To be eligible for benefits, a policyholder must usually meet specific criteria indicating a significant level of disability. For a policy to be tax-qualified it must pay benefits only when the insured person is unable to perform at least 2 ADLs without substantial assistance, or requires substantial supervision because of cognitive impairments.[19] Policies often have an "elimination period"—that is, they first begin to pay benefits only after a specified period of time, such as 90 days, has elapsed since the person first met the eligibility criteria. Policies usually specify the maximum amounts they will pay per day, per month, or in total, for services. For example, a policy may specify a payment limit of $150 per day for nursing home care, $75 per day for home care or assisted living. More flexible policies may instead provide a maximum "pool of funds," such as $150,000, which beneficiaries may draw upon to pay for services as needed. Insurers usually offer inflation protection that increases the benefit limits annually by a specified percentage amount, often 5 percent each year. As an alternative to inflation protection, some policies allow buyers to increase the benefits periodically (at a higher price, but without have to obtain a new policy).

Long-term care insurance is typically priced under the assumption that a person will hold the policy for a number years, with the goal (though not guarantee) of keeping the premium unchanged from year to year. Because the risk of needing long term care rises with age, the premium is lower for people who first purchase the policy at a younger age (than for those who first buy it at a more advanced age) reflecting their lower average risk over the period they are expected to hold the policy. If a person changes to a new policy, the new premium will be based on their age; thus, switching to an otherwise identical policy would likely result in a higher premium.

adults in their 50s and seniors. Among people age 65 and older, approximately 10 percent have private long-term care insurance.[20] There are several reasons for the limited scope of the private long-term care insurance market:

Uncertainty about the value of the product. Private long-term care insurance has some risks, which may discourage potential purchasers. Because many things may change over time, purchasers face the risk that the insurance policy they purchase now may not—in the years or decades ahead—turn out to provide the protection they expected.

Policies include a number of features designed to manage insurers' risks and thereby pose risk for consumers. In terms of services covered, types of providers or sites of care may be limited, both relative to what is available today and what becomes available in the future. In terms of dollars promised, in addition to limits on maximum benefits, policies may set daily limits that are too low to cover care costs today or fail to keep up with inflation. Even a typical inflation-protected policy increases benefits by 5 percent, compounded annually—a slower rate than recent increases in the cost of nursing home care. Between 2002 and 2006, prices grew at an average annual rate of 5.2 percent for a private room (from $168 to $206 per day) and 6.3 percent for a semi-private room (from $143 to $183 per day).[21] If the policy does not fully cover the cost of services, the policyholder may have to draw down assets to pay for the difference.[22]

Finally, deriving value from a policy requires that a policyholder be able to keep paying the premiums. Not only can purchasers' financial circumstances change, but insurers are also permitted to raise premiums under certain circumstances.[23]

Cost. For most people, buying long-term care insurance would be a significant expense. In 2005, the average price (among five major insurers) for a typical policy providing $150 daily benefit and 5 years of coverage, with a 90-day elimination period and inflation protection was $2,447 for buyers age 50 at the time of purchase, and $6,178 for buyers who first purchased policies at age 70.[24]

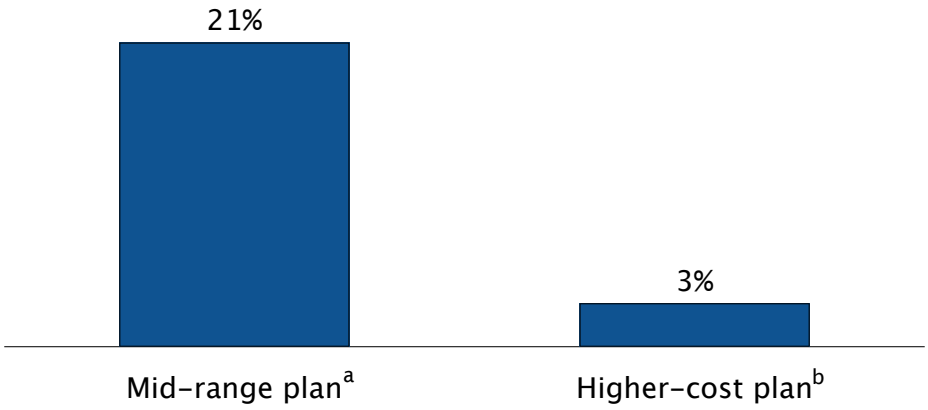
Many people cannot afford long-term care insurance; give priority to other financial needs like paying for medical insurance, medical care, and education; or consider the price high relative to the benefits.[25] The National Association of Insurance Commissioners (NAIC), consistent with the views of many experts, ex-

plicitly recognizes that long-term care insurance is not financially appropriate for everyone.[26] Accordingly, the NAIC recommends that sellers seek buyers for whom the premium would take no more than 7 percent of income and who have at least $35,000 in financial assets.[27] Experts have reasoned that younger people could only devote a smaller proportion of income to long-term care insurance because, on the whole, they have greater needs than older people for expenditures in some other areas, such as buying health insurance, saving for educational expenses and retirement, and paying off a mortgage.[28]

Using the NAIC criteria (premium not exceeding 7 percent of income and financial assets of at least $35,000), among people between 60 and 79 years old, a recent study estimated that 21 percent could afford to buy "mid-range" coverage (Figure 8). For younger couples, ages 35-59 years old (with at least one spouse working), the study used a different measure of affordability—defined as the premium not exceeding: 2 percent of income for people age 35-44, 3 percent at ages 45-54, and 4 percent at ages 55-59. The results indicate that although three-quarters of couples ages 35-59 could afford long-term care insurance, only 33 percent have adequate retirement savings, life insurance, and health insurance, and could also afford long-term care insurance (Figure 9).[29] The proportion drops

Figure 8

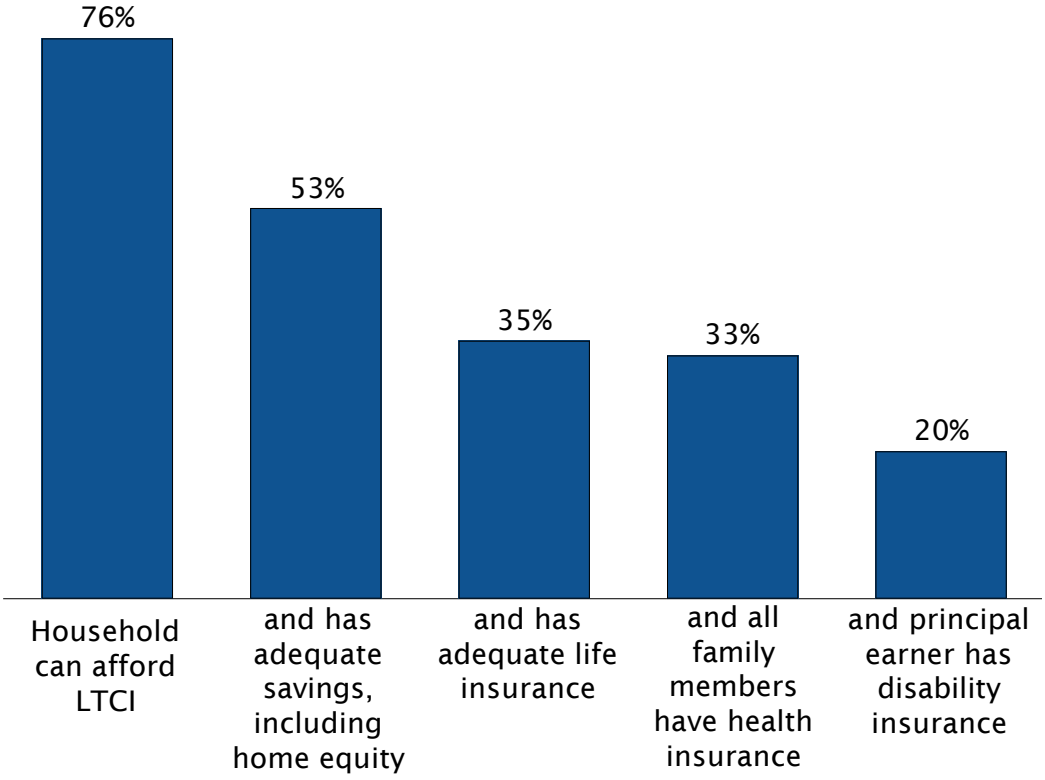
Estimated Proportion of Households Age 60–79 Who Could Afford Long-Term Care Insurance, 1998



NOTE: Assumes household can afford LTCI if the premium is not more than 7% of income and the consumer has at least $35,000 in financial assets (based on the NAIC guidelines).
a. $125 daily benefit for 3 years, 90-day elimination period, 5% compound inflation protection.
b. $300 daily benefit for 5 years, 30-day elimination period, 5% compound inflation protection.
SOURCE: M. Merlis, *Private Long-Term Care Insurance: Who Should Buy It and What Should They Buy?* (Washington, DC: Kaiser Family Foundation, 2003).

Figure 9

Estimated Proportion of Married Couples Age 35–59 Who Can Afford Long-Term Care Insurance and Meet Specific Criteria of Financial Health, 1998



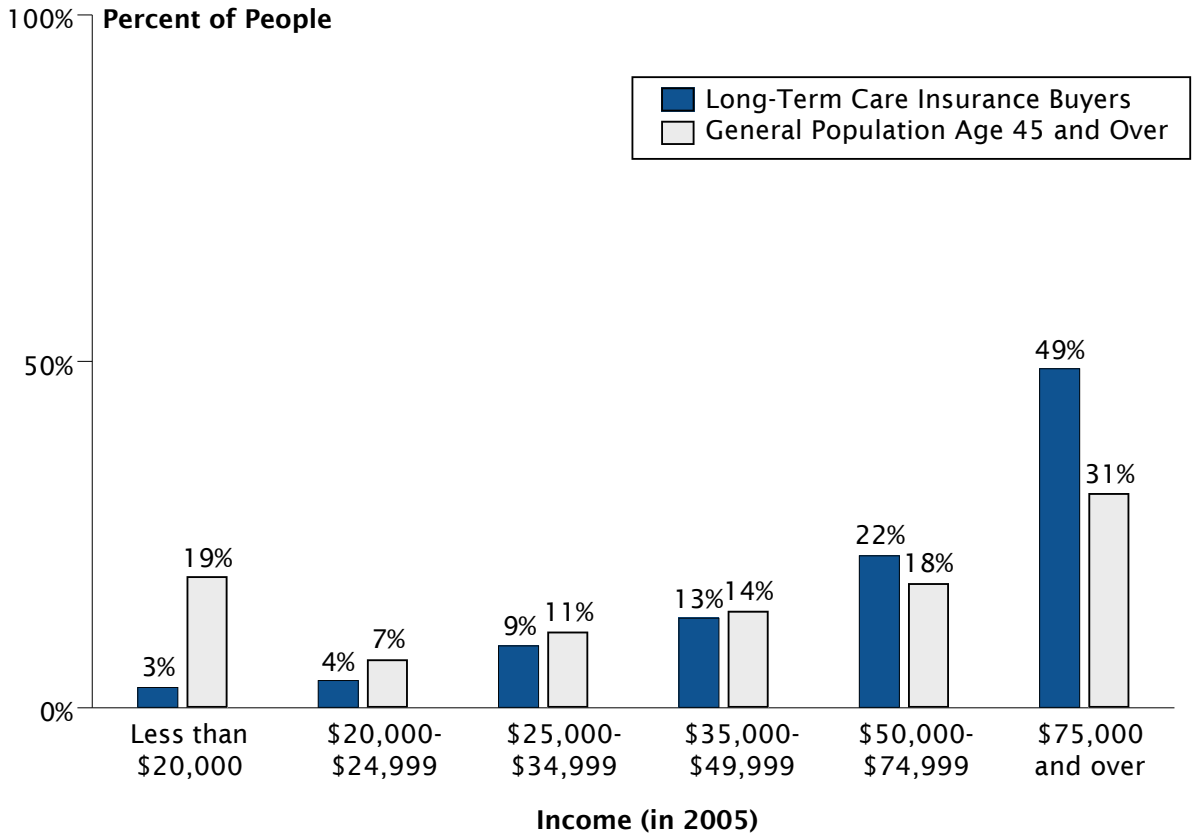
NOTE: Assumes household can afford long-term care insurance if the premium does not exceed a percentage of income that varies with age: 2% for ages 35-44, 3% for ages 45-54, and 4% for ages 55-59. Premium based on a policy providing a $100 daily benefit for 3 years, with a 90-day elimination period and 5% compound inflation protection.
SOURCE: M. Merlis, *Private Long-Term Care Insurance: Who Should Buy It and What Should They Buy?* (Washington, DC: Kaiser Family Foundation, 2003).

to 20 percent if the criteria also include disability insurance for the principal wage earner.

Given the expense of long-term care insurance, it is not surprising that those who buy it have relatively high incomes. Among people buying new policies in 2005, 49 percent had incomes of $75,000 or more; in comparison, 31 percent of the general population age 45 and over have incomes that high (Figure 10).

The individual market. Most people have to purchase long-term care insurance as an individual product rather than a group product. In contrast to their role in health insurance, the vast majority of employers do not offer long-term care insurance—and among those that do, few help pay for it.[30] High administra-

Figure 10
Distribution of People Buying New Long-Term Care Insurance Policies in 2005, by Income



SOURCE: Lifeplans, Inc., *Who Buys Long-Term Care Insurance? A 15-Year Study of Buyers and Non-Buyers, 1990-2005* (Washington, DC; America's Health Insurance Plans, 2007).

tive costs in the individual market contribute to the cost of buying long-term care insurance. These include the costs of marketing, reviewing applications, collecting premiums, and paying commissions to insurance agents.[31] A Government Accountability Office (GAO) study found, for example, that among the top five sellers of long-term care insurance, the average anticipated lifetime loss ratio for individual policies was 59 percent—that is, of the total premiums collected from a set of policies, 59 percent was projected to pay for claims.[32]

Buying in the individual market also imposes the barriers of underwriting.[33] As in the individual market for health insurance, insurers typically review medical and health-related information to determine a person's level of risk for needing services. If an insurance company determines that a person currently needs long-term care or is at high risk of needing services soon, it is unlikely to sell that person a policy. As a result, many people with existing health conditions and disabilities are not able to purchase long-term care insurance. Among people age 65-

69, an estimated 28 percent would not pass an underwriting screen for long-term care insurance purchase.[34]

Finally, buying in the individual market imposes a considerable navigation barrier. Consumers can find it difficult to choose a long-term care insurance policy.[35] Over 100 companies offer long-term care insurance in the individual market, and each company offers multiple products that differ in daily benefit levels, total coverage, elimination periods, and other features. Consumers can be overwhelmed by uncertainty about what policy to choose—what combination of features to select, how much coverage to buy, and which insurers will be most reliable.

Medicaid's role. Medicaid pays for long-term care services for eligible people, but Medicaid is not equivalent to private insurance. First of all, Medicaid does not protect assets and requires nursing home residents to commit nearly all of their income to pay for their care.[36] Further, while Medicaid's benefits overlap with private long-term care insurance benefits (and are more comprehensive than some), they are not the same. Medicaid enrollees may have difficulty obtaining the same access to or quality of care as people who have private insurance (or who pay out-of pocket) because Medicaid may offer limited home care benefits and often pays lower rates than private payers.

Still, the existence of Medicaid may play a role in people's planning.[37] For example, some people who could afford long-term care insurance may decide that they have sufficient financial resources to self-insure some of the risk, knowing that Medicaid's safety net will be there if they exhaust their assets. Medicaid can also influence buyers of long-term care insurance by affecting how much coverage they choose. Buyers may choose a lower maximum benefit, to save money on premiums, knowing that there's a safety net in case they need more care.

Policy Proposals

The following five proposals target different barriers in order to promote the purchase of long-term care insurance. The proposals vary not only in the problems they aim to solve but also in the extent to which they rely on government authority and public resources for implementation.

Reducing uncertainty about long-term care insurance and lowering the price

A new government program, **Medi-LTC**, developed by John Cutler, Lisa M. Shulman and Mark Litow, aims to encourage people to buy long-term care insurance by reducing uncertainty about the value of private policies.[38] Their goal is to "increase the number of Americans with long-term care insurance benefits… through a combination of increasing awareness of the need for long-term care insurance coverage and improving the trustworthiness and affordability of the product." This proposal uses two strategies to achieve its goals: a Medicare "seal of approval" to boost people's confidence in the product, and reliance on group marketing, through Medicare, to reduce administrative costs and premiums.

To establish the "seal of approval" the authors propose to have Medicare assume responsibility for authorizing insurers to sell approved "core" long-term care insurance policies**.** Medicare would distribute approved marketing materials and enrollment information provided by authorized insurers to all individuals on their 50th, 55th, 60th, and 65th birthdays. The Medi-LTC policies would compete with insurance policies otherwise offered in the marketplace**.**

The proposal is modeled, in part, on the Federal Long Term Care Insurance Program, available to federal employees, retirees, and certain family members, which began in 2002. The federal program reduces several of the barriers in the current long-term care insurance market. By selecting a carrier and establishing benefit standards, the federal program aims to reduce confusion and enhance confidence in the product; by making high quality information readily available, it improves knowledge and confidence. Group marketing reduces administrative costs. In addition, the availability of a "short form" underwriting application for some potential participants may reduce the underwriting barrier and hassle for some applicants and administrative costs for the insurer.

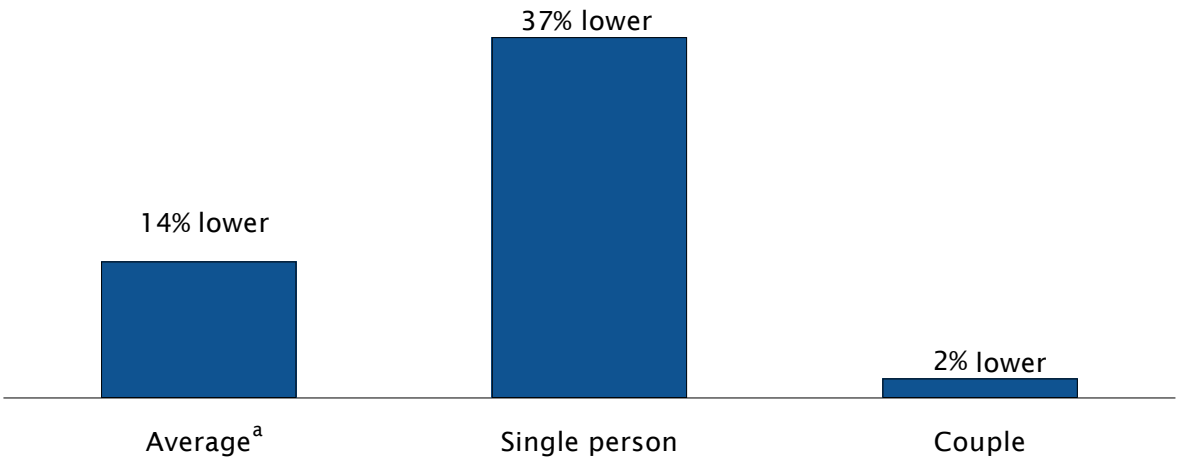
A key difference between the proposed Medi-LTC program and the federal program is that Medi-LTC would allow a number of different insurers to offer products—though with standardized "core" benefits and marketing materials—while the federal program used a competitive bidding process to select a single insurance carrier to which it granted an initial seven-year contract. The carrier offers several standard benefit packages, plus the opportunity for buyers to customize a benefit package.

Despite this difference, experience with the federal program offers a guide to Medi-LTC's potential impact. According to a GAO analysis, the federal program's features have produced considerably lower premiums than are available in the current individual market. Compared with similar products sold in the individual market by five major sellers of long-term care insurance, the GAO found that the annual premiums in the federal program in 2005 (averaged over three plan designs) were 46 percent lower for single people and 19 percent lower for married couples.[39] The difference in price is narrower when the federal program is compared to the lowest-priced products available in the individual market—presumably the price a well-informed consumer would get—but the federal program still had lower prices for most combinations of package, age, and marital status examined by the GAO. Indeed, for single purchasers, for each of the three benefit packages, the price of the federal package was lower than the lowest price available for a similar private package among the five private insurers, though this was not the case for every package and age for married couples. Averaging among packages and ages, premiums in the federal program were 37 percent lower than the lowest prices in the individual market for single people, but only 2 percent lower for married couples (Figure 11). Savings are greater for singles than couples because the federal program does not offer discounts to couples, while most companies selling in the individual market do.

If Medi-LTC were to achieve a similar price decrease, a weighted average of 14 percent (using the proportions of single and married people ages 50-64), how much would the purchase of coverage likely expand? Based on available (though limited) evidence, experts have suggested that the elasticity of demand for long-term care insurance falls in the range of -.75 to -1.25—in other words, if price were decreased by 1 percent, sales would grow by .75 percent to 1.25 percent.[40] Using this range indicates that if the entire market were offered a price reduction of 14 percent, sales of long-term care insurance would grow by roughly 11 to 18 percent or (applied to 7 million policies in force in 2005) by 0.7 to 1.2 million policies.

If, however, Medi-LTC achieved the participation levels of the federal program, its impact would be greater. According to the GAO, during the first three years of the program, about 5 percent of active federal civilian employees participated, a rate similar to participation among people who have access to long-term care insurance through an employer or similar group. (About one-fourth of

Figure 11
Average Difference Between Premiums in the Federal Long-Term Care Insurance Program and the Lowest Premiums in the Individual Market, 2005



NOTE: Averages shown are the average difference in premiums among twelve policy-age combinations consisting of three standard packages sold by the federal program, priced at ages 40, 50, 60 and 70.
a. The average difference is the weighted average of the differences for single people and couples, based on the proportions of people age 50-64 who are single and married.
SOURCE: Health Policy Institute, Georgetown University, analysis of information from U.S. Government Accountability Office, *Long-Term Care Insurance: Federal Program Compared Favorably with Other Products, and Analysis of Claims Trend Could Inform Future Decisions*, GAO-06-401, March 2006, and U.S. Census Bureau, "Table A1. Marital Status of People 15 Years and Over, by Age, Sex, Personal Earnings, Race, and Hispanic Origin, 2006," http://www.census.gov/population/www/socdemo/hh-fam/cps2006.html.

applicants were denied coverage in the underwriting process, which is similar to the proportion in the individual market.) If participation in Medi-LTC achieved a similar 5 percent participation rate among the approximately 50.4 million people in the U.S. age 50-64—approximately the age group receiving the Medi-LTC marketing materials—this would yield roughly 2.5 million purchasers of Medi-LTC policies in this age group, with somewhat fewer newly-covered individuals since some purchasers would probably already have had other long-term care insurance.[41] This is perhaps an upper bound estimate for participation since Medi-LTC target group (general population age 50-65) have lower incomes, on average, and are more likely to have health problems (and therefore to not meet underwriting restrictions) than federal employees. However, the Medi-LTC population is older, on average, than active federal workers and therefore might be more interested in long-term care insurance.

Assuming people retained their Medi-LTC policies as they aged, over time the total number of people over age 65 with long-term care insurance would also grow. Because some of these people would have bought long-term care insurance without the Medi-LTC opportunity, the additional proportion of people over 65 with long-term care insurance would be less than the 5 percent participation assumed (as an upper bound) for 50-65 year-olds. A reasonable expectation might therefore be that Medi-LTC might ultimately increase the proportion of the population age 50 and over who have long-term care insurance by as much as 3 to 5 percentage points. If this increase were applied to the 2005 population age 50 and older, the proportion of the people in this age group with long-term care insurance would increase from about 8 percent currently to roughly 11 percent to 13 percent. This would yield an increase of roughly 2.6 million to 4.4 million policyholders. This increase would come at a relatively small federal cost, consisting only of the administrative costs incurred in reviewing insurers' applications of plans for authorization, and in developing and distributing the relevant information to the targeted consumers to inform them of the program and the authorized long-term care insurance plans.

Enhancing the benefits of private long-term care insurance

In the Deficit Reduction Act of 2005, Congress promoted another strategy to promote the purchase of insurance, commonly referred to as the **Long-Term Care Partnership**.[42] All states now have the option of establishing Long-Term Care Partnership programs that allow people who purchase approved private insurance policies to qualify for Medicaid while retaining a higher level of assets than would otherwise be allowed. The Partnership's strategy for making long-term care insurance policies more attractive is to provide purchasers more extensive financial protection than the policies they purchase actually provide. That strategy enhances the value of a limited insurance product without raising its premiums and—it is hoped—thereby expands its market. An additional hope of its proponents is that among the new purchasers are individuals who, without insurance, would have qualified for Medicaid at the taxpayers' expense. A major objective of this strategy, therefore, is to reduce demands on and costs to the Medicaid program.

The Partnership was launched in four states in the early 1990s, under a Robert Wood Johnson Foundation project directed by Mark Meiners.[43] Although a

1993 law in effect prevented other states from establishing such programs, the Deficit Reduction Act of 2005 has again made it possible for all states to establish Partnership programs.[44] The program is currently operating in the original four states—California, Connecticut, Indiana, and New York—but a number of states have passed legislation that authorizes them to establish a Partnership program.[45]

In the Partnership design required by the Deficit Reduction Act for any new programs (which is also the design of currently operating programs in California and Connecticut) people buying Partnership long-term care insurance policies can become eligible for Medicaid while retaining assets equivalent to the dollar amount of insurance benefits paid out under their Partnership long-term care insurance policy.[46] Under this "dollar-for-dollar" arrangement, a partnership policyholder who purchased and received $150,000 in benefits and still needed care could qualify for Medicaid while retaining $152,000 in assets rather than the $2,000 otherwise permitted by Medicaid. To obtain Medicaid coverage, purchasers of Partnership plans must still satisfy Medicaid's income eligibility requirements. Specific income requirements vary among states, but all states require people to have low income or to use all income above specified low levels on health or long-term care expenses.[47] Thus, consistent with their goals, the Partnership policies are most likely to benefit people with lower to moderate incomes, who can meet the income eligibility requirements and have assets likely to fall to eligibility levels if extensive care were needed.

Experience in the four states with long-standing Partnership programs shows that these policies have had a notable impact on the long-term care insurance market, but have not had much impact on the purchase of coverage.[48] States extended many of the marketing and benefit standards developed to assure quality products in the Partnership to all new long-term care insurance policies. But better-quality policies have not meant an increased volume of purchases; nor have purchasers been concentrated among the modest income population. Most purchasers of Partnership policies have substantial assets—the majority of purchasers in California, Connecticut, and Indiana had more than $350,000 in assets.[49]

The Congressional Budget Office (CBO) attributed this pattern in part to higher prices associated with higher standards for Partnership policies, prior to the 1996 enactment of federal conditions for tax benefits related to the purchase of

insurance. The equalization of standards brought more comparable prices between Partnership and non-Partnership plans and higher sales of the Partnership policies (though CBO notes that shorter-term, such as one-year, Partnership policies were not proportionately less costly than other private policies with more extensive coverage).[50]

If Partnership plans were offered in all states, how many more people would purchase long-term care insurance? Because prices are not lowered by Partnership plans, it seems highly unlikely that it would create as strong a stimulus to new purchases as Medi-LTC (which potentially offers significantly lower prices). However, the target population in the Partnership program is broader, consisting of adults of all ages while Medi-LTC is targeted to people age 50 and older. New policies would substitute for some policies that individuals would otherwise have purchased. Overall, then, an increase of 2.6 million to 4.4 million in the number of people buying long-term care insurance—as estimated for Medi-LTC—would seem an upper bound on the Partnership's likely effect.

Will these purchases lower Medicaid costs? Arguments that they will are based on the assumption that Partnership policies will enable some purchasers who otherwise would have exhausted their resources and turned to Medicaid to pay for long-term care, to avoid having to rely on Medicaid (or to shorten the time period on which they rely on Medicaid). But purchasers may also include people with assets who would never previously have qualified for Medicaid, resulting in greater Medicaid expenditures. CBO estimated that on balance the Deficit Reduction Act provisions enabling all states to offer Partnership arrangements would result in a small increase in Medicaid costs—$26 million over 5 years and $86 million over 10 years.[51]

Making insurance more affordable through a tax deduction for premiums

Tax breaks for people who purchase private long-term care insurance have long been proposed to promote the purchase of private long-term care insurance. In 1996, Congress clarified what many regarded as confusion in the tax code by making long-term care expenses and premiums of qualified long-term care insurance policies eligible for tax treatment similar to that of health insurance expenses and premiums.[52] A proposal introduced as a bill in the 109th Congress by Representative Nancy Johnson would go a step further.[53] Her proposal would allow taxpayers to deduct the premiums paid for long-term care insurance from

their taxable incomes before calculating their income tax (an "above the line" deduction, available to all taxpayers whether or not they itemize deductions), or to use tax-preferred cafeteria plans or flexible savings accounts to pay for long-term care insurance.[54] Either way, people who purchased long-term care insurance (as long as policies met specific qualifications) would not pay income tax on the amount spent on premiums.

The proposal is expected to stimulate purchase of long-term care insurance by giving a "seal of approval" to the purchase of qualified policies and by reducing their price—specifically, by a percentage amount equal to the taxpayer's marginal tax rate (that is, the tax rate paid on the last dollar earned). For example, for a single person with taxable income between $7,826 and $31,850 in 2007, the marginal tax rate for federal income tax is 15 percent (that is, of the last dollar the person earned that year, 15 cents went to federal taxes).[55] Thus, for people in this income range, a tax deduction for long-term care insurance would be similar to receiving a 15 percent reduction in the long-term care insurance premium.[56] The marginal rate is higher for people with higher incomes—e.g., 25 percent for single people with taxable income between $31,851 and $77,100, and then rising in stair-steps to 28 percent, 33 percent, and a maximum of 35 percent for single people and couples with over $348,700 in taxable income.[57] For people who pay the higher marginal tax rates, the tax deduction would be equivalent to a sizable discount in the price of long-term care insurance.[58]

As noted above, experts suggest that a 1 percent decrease in the price of long-term care insurance would result in roughly a .75 percent to 1.25 percent increase in long-term care insurance sales. Assuming this responsiveness to an effective decrease in price, along with a marginal tax rate of 15 percent (the rate for the median tax payer, and 37 percent of all taxpayers, in 2005[59]) suggests that tax deductibility could result in an 11 percent to 19 percent increase in long-term care insurance sales. Thus, based on 7 million policies in 2005, roughly an additional .8 to 1.3 million policies might be purchased.

Because the tax deduction would be greater for people with higher incomes, they would be more likely to respond to this incentive than people with lower incomes. The regressive structure of tax deductibility also means that for people whose income drops at or during retirement—a common occurrence—the price of their insurance will effectively rise if they fall into a lower tax bracket (and

accordingly derive less benefit from the deduction). The result may well be difficulty or inability to continue premium payments and the loss of coverage after years of contributions.[60]

The benefits of the new tax preference would not be limited to new purchasers. Everyone purchasing would qualify. If the number of purchasers grew by .8 to 1.3 million, as estimated, approximately 85 to 90 percent of people benefiting from the deduction would have bought long-term care insurance without the added incentive.

The federal cost of a tax deduction for long-term care insurance is the aggregate amount of the reduced tax among all long-term care insurance buyers. In 2003, the Joint Committee on Taxation estimated that a tax deduction for long-term care insurance premiums, proposed in the President's fiscal year 2004 budget proposal, would reduce federal tax revenues by $1.7 billion in 2007 (the first year it would have been fully phased in, under the proposal).[61]

Expanding the market with an innovative product: an annuity that combines retirement income and long-term care insurance

A different strategy to effectively reduce the cost of long-term care insurance involves the creation of a new product—**The Life Care (TLC) Annuity**—which would combine retirement and long-term care insurance.[62] This proposal, developed by Mark Warshawsky, would allow individuals at retirement to purchase a TLC Annuity that would give them (1) income payments for life (of $1,000 per month), and (2) the guarantee that payments would increase if they became disabled (to $3,000 per month for moderate disability or $5,000 per month for severe disability). Warshawsky argues the primary barriers to insurers in offering this product are not only uncertainty and therefore risk in setting the "lump sum" price for purchasing the annuity, but also current regulatory practices. A key issue is that combining an annuity with disability insurance means that the combined product needs to comply with two distinct sets of regulations, making it more expensive for insurers to develop. This proposal seeks to reduce such regulatory hurdles.

The purpose of combining a lifetime retirement annuity with disability insurance is to overcome current barriers to the purchase of both products that result from insurers' expectations of adverse selection. Sellers of life-time retire-

ment annuities set prices to protect themselves in case buyers are people with especially long life expectancies; prices are then unattractively high. Sellers of long-term care insurance "underwrite" their policies to avoid sales to people with a high risk of disability; many people therefore can't buy at any price. The strategy behind combining the two products is to let one risk offset the other—disproportionately healthy buyers attracted by annuities balancing disproportionately unhealthy buyers of long-term care insurance—thereby making underwriting and conservative pricing unnecessary. With a product more attractive to purchasers, the expectation is not only that more individuals will buy TLC Annuities than buy private long-term care insurance, but that more employers will make it available, further lowering its price and expanding the market.

In other research, Warshawsky and colleagues have demonstrated that such a product could be offered with minimal underwriting, making it available to a much wider group of people. They estimate that with a minimal underwriting test that excluded only people who would be immediately eligible for disability benefits upon purchase, 98 percent of 65-year-olds would pass the screen, compared with 77 percent under current long-term care insurance underwriting practices.[63]

Because a TLC Annuity requires a sizable, one-time purchase, the product is targeted at people with significant savings at retirement. Warshawsky estimates that the price of the annuity for a 65-year-old individual would be roughly $169,000 (with no inflation adjustment) or $250,000 (with automatic inflation adjustment). The bulk of the price is for the income annuity portion—$140,000 (without inflation protection) or $178,000 (with inflation adjustment)—with the long-term care insurance-like component costing $29,000 (without inflation protections) or $72,000 (with inflation adjustment). Based on typical pricing of life annuities and long-term care insurance, he anticipates that couples could receive significant discounts, probably significantly greater than the 10 percent usually available for long-term care insurance.

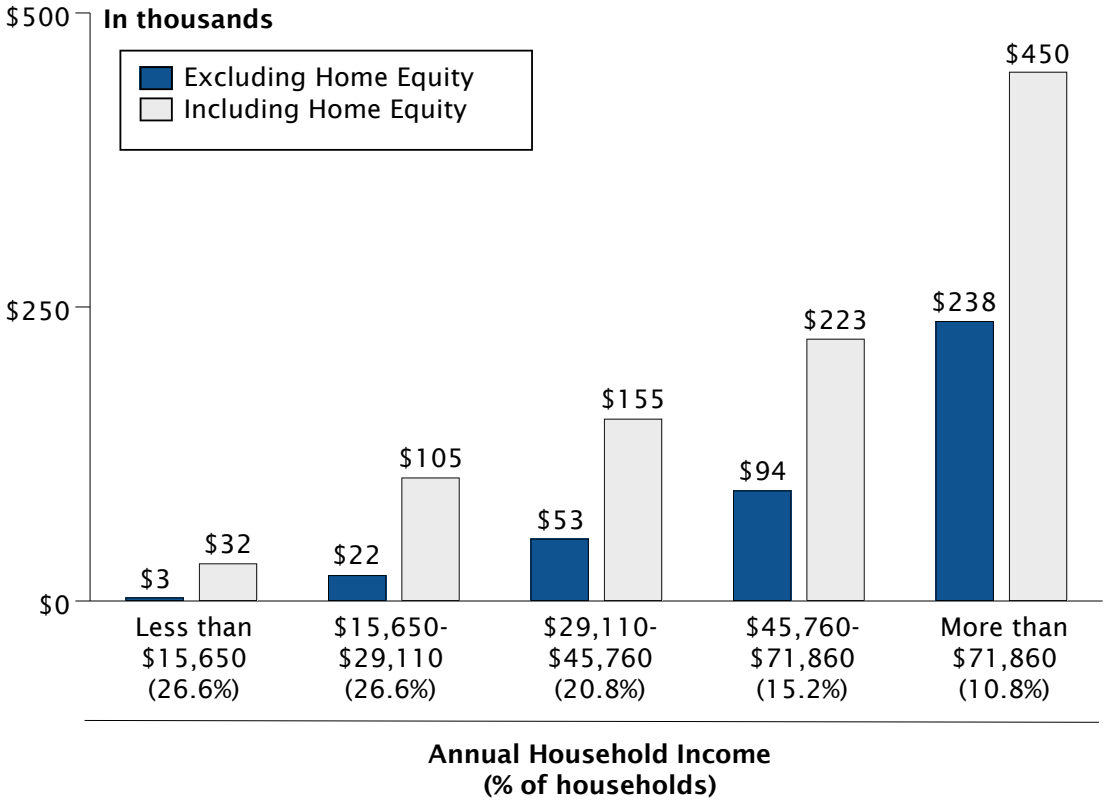
The benefit levels are similar to typical long-term care insurance policies purchased today. On top of the annuity payment of $1,000 per month, the additional benefit for severe disability—$4,000 per month or $131 per day—is similar to the daily benefit for nursing facility care in many long-term care insurance policies and is intended to be sufficient to cover, when combined with social se-

curity income, to pay for the average cost of nursing facility care. The additional benefit for moderate disability is set at half that amount, $2,000 per month, like many long-term care insurance policies which set the maximum daily benefit for home care at half the level set for nursing facility care. Still, like long-term care insurance, the benefits may fall short of the cost of needed or desired care, especially if they do not keep up with inflation.

How many people are likely to purchase such a product? Two key advantages to the product are the wider availability due to minimal underwriting and the appeal of a lifetime cash benefit for disability, which offers greater flexibility than a service benefit and does not have the possibility of "running out" like long-term care insurance policies with maximum benefit periods. The key drawback is the need to make a sizable, one-time purchase. Based on data on household net worth of people ages 65 to 69 in 2000, roughly 10 percent to 20 percent of households

Figure 12

Median Net Worth of Households with Householder Age 65-69, by Income Groups, 2000



NOTE: Income groups are household income quintiles for households of all ages. Annual income based on monthly income multiplied by twelve.
SOURCE: S. Orzechowski and P. Sepielli, *Net Worth and Asset Ownership of Households: 1998 and 2000,* Current Population Reports P70-88 (Washington DC: U.S. Census Bureau, 2003).

in this age group have enough financial assets (that is, assets excluding home equity) to make one such a purchase at retirement—and fewer could afford two policies for a couple (Figure 12).[64] Currently, about half of the seniors who can afford to purchase insurance do so. Although the limited underwriting of a TLC annuity would broaden the potential market, some people may be reluctant to make a large lump-sum purchase, especially if it required a high proportion of their savings.[65] Some buyers would substitute a TLC annuity for regular long-term care insurance. A reasonable estimate is that perhaps as many as one-fourth of those who could afford this product might become newly covered. Thus, perhaps up to an additional 5 percent of people age 65 and older would obtain coverage under this proposal, or at most an additional 1.8 million people.

Mandatory savings for long-term care insurance or services

The fifth proposal that seeks to overcome affordability or willingness-to-pay as a barrier to the purchase of long-term care insurance would both enable and require individuals to save resources during their working years to devote to long-term care during retirement. The **Forced Savings Approach**, proposed by James Knickman, would enable people to spread the costs of insurance over a lifetime "through individual savings accounts where people of one generation can save each year to ensure adequate resources to afford their own long-term care costs later in life."[66] This proposal stands out from the other proposals to promote private long-term care insurance in its reliance on a government savings requirement or payroll tax to "prefund" the purchase of insurance.

The proposal would require all workers to pay an additional tax of 1.5 percent on wages, establish a savings account in each individual's name in which funds would accumulate tax-free, and require use of the funds accumulated in that account for "approved long-term care financing purposes." The proposal would not require the purchase of a long-term care-insurance policy, but the payroll tax would apply only until an individual had accumulated "required long-term care resources" adequate to cover the expected costs of a comprehensive long-term care insurance policy (financed with a single premium) at age 65. Public subsidies would "top up" savings accounts for individuals whose work experience generated accounts that fell short of the cost of insurance. The public subsidies would be financed with resources that would otherwise have supported Medicaid's coverage of long-term care services.

Based on the estimates for the long-term care insurance-like portion of his TLC Annuity (above), the cost of a lifetime long-term care insurance policy upon retirement would be roughly $72,000 (with inflation protection), assuming it was purchased by a broad population. This provides a rough estimate of the amount of "required long term care savings" under the Forced Savings proposal—that is, the amount people would need to buy a private long-term care insurance policy at age 65 providing (remaining) lifetime protection (since the TLC Annuity payment levels were designed to be similar to the daily benefits offered by long-term care insurance policies). The estimated price of the disability portion of the TLC Annuity estimate incorporates a "savings" due to lower adverse selection than in the current market for long-term care insurance; the required amount of long-term care savings in the Forced Savings proposal could be higher than this estimate if people with a greater likelihood of needing long-term care were more likely to select the purchase of long-term care insurance, rather than holding onto the savings account, than people with a lower risk of needing long-term care in the future.

Because participation is mandatory and accounts are subsidized, this proposal would create a sizable pool of resources for everyone at age 65. The proposal would probably lead to more purchases of long-term care insurance, but the extent is highly uncertain since people can choose to retain the resources as a long-term care savings account. The factors that discourage long-term care insurance purchase would remain: it would still have to be purchased on the individual market, subject to underwriting as well as uncertainty about what product to choose and who to buy it from. Long-term care insurance purchases would depend on the rules that govern use of the accumulated savings and rules for the subsidies (in particular, whether they are only available to people who purchase long-term care insurance). They will also be influenced by how comprehensive (desirable) the product that can be purchased for the required amount is—for example, if it has substantial gaps or copayment requirements, people might not be able to afford to use it or might prefer the flexibility of retaining their funds as an long-term care savings account.

There would be a considerable federal cost to subsidizing the savings accounts for people whose own contributions did not reach the required minimum. This would be partially offset by savings to Medicaid—however, it is highly uncertain to what extent. Medicaid's safety net would still be necessary for people

whose long-term care insurance fell short of needs or had gaps in coverage they could not afford to fill, and for people who did not choose long-term care insurance and then ran out of savings.

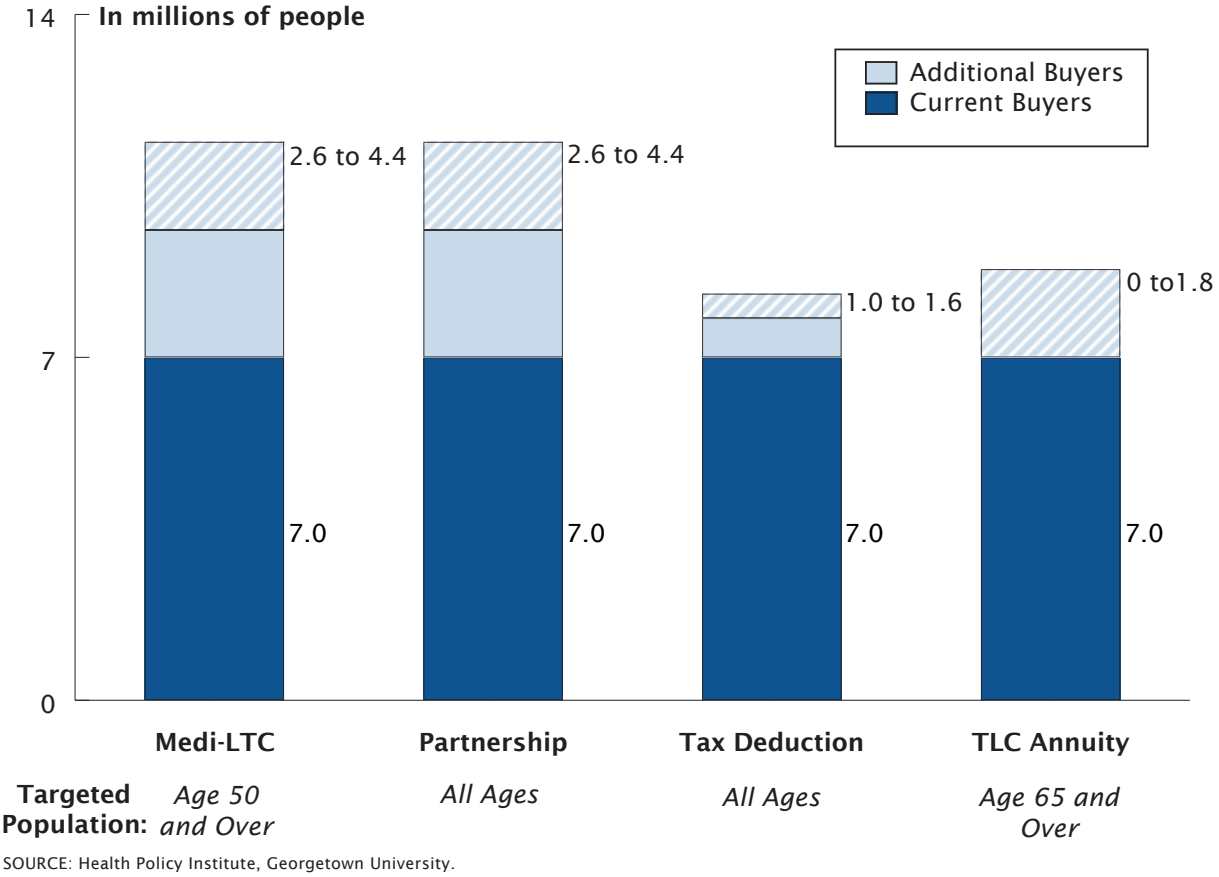
Assessing the Impact of a Strategy to Promote Private Long-Term Care Insurance

All five proposals to promote the purchase of long-term care insurance are likely to have some degree of success in enhancing the value of that insurance and its role in spreading the risk for people who may, in the future, need long-term care. However, even a substantial boost in the purchase of private long-term care insurance will leave the bulk of the current public-private partnership intact and the bulk of individuals who need long-term care at-risk, both now and in the future.

Of the five proposals, only the Forced Savings Approach has the potential to make private long-term care insurance more like private health insurance in scope, but with less risk-spreading and more administrative challenges than public insurance would impose. The impact of the other four proposals on purchase varies with their impacts on price. The TLC Annuity—a new insurance product—would reduce the need for underwriting as well as the price of its long-term care insurance component. Because this product requires a single one-time purchase of both the long-term care coverage and the annuity, its overall price is high relative to most people's retirement savings and its pool of likely purchasers modest. Among the three other proposals, which rely largely on existing insurance products, Medi-LTC would likely have the largest impact on purchase, because it combines the largest price reduction with the most visible stamp of approval. However, the highest of estimates produce an increase of only 3-5 percentage points in the proportion of people age 50 and older with long-term care insurance, or an increase of 2.6 million to 4.4 million in the number of people with long-term care insurance (Figure 13).

Proposals vary in which people, as well as the numbers of people, they are likely to reach. Although the TLC Annuity's price reduction is across the board, only people with sizable retirement savings could buy it. Tax deductibility provides the greatest price reductions to those who pay higher taxes—that is, the better-off. In addition, it benefits the better-off already purchasing private long-term care insurance. The Medi-LTC price reduction affects all potential buyers;

Figure 13
Estimated Effect of Selected Proposals on the Number of People with Long-Term Care Insurance, 2005



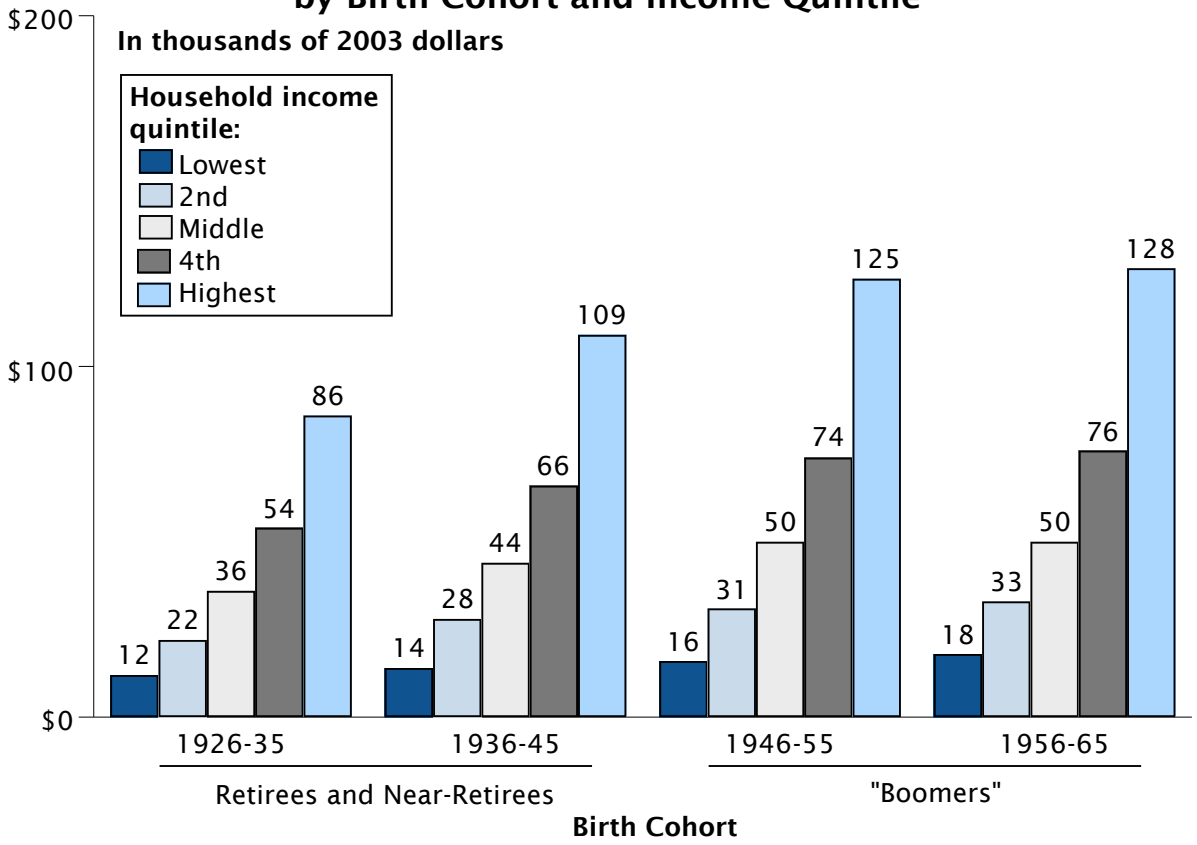
SOURCE: Health Policy Institute, Georgetown University.

and the Partnership, even with no price change, offers the greatest value to people who would be likely to seek Medicaid eligibility if they exhausted their insurance benefits. However, "affordability" of these policies remains limited and experience suggests that both policies will likely be favored by people with higher incomes, who have more disposable income available for this purchase. With the exception of the Forced Savings Approach, no proposal is likely to reach very far down the income scale.

Even in the future, affordability will be a major barrier to the widespread purchase of private long-term care insurance. Although "boomers" are expected to have higher incomes and more assets, on average, at retirement than current retirees, the distribution in financial status among individuals will continue to vary widely.[67] Projections of household income at age 67 (in 2003 dollars) indicate that although the median income among "boomers" will be $50,000—higher than the median of $36,000 to $44,000 for current retirees and near-retirees—

Figure 14

Estimated Median Household Income at Age 67, by Birth Cohort and Income Quintile



SOURCE: B. Butrica and C. Uccello, *How Will Boomers Fare at Retirement?* (Washington, DC: AARP Public Policy Institute, 2004).

the one-fifth of "boomers" with the lowest incomes will have median household income of $16,000 to $18,000 (Figure 14). Further, the "replacement rate" for income—a measure of ability to maintain pre-retirement standard of living—will be only marginally higher for early boomers (people born in 1946-1955) than for current retirees, and will be lower for late boomers (people born in 1956-1965). Median replacement rate (the ratio of income at age 67 to income at ages 50-54) is estimated to be 86 to 87 percent for current retirees and near-retirees, 88 percent for early boomers, and 80 percent for late boomers.[68]

Proposals also vary in their implications for federal costs. Whatever expansion in coverage the Partnership and the TLC Annuity generate entails little in new federal costs. Medi-LTC—which offers no subsidies and imposes only administrative costs—seems likely to yield the largest increase for the smallest expenditure (the biggest "bang-for-the buck"). By contrast, the subsidies associated with tax-deductibility mean a substantial revenue loss, without a substantial

gain—since so much "spending" will be on behalf of existing rather than new purchasers. The Forced Savings Approach would perhaps be the most expensive because the federal government would need to subsidize people who were unable to accumulate the required savings (and those subsidies would only partially be offset by lower Medicaid costs)—and, as its name makes clear, it "forces" the savings to support itself.

Finally, none of these proposals eliminates the need for Medicaid. CBO estimates that The Partnership, which aims to substitute private insurance for Medicaid, is more likely to increase Medicaid costs (albeit slightly) than to reduce them—as purchasers become eligible for Medicaid sooner. Although the Forced Savings proposal covers everyone, even it would require a safety net to "top up" savings for people with too little to purchase long-term care insurance,

In sum, making private long-term care insurance policies better for those who can afford them makes sense, but making it the cornerstone of a new public-private partnership for long-term care financing does not. Policy initiatives can help people who have resources use them wisely and plan more effectively. Even for people who can afford insurance, the adequacy of benefits is uncertain. More importantly, for people with limited resources, private long-term care insurance is unlikely to be an option. Overall, a strategy to promote private long-term care insurance leaves at future risk most older and younger people, and does nothing for the people, old and young, currently in need of long-term care.

Proposals to Expand the Long-Term Care Safety Net for People with Low-to-Modest Incomes

An alternative approach to altering the current partnership focuses on enhancing its current public side: specifically, strengthening protections for low and modest income people who need long term care. These proposals aim to address specific shortfalls in the current Medicaid safety net for people of all ages, now and in the future, who need long-term care. Because eligibility is means-tested, a social safety net is not the same as social insurance. Nevertheless, all taxpayers share in the financial risk and people in need who are least able to protect themselves are protected by the public safety net.

Why is the Medicaid Safety Net Inadequate?

Before identifying its holes, it is important to recognize Medicaid's importance as the nation's current long-term care safety net. In 2005, Medicaid paid for close to half of long-term care expenditures, and—despite the fact the vast majority of Medicaid beneficiaries are low-income adults and children not needing such services—long-term care accounted for nearly a third of Medicaid spending.[69]

Most nursing home users who qualify for Medicaid have such limited resources that they satisfy Medicaid's income and asset eligibility requirements on admission. Of people who use nursing homes after age 65, an estimated 27 percent are eligible for Medicaid throughout their stays, while 16 percent begin their nursing home stays using their own resources and then become eligible for Medicaid when their assets are exhausted.[70] Because the costs of long-term care are so high relative to most people's income and resources, the opportunity to "spend down" to eligibility—spending virtually all income and assets in order to qualify—is essential to ensure access to care.

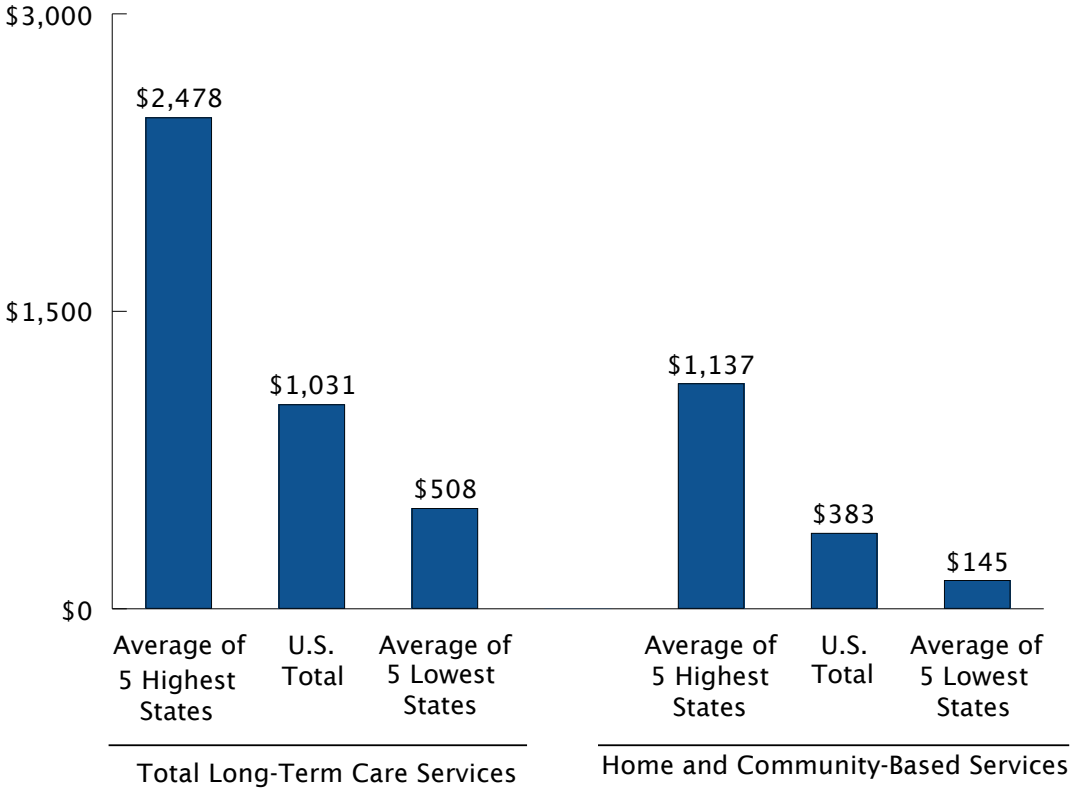
Despite Medicaid's critical role in providing long-term care, Medicaid's services fall far short of meeting the needs and preferences of people who need care. Medicaid's benefits focus overwhelmingly on nursing home care—an important service for some, but not the home care services preferred by people of all ages. In the last decade, Medicaid home care spending has increased from 14

percent to 29 percent of Medicaid's total long-term care spending.[71] But nursing homes still absorb the lion's share of Medicaid's support for long-term care. Further, most states have expanded home and community-based care through programs that "waive" some statutory Medicaid requirements—specifically, the entitlement to service for people who qualify due to a need for care. The ability of states to limit, through waiver programs, the number of people who can receive assistance—to create waiting lists—can leave large numbers in need of assistance without service. Although the Deficit Reduction Act of 2005 permits states to provide home and community-based care under Medicaid without seeking a waiver (that is, as a state "option"), it allows states to continue these restrictions on services provided.[72]

Medicaid protection also varies considerably from state to state. As a federal-state matching program, Medicaid gives states the primary role in defining the scope of both eligibility and benefits. Medicaid spending for long-term care services—home and community-based care and nursing home care—per state resident with low income (household income below 200 percent of the federal poverty level) was $2,478 in 2005 in the five highest-spending states, more than double the national average of $1,031, and nearly five times the average of $508 in the five lowest-spending states (Figure 15). The variation in home and community-based care is even greater; 2005 spending per low-income resident in the five highest-spending states ($1,137) was nearly three times the national average ($383) and nearly eight times the average in the five lowest-spending states ($145). Research shows that differences in state policies have enormous consequences for people who need long-term care.[73] A person who is financially eligible and sufficiently disabled to receive Medicaid services in one state might not be eligible for Medicaid in another—and, if found eligible, might receive a very different mix or frequency of services.

This variation—as well as ups and downs in the availability of benefits over time—undoubtedly reflects variation in states' willingness and ability to finance costly long-term care services. The consequences of fiscal pressure were apparent in the early 2000s, as the prospect of significant budget shortfalls led states to cut Medicaid spending, potentially endangering access either for low-income families needing health insurance, people needing long-term care, or both.[74] As the population ages, the pressure to make difficult tradeoffs is likely to grow

Figure 15
Medicaid Long-Term Care Spending per State Resident with Income Below 200% of Poverty Level, 2005



NOTE: The 5 highest and lowest states differ between total services and home and community-based services. For total services, the 5 highest states are CT, MA, MN, NH, and NY, and the 5 lowest are FL, ID, NV, TX, and UT. For home and community-based services, the 5 highest are AK, CT, MN, NY, and VT, and the 5 lowest are FL, GA, MS, NV and UT.
SOURCE: Health Policy Institute, Georgetown University, analysis based on data from: B. Burwell, K. Sredl, and S. Eiken, "Medicaid Long-Term Care Expenditures in FY2005" (Cambridge, MA: Medstat, July 5, 2006, memorandum); and U.S. Census Bureau, American Community Survey, 2005.

even stronger. In the future, long-term care financing may therefore be even less equitable and less adequate across the nation than it is today.

Finally, for the services that Medicaid does provide, concern abounds about quality of care—indeed, those concerns are not limited to Medicaid but extend to privately-financed nursing home care as well. Despite quality-assurance legislation enacted twenty years ago, recent oversight has identified one in five nursing homes with deficiencies causing actual harm or posing immediate danger to nursing home residents,[75] and nine out of ten as having insufficient staff to meet residents' care needs.[76] Outside nursing homes, standards either rarely exist or are poorly enforced. Families are the primary "enforcers" of quality care—a burden they are too often unequipped or unable to meet and a protection not even available to long-term care users without family support.

Policy Proposals

Two proposals developed for this project offer initiatives designed to shore up the safety net. These proposals reflect the view that there is an urgent need for better, more affordable care for people who need it now, not just in the future, and that a public role is essential to adequately protect people with low and moderate incomes. Both proposals would establish a national floor of protection for people who need care, standardizing eligibility for coverage regardless of the state in which a person lives. The proposals differ in the generosity of that floor and in the additional shortcomings in Medicaid they aim to correct: the first emphasizing increased access to home and community-based care; the second, payment rates and staffing requirements to improve nursing homes' quality of care.

Nationally-defined, consumer-controlled, home and community-based care

Marty Lynch, Carroll Estes and Mauro Hernandez propose a nationally-defined home and community-based care benefit to correct what they see as the greatest failing in public long-term care protection: the emphasis on institutional care over care at home or in the community.[77] Under their proposal—**Consumer-Controlled Chronic Home and Community Care (the Consumer-Controlled Benefit)**—state Medicaid programs would be required to provide individuals assessed as having modest as well as severe disabilities and incomes below three times the federal poverty level a "capped service budget" authorizing the purchase of services that consumers choose themselves or with professional support. States would determine budgeted amounts, varied by individuals' disability level and usable in assisted living facilities as well as at home. In setting budget amounts, states would be subject to the federal standard of "cost-effectiveness" that has applied in waiver programs for home and community-based care—that is, that the cost of new services be offset by reductions in projected spending growth for existing services and not cause an increase in total spending. The authors would also substantially improve asset protection for couples in the community, when one spouse needs long-term care.

The authors of this proposal have several objectives. First, they aim to assure a national floor of protection for those who need long-term care—a level of income and assets that would assure eligibility without impoverishment for mod-

est- as well as low-income people. The proposal would establish income eligibility at 300 percent of the federal poverty level—about 50 percent higher than the level of eligibility that currently applies in the most generous states.[78] At the same time it provides enhanced asset protections that make it more feasible for people to remain in the community. Specifically, the proposal would give community spouses of community residents needing long-term care the same spousal impoverishment protections as community spouses of nursing home residents—which several but not all states do now[79]—and would set national standards for those protections at the level currently in place in states with the highest thresholds now.

Second, they make home and community-based care more than an "alternative" to nursing home care, by requiring that all states extend eligibility for home and community-based care to individuals needing assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs). Third, they aim to "empower" consumers by prescribing "budgets" or dollar amounts of care, rather than specific benefits, thereby allowing consumers to choose the services they need (similar to the Cash and Counseling demonstration programs now operating in 15 states).[80] And to assure empowered consumers adequate support, they establish access to Medicare-funded care coordinators to guide or, if consumers wish, care managers to determine, actual spending decisions. Finally, they aim to assure affordability to the states required to provide this benefit—by enabling them to determine—that is, limit—budgets to satisfy cost-effectiveness requirements and by having the federal government bear some of the risk of higher-than-anticipated costs; and to lower costs by establishing a Medicare care-coordination benefit to coordinate recipients' acute as well as long-term care, thereby promoting efficient use of both.

Nationally-defined long-term care benefits in Medicaid

As part of a broader proposal (see Federal Catastrophic Long-Term Care Insurance Program in the next section below) Christine Bishop also establishes a national floor of protection or eligibility standard for Medicaid long-term care benefits (**Uniform Medicaid Benefits proposal**), albeit somewhat less generous than the Consumer-Controlled Benefit's.[81] The author proposes that all individuals showing a "qualified level of disability"—regardless of the state they live in—would be eligible for a standardized Medicaid long-term care benefit (including

community-based as well as nursing home care) if their income and resources fell below a national standard—set at the level now established by the most generous states.

The Uniform Medicaid Benefits proposal not only eliminates variation in eligibility requirements and benefits across states with this proposal, it also promotes payment and regulatory standards in order to assure access to quality care. Specifically this proposal has the federal government establish nursing home payment rates (adjusted to reflect geographic variation in labor costs) that vary with beneficiaries' level of disability, set maximum rates for room-and-board, and enforce federally-determined staffing standards (based on hours of care by disability level, both at home and in institutions). Although this proposal does not promote the cash or budget approach recommended in the Consumer-Controlled Benefit above, it would allow individuals who so choose to "cash-out" prescribed service benefits (at a 50 percent discount) to pay relatives or other informal care providers.

The primary objective for a uniform Medicaid initiative is to assure that the most vulnerable Americans have access to a decent standard of care. Christine Bishop's full proposal (see next section) rests on the premise that Medicaid's role as the financer of last resort for most people needing long-term care will deteriorate over time, absent policy action. By creating a national standard of eligibility and adequate financing of quality care, this proposal aims to prevent an unacceptable deterioration in already problematic current protections.

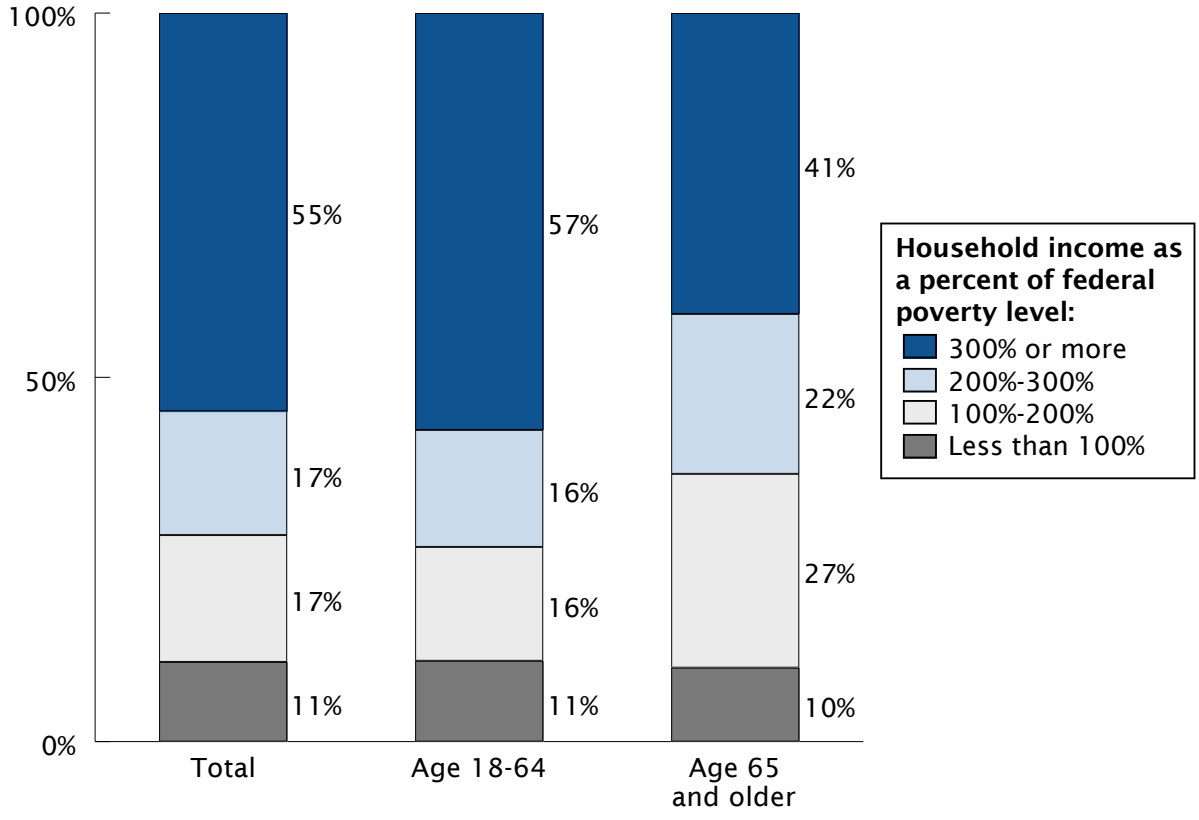
Assessing the Impact of a Strategy to Expand the Safety Net

Establishing uniform national standards, the goal of both proposals, would likely have its largest impact on access to Medicaid-funded home and community based care. The Uniform Medicaid Benefits proposal—which addresses nursing home care as well as home care—would likely expand somewhat the number people financially eligible for Medicaid nursing home care primarily by extending from two-thirds to all states the maximum income and resource protections for spouses of nursing home residents.[82] But, given current variation across states in eligibility rules and benefits, the largest impact of both proposals would likely be in the establishment of uniform national standards for determining eligibility for home and community-based benefits in Medicaid.

Eligibility for Medicaid's home and community based service depends on meeting both criteria related to level of disability (long-term care needs) and financial status (income and counted assets). Both proposals would expand eligibility in both dimensions—the Uniform Medicaid Benefits proposal by setting eligibility criteria to be similar to the most generous states now, and the Consumer-Controlled Benefit proposal by being even more expansive.

Because of the complexities of eligibility rules, now as well as under these proposals, it is difficult to estimate the number of people who would actually benefit. It is also important to note that the number of beneficiaries would vary considerably across states, with people in the least generous states benefiting the most. Figure 16 illustrates the potential impact of these proposals by showing the proportion of adults who would meet the proposed income eligibility standards and would therefore be protected against the risk of not getting needed

Figure 16
Distribution of Adults by Household Income Relative to the Federal Poverty Level, by Age Group, 2005

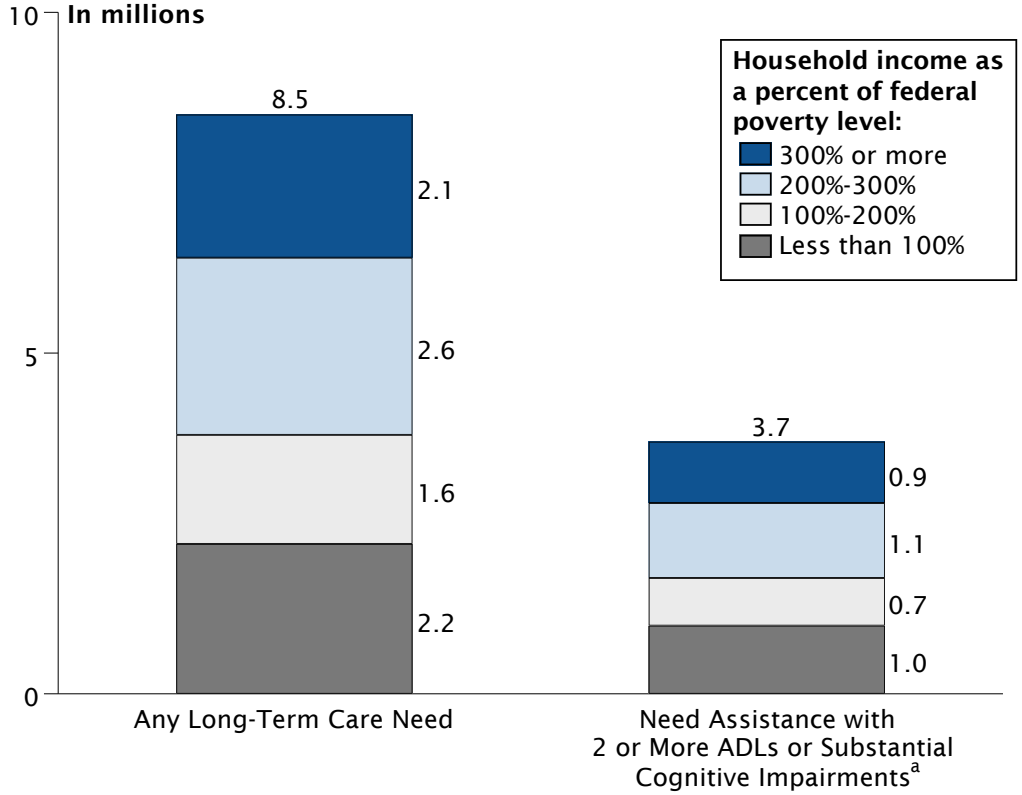


NOTE: Based on civilian, non-institutional population age 18 and older. For people under age 65, the 2005 poverty thresholds are: $10,160 for single people and $13,145 for couples; for people age 65 and over, they are $9,367 for single people and $11,815 for couples. (U.S. Census Bureau, *Poverty Thresholds 2005*, http://www.census.gov/hhes/www/poverty/threshld/thresh05.html.)
SOURCE: Health Policy Institute, Georgetown University, analysis of U.S. Census Bureau, Current Population Survey, 2006 Annual Social and Economic Supplement.

services if they have a qualifying level of disability and exhaust their assets. (Children would also be protected, but data limitations make estimates difficult.) Among adults, 28 percent have incomes below 200 percent of the poverty level, or approximately 300 percent of SSI, the income limit in the Uniform Medicaid Benefit proposal. A considerably larger proportion—46 percent—have incomes below 300 percent of the poverty level, as specified in the Consumer-Controlled Benefit. Importantly, many people, probably most, with a qualifying level of disability would not immediately be eligible for benefits—they would be eligible only after their assets were spent down to the allowed level.

Among people with current long-term care needs, how many would get benefits under each proposal? Again, it is difficult to estimate because of the complexity of rules (and limited data), but Figure 17 provides a rough approximation. Of the total 8.5 million community adults with long-term care needs, an approxi-

Figure 17
Number of Community Adults with Long-Term Care Needs, by Level of Need and Income Relative to Poverty Level, 2005



NOTE: People with long-term care need require assistance from others with activities of daily living (ADLs) or instrumental activities of daily living (IADLs) due to physical, mental, or emotional conditions. The six ADLs reported were: bathing or showering, dressing, eating, getting in and out of bed or chairs, using the toilet, or getting around inside the home. IADL need was based on a single question asking people if they required help for routine needs such as everyday household chores, doing necessary business, shopping, or getting around for other purposes.
a. People with substantial cognitive impairments are estimated here as one-fifth of people who reported needing assistance with IADLs and one or no ADLs.
SOURCE: Health Policy Institute, Georgetown University, analysis of data from the 2005 National Health Interview Survey.

mate 1.7 million (or 20 percent) would meet the functional and income tests for the Uniform Medicaid Benefits proposal (but would still need to meet the asset test). [83] Considerably more—6.4 million of the 8.5 million (75 percent)—would meet the functional and income tests for the Consumer-Controlled Benefit (but again, would need low—or to exhaust—assets before receiving Medicaid benefits). The higher number of people eligible for the Consumer-Controlled Benefit is mostly due to the broader functional eligibility requirements—among the adults who meet this proposal's functional and income tests, only about 40 percent have the disability level used to estimate functional eligibility for the Uniform Medicaid Benefit proposal (limitations in two or more ADLs or substantial cognitive impairments).

Research indicates that enhancing the availability of publicly-financed home-and-community-based care does not simply replace care paid for or provided by people who need service. It actually improves the adequacy of care. A comparison of people's experience in six states which varied considerably in the proportion of Medicare-Medicaid dual-eligibles receiving paid long-term care found a lower incidence of unmet need in the states with the broadest reach than in states with the narrowest.[84] This result is consistent with a large body of research showing that use of paid services eases the burdens of, but does not replace, family caregivers.[85]

Use of budgets that allow consumer choice rather than prescribing specific benefits, as in the Consumer-Controlled Benefit, similarly reflects evidence of consumer satisfaction with this approach.[86] According to a recent review of this approach, which the Deficit Reduction Act of 2005 now allows states to adopt without a waiver, success with this approach depends on assuring that budgets appropriately reflect the costs of services and allow individuals the choice of how much they wish to manage on their own, elements included in the proposed Consumer-Controlled Benefit.[87]

The Uniform Medicaid Benefits' proposal to establish federal payment systems and other mechanisms to enhance quality of care in nursing homes also builds on considerable evidence and experience. Nursing home payment methods that fail to reflect the needs associated with patients or fail to target dollars to patient care, encourage reluctance to serve the sickest or most time-consum-

ing patients or fail to secure appropriate care.[88] This proposal would therefore likely improve quality of care, albeit at increased costs.

These proposals to enhance the safety net raise four types of questions. First is whether reinforcing the safety net will not simply serve those in need but will "crowd out" or replace private insurance that people would otherwise buy. As discussed in the previous section, the evidence is weak that Medicaid, as it currently exists, is the primary or even a substantial barrier to the purchase of long-term care insurance. Even enhanced as proposed here, the safety net would still leave individuals at risk of losing all resources above eligibility standards. Although individuals with resources close to the proposed higher eligibility standards for home care might choose not to purchase insurance, that decision might be a socially desirable one—given the high cost of insurance and its limited benefits, relative to their incomes. Further, since even with very restrictive eligibility for Medicaid, most people are not likely to purchase insurance,[89] the policy question here is whether the risk of substitution is outweighed by the risk of suffering that results from failure to provide a floor of protection.

A second is whether responsibility for sharing in the expanded financing needed to support higher standards—for eligibility or payment—is appropriately placed on the states. Although theoretically possible, requiring states to spend may not be equitable, fiscally feasible, or politically practical, given the limits on states' willingness and ability to spend. Specific features of both safety net proposals reflect sensitivity to the problem of reliance on the state governments to expand protection, although the effectiveness of specific proposals—especially the Consumer-Controlled Benefit's budget-neutral ceiling on state spending—seems questionable.[90]

As noted above, states vary considerably in their investment in long-term care. But they also vary considerably in the demand for care relative to the ability to pay for it, both today and in the future. Especially since some of the states that have spent the least on long-term care face the largest growth in demand relative to resources, there is reason to question whether they will sustain the existing safety net, let alone be willing to improve it.[91] As the states themselves have recognized, federal financing to meet long-term care (and other needs) especially of the elderly population is a responsibility that may be more equitably as well as effectively handled at the national level.[92]

The third question raised by a focus on the safety net is whether, by itself, it's a "good enough" solution to the problems posed by long-term care financing. Establishing a floor of protection makes a significant portion of people in need of long-term care eligible for service and establishes a clear public responsibility for "insuring" low- and modest-income people a reasonable level of service when they need long-term care. The private role—whether financed through resources or the purchase of insurance—is left to people with greater capacity to purchase services—or insurance—on their own. Some argue that a lean safety net is the best strategy to assure personal responsibility in long-term care financing. Alternatively, improving the safety net is arguably the best-targeted policy intervention, achieving, dollar for dollar, the greatest impact on the people who are least able to pay for long-term supportive services—people of all ages, both now and in the future. An improved safety net, however, is not the same as insurance. Any safety net leaves middle-income people at risk of exhausting resources and not having adequate access to care.

Proposals to Establish Public Catastrophic Long-Term Care Insurance and Promote Complementary Private Insurance

A third approach to altering the public-private partnership for long-term care financing would create new public financing for "catastrophic" long-term care, either contingent upon or designed to encourage the purchase of complementary private insurance. Like the Long-Term Care Partnership discussed in Section II, these proposals aim to enable private insurers to sell policies with limited benefits by enhancing their value, but unlike the Partnership they also enable individuals to obtain comprehensive coverage without shifting to Medicaid.

Policy Proposals and Assessment

The two proposals presented here differ from each other primarily in the way they define "catastrophe"—or, in other words, the "hole" left to be filled by private insurance—and how tightly they tie availability of public catastrophic insurance to the purchase of private insurance. Both proposals design a catastrophic benefit for Medicare beneficiaries, specifically seniors.

An optional long-term care benefit in Medicare linked to purchase of private long-term care insurance

In their proposal for **Linking Medicare and Private Health Insurance for Long-Term Care (Linked Insurance)**, Anne Tumlinson and Jeanne Lambrew define catastrophe in terms of spending that exceeds a specified dollar amount that varies with income.[93] Under their proposal, Medicare beneficiaries would, at enrollment, be given the option to "trade" their limited Part B home health benefit for a new Medicare long-term care benefit, on the condition that they simultaneously purchase an approved private long-term care insurance policy (which would include the home health services covered under Part B of Medicare). The policy would be patterned on the long-term care insurance policies now offered to federal employees but specifically designed to provide "seamless coverage beneath" the new Medicare catastrophic benefit.

Seamlessness is created by "triggering" the new Medicare catastrophic benefit at the exhaustion of the lifetime maximum benefit provided by the private insur-

ance policy that people would be required to buy. The policy's lifetime maximum would vary with income. Individuals with incomes of at least $50,000 (couples with at least $75,000) would be expected to buy policies with lifetime maximum benefits of $100,000; Medicare would assume responsibility for covered long-term care expenditures above that amount. People with lower incomes would be expected to buy lesser amounts of lifetime protection (half the threshold for people with zero income, and scaled, with income, to reach thresholds and income levels specified above). Lower lifetime benefits would mean lower premiums and greater Medicare benefits for people with lower incomes. Medicaid would remain for people who do not elect the new benefit or are otherwise unable to afford long-term care.

This proposal makes comprehensive coverage automatically available to every Medicare beneficiary who buys the requisite, limited private insurance. How large that population will be, will depend on people's willingness and ability to buy private insurance to fill the "hole." This proposal, like the Medicaid-based Partnership, will not lower the cost of insurance; rather, by strengthening its benefits with the federal catastrophic benefit, it will add to the value of a limited policy.

By using Medicare to help market qualifying insurance, the proposal might yield some reductions in consumer prices, such as in the Federal Long Term Care Insurance Program. Based on premiums in the federal program, it would cost about $1,630 per year for a 65-year-old to purchase a policy with a maximum lifetime benefit of $109,500, roughly the minimum required for seniors with higher incomes. [94] This level of coverage is approximately equivalent to a policy providing $150 daily benefit for 2 years. On exhaustion of that benefit, the policyholder would qualify for public catastrophic protection.

Assuming premiums were similar to those in the federal program, and that people could afford the premium if it cost no more than 5 percent of their income, about one-third of seniors could afford to buy the linked insurance.[95] This group includes the approximately one-fifth of seniors who have sufficient income to fall into this proposal's higher income category (at least $50,000 for an individual or $75,000 for a couple) and would therefore need to purchase $100,000 in lifetime coverage, plus some people in the lower income portion specified by

the proposal, for whom the premium for the scaled coverage is less than 5 percent of income.

However, for most people in the lower income group, affordability will be problematic. Although the amount of coverage people would have to buy is scaled to their income, the reduction is not steep enough to make insurance affordable for all. For example, people with zero income would be required to buy insurance providing maximum lifetime coverage of $50,000 (half of the base trigger amount of $100,000) and therefore pay a premium of approximately $800 per year (again using premium estimates at age 65 from the Federal Long Term Care Insurance Program). As a result, most people in the lower-income portion would probably not make the "trade."[96]

Although relating the required purchase of coverage to people's incomes should, in theory, enable more people across the income scale to obtain comprehensive benefits, as designed the benefits of this "linked" proposal go primarily to the more affluent elderly Medicare beneficiaries. The impact of this proposal on the likelihood of insurance purchase would probably exceed the impact of the Medicaid-based Partnership. Its "seamless" coverage eliminates the need to draw down assets to the protected level and to meet income eligibility requirements that apply in the Partnership approach, and it relies on a new federal program rather than a program now perceived as a "last resort." But the costs of private insurance and the limited incomes of Medicare beneficiaries will undoubtedly limit its impact.

Given the scaled coverage requirement, a Medicare "seal of approval," and the value of the catastrophic coverage, the "linked plans" will likely attract more buyers than any of the private long-term care insurance proposals presented above. Of the estimated one-third who could afford the required coverage, underwriting will likely exclude about one-quarter (the proportion of applicants currently excluded by underwriting), and not all who can afford insurance will want to buy it. Thus, about 20 percent of people age 65 and older might purchase, compared with 10 percent currently. In 2005, this would mean up to 3.7 million more seniors with long-term care insurance. In addition, knowing they would get linked coverage when they became eligible for Medicare would probably lead some younger people to buy coverage, to reduce their risk of failing underwriting and to obtain lower premiums (marketing through Medicare and price re-

ductions would also increase demand among this age group). If the proportion of people ages 50-64 buying long-term care insurance increased by 3 to 5 percentage points (as expected with Medicare marketing and price reductions in the Medi-LTC proposal, above), it would yield 1.5 million to 2.5 million more people ages 50-64 with long-term care insurance. Thus, in total, perhaps as many as 5.2 million to 6.2 million more people might buy long-term care insurance.

Federal catastrophic insurance for long-term care

Rather than defining "catastrophe" in terms of expenditures, Christine Bishop's proposal for a **Federal Catastrophic Long-Term Care Insurance Program** defines "catastrophe" in terms of the duration of significant care needs—specifically, care needs lasting for more than three years.[97] On top of the improved safety net discussed in the previous section, Bishop proposes creation of a new federal catastrophic insurance program, designed to provide benefits three years after Medicare beneficiaries have satisfied eligibility requirements based on disability (specifically, needing assistance with 2 or more ADLs or because of significant cognitive impairment). Bishop's assumption is that a "guarantee of the Federal stop-loss insurance" would reduce people's uncertainty about liabilities and thereby encourage better planning for future risk—including greater willingness to purchase private insurance.

Using the Federal Long Term Care Insurance Program premiums once again, the estimated premium for a 3-year policy with $150 daily benefits would be about $204 per month (or $2,450 per year).[98] Because insurance to fill the 3-year "gap" requires about 50 percent more coverage than the required coverage level in the Linked Insurance proposal (above), its premium is about 50 percent higher. As a result—and because the required coverage is not scaled by income as it is in the linked proposal—a smaller proportion of older people who would find this insurance affordable. The predictability Bishop hopes to establish might induce more people under age 65 to purchase a policy; if they did so, then more could afford insurance when they became seniors, since their policies would have been priced at the time of first purchase. Overall, this proposal would be similar, though somewhat more modest, in its effect on the purchase of insurance than the Linked Insurance proposal.

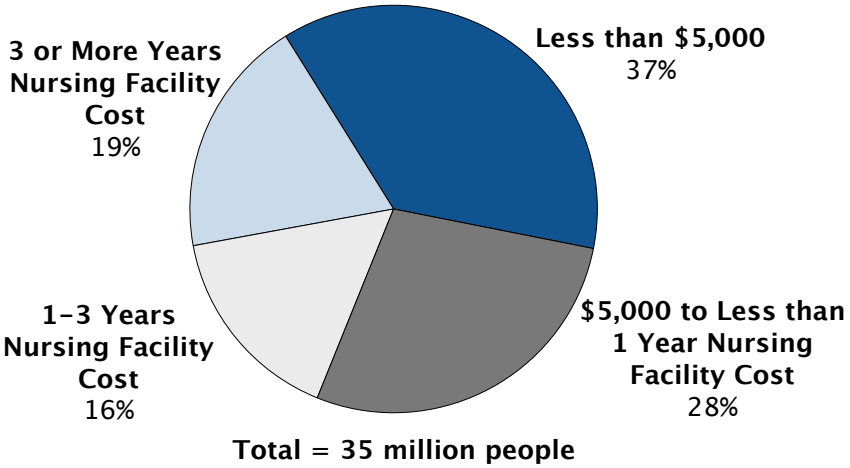
Unlike the Linked Insurance proposal, however, the Federal Catastrophic Insurance proposal makes catastrophic insurance protection available to everyone,

regardless of how they "fill the gap." Approximately one-third of people turning 65 can expect to need long-term care for three or more years during the rest of their lives,[99] though somewhat fewer may have a triggering level of disability, as defined in the Federal Catastrophic Insurance proposal, for this length of time. All of these individuals would potentially benefit from the existence of catastrophic coverage.

How much would they benefit? That would depend upon their resources and their care needs during the 3-year "waiting period." The majority of people would not buy private long-term care insurance and would therefore be on their own for the 3-year period. Most people who need nursing home care or extensive paid care at home during that period would exhaust their resources before they became eligible for the proposed coverage. As shown in Figure 18, among people age 65 and older living in the community, two-thirds do not have sufficient financial assets to pay for one year of nursing home services, and four-fifths could not pay for 3 years. Among older individuals who are at greatest risk for nursing home need, 84 percent could not afford to pay for one year of nursing home care (Figure 19). Hence, the new benefit would provide most older people no better protection against impoverishment then the Medicaid safety net.

Figure 18

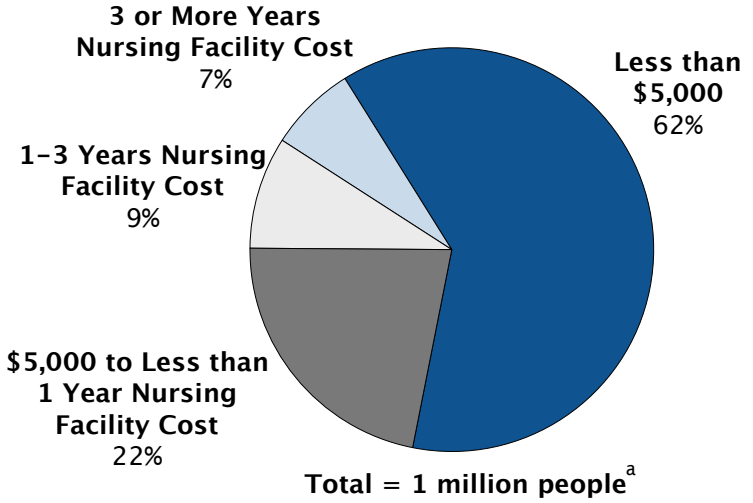
Distribution of People Age 65 and Over Living in the Community, by Level of Financial Assets, 2005



NOTE: Nursing facility costs based on average annual cost of $70,000.
SOURCE: B. Lyons, A. Schneider, and K. Desmond, *The Distribution of Assets of the Elderly Population Living in the Community* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2005).

Figure 19

Distribution of People Age 65 and Over Living in the Community at High Risk for Nursing Home Use, by Level of Financial Assets, 2005



NOTE: Nursing facility costs based on average annual cost of $70,000.
a. People age 85 or older, with no spouse, who need help with functional or cognitive limitations.
SOURCE: B. Lyons, A. Schneider, and K. Desmond, *The Distribution of Assets in the Elderly Population Living in the Community* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2005).

However, because eligibility for the catastrophic benefit is triggered by the need for care rather than the use of formal services (such as three years in a nursing home), even low and modest income people could benefit from the new program if they could manage with informal supports for three years. Further, even people whose resources are exhausted during the three-year elimination period—and become eligible for Medicaid—would be covered by the catastrophic benefit once the three years had passed (though to the extent that they received initial care in a nursing home, their ability to take advantage of home care at this point would seem compromised). Whether their nursing home care would be enhanced, relative to that financed by Medicaid, would depend on how well financed the new benefits would be, relative to the enhanced Medicaid-financing also included in this proposal.

Although this proposal potentially benefits a substantial group, the primary beneficiaries of its partnership are likely to be the relatively affluent—the minority who bought insurance or would have resources left after paying for three years of care. Could the reach of this proposal be extended if its waiting period were decreased—if, as in the Linked Insurance, a shorter waiting period were applied to people with more modest incomes? Although it is analytically tempt-

ing to pursue an income-related approach to designing catastrophic protection, the evidence on incomes and assets of older people suggest that significant extensions of private insurance purchases down the income scale are unlikely. Because so many elderly have so few resources, even a one-year waiting period will leave the majority of elderly without insurance protection and expose those who most need care to impoverishment.

That leads to a final issue raised by these proposals—the quality of the safety net. Neither of these two proposals to move toward more comprehensive coverage would eliminate the safety net—in all likelihood because the authors recognize that in both proposals millions of people needing long-term care services would not qualify for new public or private support. Bishop's proposal to assure quality in the safety net (the Uniform Medicaid Benefits proposal discussed in the previous section) is therefore particularly noteworthy—specifically her recommendations for higher payment rates to support better staffing (which, in her proposal, are financed through the savings that would accrue to Medicaid from full federal responsibility for financing catastrophic care). It has often been observed that paying more for care will not necessarily enhance its quality, but Bishop makes a persuasive argument that unless we spend more, and pay wisely, care will actually deteriorate. Any proposal for long-term care reform that continues to rely on the safety net should be held accountable to the standard of care it is likely to provide.

Proposals to Establish Universal Public Long-Term Care Insurance

The final four proposals share the premise that the private insurance market will likely remain beyond the reach of many in need of long-term care and that a universal program—similar to Social Security or Medicare—offers the most efficient equitable foundation for a new public-private partnership. These proposals by no means eliminate the role of private insurance. Rather, like Social Security and Medicare, they establish a core around which private insurance builds.

Policy Proposals

The proposals for universal public insurance presented here differ primarily in terms of the scope of their core benefits and the approach they take to the timing and financing of the benefits. Two proposals focus on a basic or explicitly limited benefit, and two are more comprehensive in scope. Two would begin immediately; two would be phased in over time. None would cover everyone or cover costs and needs completely, leaving a role for private insurance and for the public safety net—not unlike Medicare's current structure.

Using a small portion of Social Security benefits to finance a basic public long-term care benefit

The ***Trade-Off Proposal*** developed by Yung-Ping Chen rests on the premise that, despite the importance of long-term care financing, new public funds are unlikely to be available to support it.[100] He therefore proposes "tradable benefits in using existing resources"—specifically, creating a compulsory public social insurance program for covering basic long-term care by using a small portion, perhaps 5 percent, of individuals' Social Security benefits for all except people with the lowest incomes who would receive the new long-term care benefit but not have their Social Security benefit reduced.

The purpose of this social insurance is to provide "basic protection," supplemented by private insurance or private savings. Indeed, the proposal is explicitly intended to replicate the "three-legged stool"—of savings, pensions, and social insurance—that includes Social Security and constitutes the basis for retirement

income. This proposal notes that the savings and private insurance components of long-term care protection could also be financed through the trade-off principle: using a portion of private pension benefits to finance long-term care insurance or a portion of employment-based savings vehicles to enhance savings (as in the Forced Savings Approach discussed earlier). Overall, the Trade-Off Proposal aims for a "higher level of economic security," by protecting individuals against risks of catastrophic long-term care needs and expenses which they face under current arrangements.

This proposal makes crystal clear that insurance protection for long-term care needs and expenses is a critical element of retirement security. And a proposal to rely on social insurance—even for a basic benefit—allows a broad pooling of risk, provides some fiscal relief for states now supporting long-term care through Medicaid (though the need for a safety net remains), and makes benefits available to people of all ages currently in need of long-term care as well as people likely to need care in the future.

However, this proposal to "trade" benefits supported by an existing payroll tax comes at a time when the current payroll tax is regarded as inadequate to support retirement income promised under current law. The inadequacy of currently-scheduled payroll taxes to finance future Social Security benefits has been a matter of policy concern for at least the last several years. To summarize briefly, at current benefit commitments and tax rates, the 2007 trustees' report projects that annual Social Security expenditures will exceed revenues in 2017.[101] At that point, paying for benefits will require drawing down revenues in the Social Security Trust Fund (that is, redeeming the Fund's Treasury bonds). In 2041, the Trust Fund is projected to be exhausted and annual revenues sufficient to cover only 75 percent of promised benefits. Recognition of this difficulty has generated discussion of an alternative to Social Security—replacing some or all of the existing program with "private accounts"—as well as an array of proposals to adjust both tax rates and benefit commitments to bring funding into balance. Since it is tied to Social Security benefits, the proposed new benefit would run into similar fiscal insecurity in future years.

Even if the revenues to support the proposed basic long-term care benefit were available, the proposed reduction in Social Security benefits raises concern about the adequacy of retirement income. Although people with the lowest in-

comes would not have to make the trade, for other people who rely on Social Security income, the 5 percent trade might be difficult to absorb. If the limit were set at the poverty level, about 10 percent of seniors would not have to make the trade. In 2004, 30 percent of people age 65 and older relied on Social Security benefits for 90 percent or more of their income, with 19 percent relying on Social Security as their only source of income.[102]

Independent of its financing, however, the Trade-Off Proposal raises the prospect of offering a universal "basic" long-term care benefit, explicitly designed to be supplemented by private insurance (by people with higher incomes) and Medicaid, or some alternative, as a safety net. A "basic" benefit is distinguishable from catastrophic coverage in its availability regardless of other coverage or other expenditures. Rather than designing a public benefit with a gap to be filled to encourage private insurance, this approach establishes a core level of public protection around which private insurance could build. One way to structure such a benefit might be to specify a number of covered days in a nursing home or hours of home care, based on meeting some target of needed care at different disability levels or based on the amounts funding would allow (most likely varied by level of care need). An alternative might be to provide a disability cash payment, as suggested in several other proposals—set to cover the cost of some level(s) of service needs or based on available funding.

Policy decisions as to the definition of "basic" are clearly critical to the benefit's impact. These incorporate not only the size of the benefit (in services covered or cash payment) but, importantly, who would be eligible for the benefits. Eligibility could be broad—for example, it could include everyone with some long-term care needs as in the Consumer-Controlled Benefit proposal discussed above, with benefit levels varying according to need; or, it could be narrower—for example, eligibility criteria could be based on needing help with 2 or more ADLs (or having cognitive impairments that produce an equivalent level of need), like most private long-term care insurance and the Uniform Medicaid Benefits proposal. By providing some coverage to everyone who has a qualifying level of disability, the Trade-Off Proposal would significantly expand the population receiving long-term care benefits—especially in the community—and offset at least a portion of the safety net's spending. However, if designed to fall short of meeting the most substantial needs (consistent with the concept of a "basic benefit") many people with the greatest needs would—in addition to family care and pri-

vate supplementation—in all likelihood need to rely on a public safety net for receipt of adequate care.

A voluntary federal program providing a cash benefit, financed through payroll deduction

Legislation introduced by Senator Edward Kennedy in the last Congress offers an example of what might be considered a basic benefit, financed with new revenues, in ways that are similar, though not identical to social insurance. The **Community Living Assistance Services and Supports Act (CLASS Act)** proposes cash benefits of $50 or $100 per day, depending on disability level, to people whom state agencies assess as needing assistance in 2 or more ADLs or having an equivalent level of need due to cognitive impairments.[103] Benefits can be used as beneficiaries see fit, including applied to the costs of nursing home care should they find one appropriate.

The benefit would not be financed through a payroll tax; rather it would be financed through voluntary payroll deductions—set at $30 per month. Employees would be automatically enrolled in the program, unless they explicitly opted out. The practice is similar to Medicare Part B, for which premiums are deducted from Social Security benefits, unless a beneficiary explicitly requests that they not be. Individuals would become eligible for benefits once they had paid into the program for at least five years.

This proposal offers a number of interesting features. First is its reliance solely on a cash benefit, which has been advocated as providing maximum flexibility for beneficiaries to tailor services and other purchases to suit their particular needs. Second, and perhaps related, although all workers and retirees would become eligible for protection over time, the CLASS Act directly targets the working-aged disabled population—the group who has been the strongest advocates for cash benefits and the least likely to use institutions. Although the proposal does not address needs of people with disabilities who are unable to establish a five-year work history, its focus has the potential to transform consideration of financing long-term care—from a retirement issue to the issue of basic protections for people of younger as well as older ages.

As an example of the way in which "basic" benefits could be defined, the CLASS Act is also instructive. In today's terms, its dollar benefits exceed Medic-

aid's support for home care in many states—approximating the level proposed for expanding the Medicaid safety net, as discussed above. Eligibility for CLASS Act benefits requires that a person need help in 2 or more ADLs (or the equivalent), which would be similar to level of need addressed by the Uniform Medicaid Benefits proposal and not as expansive as in the Consumer-Controlled Benefit proposal. And, because the benefit could be applied to nursing home costs, as older people became eligible, it would substitute in part for Medicaid. However, even its relatively generous payment levels fall short of nursing home rates and home care needs for people with the greatest needs, posing a continuing need for a safety net and a role for private insurance.

Because the incidence of disability is low among people of working age, initial benefits should be relatively easy to finance, if participation is substantial. Automatic eligibility—or the default of opting into the program rather than out of it—has been shown to substantially increase participation in employment-based savings programs.[104] Its use for this program has significant potential, although it remains a voluntary program for which participation will be heavily influenced by the level of the required contribution.

Over time the program would also become applicable for individuals who established eligibility during their working years but were well into retirement. A third feature of the program—pre-funding of future needs—is therefore also worthy of note. Pre-funding, while fiscally responsible, means waiting a long time to reach the pressing needs of the older population. Its adequacy to support promised benefits—as retirees become eligible—is also not clear. Contribution rates and benefits may need to be adjusted in future years to keep the financing in balance. Finally, flat dollar payroll deductions are even more regressive than income-related payroll taxes as a basis for financing benefits, raising equity concerns.

Social insurance similar to Germany's

An alternative to creating a "basic" social insurance benefit for long-term care is to create a comprehensive social insurance system for long-term care, with financing modeled on Social Security. Even a comprehensive benefit would be likely to require out-of-pocket contributions and would offer specified, but not unlimited, benefits (like the number of home care visits)—leaving a role for private insurance. "Comprehensive" is distinct from "basic" coverage, not by com-

mitting to meeting everyone's needs in full, but by meeting a greater proportion of need for those who need a lot. Though broader than basic coverage, its benefits clearly leave a role for supplementation with private insurance, as well as a need for a safety net.

Germany established this kind of insurance in the mid-1990s.[105] A key feature of the German system is that people eligible for home care benefits can choose to receive a cash benefit, a service benefit, or a combination of the two. The nursing home benefit pays for long-term care services, but does not cover the room and board costs of nursing home care. Both home care and nursing home benefits vary with three levels of need: substantial, severe, and very severe. The covered services for each level of need are specified and a set amount of funding is budgeted to cover them. For people who opt for a cash benefit instead of home care services, the ratio of the cash payment to the value of the service benefit ranges from 45 percent to 53 percent, depending on the level of need.[106]

All members of Germany's social health insurance system are automatically covered by the long-term care system. About 90 percent of Germans are enrolled in the public long-term care system, which is mandatory for about 75 percent of the population (based on income below a specified limit), and about 9 percent have private long-term care insurance. The program is primarily funded by a payroll tax shared equally between employees and employers.[107]

A universal, mandatory, public long-term care insurance system for the U.S. could be designed in a similar manner to the German system. Specific benefit levels would be instead tailored to U.S. patterns of use and cost of services. Similarly, the amount of payroll tax needed to support the insurance is likely to be different in the United States. Participation in the system could be mandatory for everyone—or, like in Germany, it could be required for most of the population but permit a minority with higher incomes to opt for private insurance coverage instead.

As with the basic benefit discussed above, establishing a new comprehensive social insurance program for long-term care establishes a new revenue stream, pools risk over the broad population of taxpayers, relieves a portion of the burden states face in financing Medicaid, and assures protection to people of all ages who now need long-term care as well as people likely to need care in the future.

As noted at the outset, the German long-term care insurance benefit by no means eliminates out-of-pocket costs for its beneficiaries. Indeed, the German system explicitly ties institutional cost-sharing to room-and-board costs. In the U.S. context, some experts have argued that individuals who need long-term care can be expected to finance the housing and other costs they would have had to manage if they had remained at home.[108] This approach offers a conceptual framework for structuring reasonable out-of-pocket contributions as an alternative to "spend-down." However, implementation would raise controversial questions such as maintaining a capacity to return to the community and protection of spouses and dependents.

Germany's approach to the provision of cash alongside service benefits is also instructive. In Germany, cash can be used to "pay" family members, supplement family incomes, remodel homes, or support other expenditures that might be difficult to specify or cover in a prescribed benefit package. A cash option appears to be both appealing and costly, relative to a service benefit. Individuals who may not want service providers in the home are likely to welcome enhanced income. Further, cash is likely to "pay" for services beneficiaries already receive from family members without charge. Both factors may significantly increase program costs, relative to a more typical service benefit. But in developing its package, German policymakers deemed the outcome worth the costs;[109] and, in U.S. demonstrations (mentioned above), paying for family-provided care enhanced beneficiary satisfaction, even though it did not increase the volume of service people received. In order to compensate, the German system therefore limits cash payments to roughly half of the estimated cost of a prescribed benefit package.

Clearly, establishing full-scale social insurance for long-term care seems would be challenging at a time when the U.S. is debating whether and how to continue its existing social insurance programs for Social Security and Medicare. The payroll tax for Social Security tax is 6.2 percent of wages for employees and employers—on incomes up to $97,500 in 2007.[110] The Medicare's payroll tax is 1.45 percent of all wages for employees and employers. Most economists believe that the employer as well as the employee share of the payroll tax is usually borne by the employee, in wages foregone.[111] The overall tax burden is therefore 15.3 percent. As noted above, the regressivity of this tax is an increasing matter of concern. Whether reliance on this tax mechanism should be extended—rather

than potentially reduced or replaced—is a critical question not only for long-term care but also for promoting the solvency of Social Security and Medicare and for financing health insurance for the working-age population.

A Medicare long-term care benefit, financed with an income tax surcharge

A Proposal to Finance Long-Term Care Services through Medicare with an Income Tax Surcharge, by Leonard E. Burman and Richard W. Johnson, focuses directly on this and other financing questions—proposing a Medicare long-term care benefit (Medicare Part E) that would replace Medicaid financing with general revenues, and out-of-pocket financing with an income tax surcharge.[112] The proposal is grounded in two fundamental premises: the desirability of comprehensive social insurance (albeit with cost-sharing) and of pre-funded, progressive financing.

The proposed Medicare Benefit would cover nursing home services and up to 100 hours per month of home care for persons meeting disability criteria. Cost-sharing and deductibles would be required, up to a maximum out-of-pocket ceiling (and subsidized for low-income beneficiaries).

In order to allow revenues to accumulate to support the benefit, the new program would not apply to current Medicare beneficiaries aged 60 or older. All individuals under the age of 55 would participate, with individuals aged 55-59 given the option of participating by paying an additional lifetime surcharge. Five years after the surcharge begins, participating Medicare enrollees would be eligible for benefits, and Medicaid would cover the cost-sharing and deductibles for low-income beneficiaries. Like the CLASS Act, then, the proposed Medicare long-term care benefit calls particular attention to inclusion of the working-aged population in long-term care financing and protection (but does not protect people without a work history or not yet eligible for Medicare benefits).

The financing mechanisms used to support the proposal stand out in their attention to pre-funding and progressivity. To assure pre-funding, dedicated revenues would be placed in a trust fund, as currently in Medicare. But unlike Medicare, contribution rates would be designed and the trust fund structured to pre-fund future expenses by investing in nongovernmental securities, "so that revenues raised would be exactly offset by outlays and could thus not be used to mask budget deficits." Further, this proposal's revenue sources have been ex-

plicitly selected to replicate the existing distribution of long-term care financing across income groups, but to spread them across the full population, rather than concentrate them on users. General revenues support the new system, just as they support Medicaid. As documented in this proposal, private financing already increases with income, whether through Medicaid spend-down for the near-poor and people with modest income or through self-financing for the better-off. The proposal would therefore replace private financing with a surtax on the income tax, which would vary similarly with income.

The financing mechanism is not only promoted as a mechanism for more equitably and adequately supporting long-term care but also as a means to raise national savings—or to pre-fund future expenses. By establishing and investing the trust fund, it is designed to "improve the nation's ability to cope with the long-run fiscal imbalances that will start with the retirement of the baby boom generation." Essentially, this proposal allows future generations to finance their own benefits—paying now to support future needs. Although the Forced Savings Approach, discussed above, differs in its advocacy of savings and private insurance, rather than social insurance, it shares this distinctive feature.

The pre-funding that is this proposal's primary advantage also poses its primary disadvantage: its benefits would not be available to people who are now age 60 or older. Therefore, the problems of an inadequate safety net and inadequate coverage would remain for a long time.

Assessing the Impact of a Strategy to Create Universal Public Long-Term Care Insurance

All four of these proposals have the fundamental advantage of insurance—spreading risk of long-term care expenses across a broad population rather than concentrating its burdens on the minority with extensive, costly needs. Three of the four proposals (all but the Trade-Off Proposal) are particularly noteworthy in their inclusion of the working-aged disabled—albeit (except in the German model) only for those who qualify for Social Security or have at least a five-year work history. All four would partially replace Medicaid financing with federally-generated revenues, alleviating pressure on state revenues and assuring everyone, regardless of their place of residence, the same protection against the costs of care. And all four would make participation mandatory and thereby avoid the need

for underwriting that rules out protection, or charges more, for people deemed higher risk.

All would also retain a role for private insurance or self-financed care. The Trade-Off (basic benefit) Proposal is explicitly modeled on Social Security and disability insurance, programs whose history demonstrates the compatibility of public and private insurance benefits. Historians have documented that public financing of these benefits, in the 1930s and 1950s respectively, established a core around which private benefits could build. And they did.[113] As in Social Security and Medicare, supplementation is more likely for higher-income people than for modest- and low- income people and a safety net will remain a critical "catastrophic" protection. Medicaid would continue to be necessary (though its reach would be more limited) just as Supplemental Security Income is necessary alongside Social Security. The more comprehensive approach, represented by the German model and the Medicare Benefit proposal, design protection to cover a broader range of need and pay cost-sharing for the lowest-income beneficiaries, replacing Medicaid except for the population not covered (in the Medicare Benefit proposal, younger people with disabilities who do not qualify for Medicare). Both for cost-sharing and for an even broader scope of benefits, a role for private insurance remains.

The financing arrangements encompassed by these proposals illustrate the challenges involved in securing current as well as future benefits. Shifting benefits from retirement income to long-term care—as in the Trade Off Proposal—is creative but likely unrealistic. Higher payroll taxes—or flat dollar deductions—would add to an already regressive financing system. The third mechanism, proposed for the Medicare Benefit, has perhaps the most promise for the future—because of its pre-funding and its progressive financing. But clearly it would raise its own set of challenges, not least of which is sustaining the current system while waiting for the funds to build.

It is interesting to note that other industrialized nations, alongside Germany, are moving toward universal public protection for long-term care financing. According to an analysis of 19 Organization for Economic Cooperation and Development (OECD) countries, this movement does not imply the absence of private obligations (cost-sharing and other out-of-pocket spending), nor does it imply unlimited service or exploding costs. Rather, in general, it reflects an effort to bal-

ance public and private financing in a way that relates personal contributions to ability-to-pay and targets benefits to the population with the greatest need for care. [114] Because so many of these nations have demographics that more closely resemble the way the U.S. will look in the future than the way we look today, they can provide important lessons as we aim to design a more effective long-term care system.

Strategies to Improve the Public-Private Partnership for Long-Term Care Financing: A Comparative Assessment

Dissatisfaction with the current public-private partnership for financing long-term care is widespread. For people of all ages, the risk of needing extensive long-term care is uncertain, the costs of such care—in dollars and family caregiving—can be catastrophic, and the availability and quality of care may fall unacceptably short. Instead of the insurance protection we rely upon to spread the cost of other risks and assure access to needed service, when it comes to long-term care, costs are concentrated on the individuals and families of those who use service, backed only by a public program of "last resort." Under this partnership, one-fifth of people who currently need long-term care report not getting the care they need, and are more likely to suffer serious consequences (like falling, or being unable to feed or bathe themselves) as a result.

The purpose of this project has been to explore strategies that move us toward an alternative public-private partnership—one that spreads the cost of financing adequate long-term care beyond the minority who need it to everyone at risk. A new partnership not only matters for people of all ages who need long-term care today, but also for the growing number of people who will need care in the future. The number of people over age 85, who are most likely to need long-term care, will more than triple in the next four decades. The number of people with disabilities under the age of 65 is likely to grow similarly. Although medical and technological advances may reduce disability rates and the need for associated supports, there is little doubt that the number of people who need long-term care will increase substantially in the years to come. Without policy action to better address their needs, we will depend increasingly on a partnership that we know is grossly inadequate.

This project aims to shift our policy and political focus from bemoaning the woeful incapacity of our current long-term care financing system to analysis of what kind of system will best meet needs, both today and in the future. Given upcoming demographic change, we can consider ourselves on the "ground floor" of a long-term care system yet to be built. Building an effective system will not be easy. Any change in course will face fundamental policy and political challenges, not the least of which are considerable competition for strained public and pri-

vate resources and a deep political divide over the respective roles of collective and individual responsibility. Analysis cannot eliminate political choices, but it can inform them. That is the goal of this project and the proposals it contains.

Eight proposals from experts commissioned for this project and four proposals from other sources have given us four distinct strategies for charting a new course:

- A strategy aimed at promoting private long-term care insurance, retaining public financing as a safety net;
- A strategy to expand the safety net for people with low-to-modest incomes (with the better-off expected to rely on private financing);
- A strategy to establish public catastrophic long-term care insurance and stimulate complementary private insurance to fill in the gap (along with the safety net); and
- A strategy to establish universal public long-term care insurance, to be supplemented with private financing and a public safety net.

There is promise in each strategy and the strategies are not mutually exclusive. It is clearly possible and perhaps desirable both to improve the private insurance market and public protection. But it is the difference across strategies—who is most likely to benefit? who will be left out? how will costs be distributed across taxpayers and individuals?—that requires a choice of direction.

Two of these four strategies rest on the choice to make private long-term care insurance the core of a future public-private partnership. Both the private insurance strategy and the strategy that combines private insurance with public catastrophic insurance spread risk very differently from strategies that rest on a public core. We therefore examine their impacts first, then turn to the two strategies grounded in public protection.

A strategy that relies on private insurance aims, for the most part, to spread risk without increasing (indeed, some of its promoters hope, actually decreasing) demands on public budgets and taxpayers to support long-term care. For four proposals sharing this goal, we examined the effectiveness of their policies to increase confidence in insurance products, enhance their value, lower their price,

or alter their character (by combining them with an annuity). Considered alongside the resources of potential purchasers, these proposals might increase the number of purchasers as much as 40 to 60 percent—from the 7 million policyholders in 2005 to over 11 million policyholders among the adult population. The fifth policy proposal in this group, the Forced Savings Approach, promotes the purchase of private long-term care insurance or increased savings by requiring payroll tax contributions to dedicated accounts. Its mandatory financing has the potential to make private long-term care insurance much more like public insurance in scope, but how much more is difficult to determine.

Three of these proposals (Medi-LTC, the Long-Term Care Partnership, and the TLC Annuity) would expand coverage at little public cost (though none would reduce expenditures on the safety net). The proposal that relies on tax deductibility to reduce the effective price of insurance entails a tax loss estimated by the Joint Tax Committee at $1.7 billion for 2007—spent primarily in new tax benefits for people already purchasing private insurance, not new policyholders.

Who are the people the private insurance strategy is most likely to protect against risk? The insurance industry, as well as its regulators, recognizes that the appropriateness along with the likelihood of purchasing private insurance is a function of affordability. Given the cost of private insurance, even as affected by the policies considered here, purchasers will be skewed toward the upper end of the income scale. Who's left at risk by this strategy? For most people, the purchase of private long-term care insurance is unlikely. That means that a private insurance strategy will leave at risk most of the future elderly, along with people under age 65 (young accident victims, people with intellectual disabilities, people suffering from cerebral palsy, early-onset Alzheimer's, or other disabling conditions) for whom private long-term care insurance is not designed. For those who currently need long-term care, regardless of age, the private insurance strategy, by design, has no impact.

As a result, none of these proposals—including the Forced Savings Approach—eliminates the need for the Medicaid safety net Except in that approach, it would remain the primary source of protection now and in the future for most people with extensive long-term care needs.

A strategy to establish a public catastrophic insurance with private insurance to "fill the gap" has the potential to spread risk for a larger population than private insurance alone. Not only could such a strategy reduce price and enhance confidence for private insurance, as in the first strategy, but its linking of private with public protection would also enable a purchaser of private insurance to obtain comprehensive coverage—considerably enhancing a policy's value. This strategy, targeted to seniors (as proposed here), has the potential to double the number of seniors with private long-term care insurance and also increase the number of younger purchasers, yielding perhaps as many as 6.2 million new buyers of all ages, an increase of nearly 90 percent.

If, as in the Linked Insurance proposal in this category, public catastrophic protection were contingent on the purchase of private long-term care insurance, that is all it would do—leaving 80 percent of the future elderly population at risk of catastrophic cost or inadequate care. If instead, as in the Federal Catastrophic Insurance proposal, public catastrophic benefits were available with or without the purchase of insurance to everyone over 65 needing care after three years, many more could benefit from the new program's significant new public investment (some of which would substitute for current spending on Medicaid). But making service available is not the same as eliminating risk. Because it would leave the vast majority of older people without private insurance, this strategy's impact on risk depends upon people's ability to fill the front end "gap."

Unfortunately, for the majority of the elderly population, for whom these proposals were designed, resources limit the ability to finance extensive care needs. Only a third of older people could cover nursing home costs for even a year, and the percentage is even smaller (16 percent) for people most likely to need long-term care. Although the new benefit would assist anyone, regardless of income, who could manage the waiting period with informal care, a public catastrophic program spreads risk most effectively for the better-off among the elderly population. Whether because they can afford private long-term care insurance or still have resources even after the waiting period, it is this population that derives the greatest protection from this approach.

Who is left out? Because of their limited resources, the bulk of the older population remains largely unprotected against financial catastrophe. Alternatively stated, the current partnership remains in place and most people remain depen-

dent on Medicaid for protection after financial catastrophe strikes. These proposals are not designed to serve the younger population at risk of disability.

With catastrophic insurance, the safety net clearly remains essential. It is not surprising, then, that the author of the Federal Catastrophic Long-Term Care Insurance Program proposes that it be accompanied by improvements in the safety net, on which the majority of older people will continue to depend if they need extensive care. Because it does not protect people from the risk of having resources fall to eligibility levels, a safety net is not the same as insurance. Nevertheless, all taxpayers share in financing service costs and a public safety net protects people in need who are least able to protect themselves. We therefore consider improving the safety net as a means to enhance the current public-private partnership.

A **strategy to improve the safety net** contrasts with a private insurance strategy in several respects. First, it targets rather than excludes people who currently need long-term care, not the broader population at risk. Second and related, it addresses the needs of people of all ages, including not only the working-aged population but also those who, because of the early onset of disability, will never have the capacity to plan for the future. Third, it targets people with the least, rather than the most, economic resources.

As designed in the proposals reviewed here, the establishment of uniform national standards would likely have its largest impact on access to Medicaid-funded home and community based care, for which states policies currently exhibit the greatest variation. The two safety net proposals vary in the terms of eligibility they would uniformly apply—in terms of both income levels and qualifying level of disability. Looking at income levels of the overall adult population, the proposal to set income eligibility at twice the federal poverty level (or three times the SSI level) would make almost a third of the population eligible if they developed a qualifying long-term care need and exhausted their assets. The proposal to set eligibility at three times the federal poverty level would protect almost half the population, once they met disability and asset criteria. Among the 8.5 million community adults who currently have long-term care needs, about one-fifth would meet the disability and income eligibility requirements in the proposal with the more restrictive criteria, while about three-quarters would meet them in the proposal with the more generous income and disability criteria. Not all these

people would immediately be eligible for a Medicaid benefit, however, because, in both proposals, they would need to additionally meet asset requirements.

One of this project's safety net proposals is limited to home and community-based care, leaving current arrangements in place for people who need nursing home care. The other, would likely somewhat expand the number of people financially eligible for Medicaid nursing home care, primarily by extending to all states (from the current two-thirds) maximum income and resource protections for spouses of nursing home residents. In addition, its policies have the potential for a substantial impact on nursing home quality. Specifically, that proposal recommends higher payment rates to support better staffing (which, in this proposal, are financed through the savings that would accrue to Medicaid from full federal responsibility for financing catastrophic care). Although paying more for care will not guarantee higher quality, the author makes a persuasive case that without more federal resources, spent wisely, quality will actually deteriorate.

By creating a floor of protection, an improved safety net can dramatically and immediately addresses unmet need and strengthen long-term care services for people least able to protect themselves. Private insurance remains significant for people with higher incomes, who are already most likely to purchase it. However, a partnership that rests on a means-tested safety not is not the same as insurance. First, it leaves people with modest income at risk of impoverishment and going without needed care. No matter where the line is draw for eligibility, there will likely always be a significant gap between the ability to qualify for the safety net and the ability to finance one's needs or secure adequate private insurance protection. The risk that modest income people will exhaust their resources will therefore remain. Second, reliance on a safety net will always be subject to the criticism that its availability deters people from protecting themselves. Although evidence is weak that the current safety net, Medicaid is the primary or even a substantial barrier to the purchase of long-term care insurance, a safety net will always have some effect in deterring people whose resources are close to its eligibility standards from purchasing insurance or saving for long-term care needs. From a policy perspective, reducing unmet need may be more important than avoiding substitution of public for private spending. Nevertheless, concern that the public program will "crowd out" private funding will continue—creating dissatisfaction with enhancement of the public part of the current public-private partnership and potentially weakening support for an adequate safety net.

A **strategy for universal public insurance** has the potential to spread the risk of needing service across the broadest population. Even with considerable expansion of private long-term care insurance—even if it doubled—most people are likely to be without it when they need long-term care. And even considerable expansion of the safety net will leave middle income people at risk of exhausting resources and not having adequate access to care A universal public insurance program allows people at risk to contribute—whether through voluntary or tax contributions—and can assure benefits to people across the age and income spectrum.

The proposals reviewed here offer alternative designs for the scope, timing and financing of benefits. A universal public program can be designed to provide a basic benefit to everyone in need or benefits sufficiently comprehensive to meet substantial needs. Both approaches require a significant investment of public resources—with the comprehensive a larger investment than the basic, though both would partially replace Medicaid. And both would leave a role for private insurance or private financing (larger in the basic than in the comprehensive), in filling in cost-sharing and adding on benefits.

Basic and comprehensive policies examined in this project are perhaps most interesting for their timing and financing. A public insurance proposal could be implemented immediately, improving care for those who currently need it, regardless of age or income, and alleviating Medicaid's fiscal pressure on the states. Or, as in some of the proposals reviewed here, they can phase in coverage as resources accumulate—that is, prefund future costs. (The Forced Savings approach, discussed above as a strategy to promote individual savings and private insurance, also relies on pre-funding, through the payroll tax.) The CLASS Act starts out with the working aged population, covering every worker who opts for payroll deductions contributed to a designated fund for five years. A more progressive financing approach—similarly starting with individuals under age 60—would combine a lifetime income tax surcharge with general revenues. This Medicare Benefit proposal aims to replicate the income distribution of current long-term care financing across income groups, while spreading costs across the full population, rather than concentrating them on users. General revenues support the new system, just as they support Medicaid. Private financing, which currently increases with income, is replaced by a surtax on the income tax, which

would do the same. Essentially, this proposal allows future elderly to pool their resources to finance future benefits—paying now to support future needs.

Over time, these proposals spread risks for most people. However, now and in the future, they leave some people out. The income-tax-financed Medicare benefit would immediately cover Medicare beneficiaries under age 55, but, until they "age in," would leave out younger people with disabilities who never qualify for Social Security or Medicare, as well as people who are currently age 60 or older. The CLASS Act similarly has gaps—perhaps most importantly excluding people with disabilities unable to establish a five-year work history.. By design, a basic benefit falls short of meeting all the needs of the people who need the most services. And even a comprehensive benefit will require cost-sharing and have benefit limits. Any benefit for everyone, whether basic or comprehensive will leave "holes" to be filled by private insurance for higher income people and the always-essential safety net for low-income people.

Looking across the four strategies, is there a bottom line? Analysis cannot tell us which strategy to choose. But it can demonstrate the importance of actually making a choice, and the likely consequences of choosing a particular direction.

Without an explicit choice to act differently, the implicit choice is to continue reliance on the current public-private financing partnership. Over time, private insurance will likely grow, expanding protection among people with higher incomes. Alongside it, the public safety net may well deteriorate, under the pressure of growing demand. The outcome of this path of least resistance is clear, but it is hardly desirable.

An explicit choice means deciding whether the future long-term care financing partnership should rest on a private or public foundation. Analysis tells us that policy changes can improve and extend private insurance. But its benefits will inevitably be limited to the top tier of the income distribution; it has little potential to spread risk for the rest. Even if it is accompanied by a universal public catastrophic benefit, a strategy grounded in private insurance will enhance protection primarily for older people with higher incomes, leaving most older people and all younger people with disabilities at considerable risk—or dependent on the safety net if they need substantial care. Making private long-term care in-

surance policies better for those who can afford them makes sense, but making it the centerpiece of the nation's long-term care policy does not.

If we wish to spread risk across the broad population, public insurance must be at the core of future policy. To make public insurance fiscally manageable, its benefits can be basic rather than comprehensive and they can be phased in over time as future older people prefund their own care, rather than shifting costs to their children. Further, no matter how generous that insurance, it will not cover all service needs or eliminate the importance of personal financial contributions of family care. Planning for the future and caring for one's family members will, as they should, remain critical to an effective long-term care system. But private support will be built around a predictable core that everyone can count on.

Not only does that mean that there will always be a private part of the public-private partnership—in family care and personal resources. It also means that we cannot ignore the importance of an adequate public safety net. No matter how thoughtfully we design our policy, now and in the future, substantial numbers of younger and older people who need long-term care will simply not have the resources to fill the inevitable gaps. Now and in the future, policy must therefore place a high priority on improving that safety net—if not along lines considered here, at the very least, in terms of assuring that everyone, regardless of the state in which they live, has access to services that assure a safe and decent quality of life.

As noted at the outset of this report, in just four years, the first of the baby boomers will turn age 65. With so much change ahead, we have a lot to gain and little to lose from building the long-term care system we want, rather than simply accepting the one we have. Now is the time to confront the policy, political, and fiscal challenges of building a new long-term care system. We can and should do better.

Notes

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3. For the experts' papers describing their individual proposals, see http://ltc.georgetown.edu.
4. In 2005, public payers accounted for 45 percent of national health expenditures (which include long-term care). http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf.
5. Medicare Payment Assessment Commission, *A Data Book: Healthcare Spending and the Medicare Program*, June 2006, http://www.medpac.gov/publications/congressional_reports/Jun06DataBook_TofC.pdf; and Harriet L. Komisar, "Rolling Back Medicare Home Health," *Health Care Financing Review* 24, no. 2 (Winter 2002):33-55.
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7. Richard W. Johnson and Joshua M. Wiener, *A Profile of Frail Older Americans and Their Caregivers* (Washington, DC: Urban Institute, 2006).
8. Peter Kemper, Harriet L. Komisar, and Lisa Alecxih, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?" *Inquiry* 42, no. 4 (winter 2005/2006):335-350.
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12. U.S. Census Bureau, "Table 2a. Projected Population of the Unites States, By Age and Sex: 2000 to 2050" (2004), http://www.census.gov/ipc/www/usinterimproj/natprojtab02a.xls.
13. The Lewin Group, Inc., "Elderly Long-Term Care Projections" (May 2004, memorandum).
14. Stephen Kaye, "Trends in the PAS [personal assistance services] Workforce: Where Have We Been and Where are We Going?" presentation at PAS Center State of the Science Conference, Washington, DC, April 27, 2007, http://www.pascenter.org/sos_conference/index.php. Research on trends in disability and the need for personal assistance among the population under age 65 do not give a clear indication of what to expect in the future. During the past two decades, the rates among younger adults have fluctuated: the proportion of people age 18-64 needing personal assistance increased in the early 1990s, leveled and dipped in the mid- and late 1990s, and then increased between 2000 and 2002. See: H. Stephen Kaye, "Recent Trends in Disability Among Working-Age Adults," Disability Statistics Center Working Paper No. 0401, August 2004; and H. Stephen Kaye, Mitchell P. LaPlante,

Dawn Carlson, and Barbara L. Wenger, *Trends in Disability Rates in the United States, 1970-1994*, Disability Statistics Abstract Number 17 (San Francisco, CA: Disability Statistics Rehabilitation Research and Training Center, University of California, November 1996).

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16. Organization for Economic Cooperation and Development (OECD), *Long-Term Care for Older People*, The OECD Health Project (OECD, 2005).
17. Jeffrey S. Crowley, *Medicaid Long-Term Services Reforms in the Deficit Reduction Act*, issue paper (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2006).
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30. Susan Coronel, *Long-Term Care Insurance in 2002* (Washington, DC: America's Health Insurance Plans, June 2004).

31. Merlis, *Private Long-Term Care Insurance: Who Should Buy It and What Should They Buy?*

32. U. S. Government Accountability Office (GAO), *Long-Term Care Insurance: Federal Program Compared Favorably with Other Products, and Analysis of Claims Trend Could Inform Future Decisions*, GAO-06-401 (Washington, DC: GAO, 2006).

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35. Bonnie Burns, *Comparing Long-Term Care Insurance Policies: Bewildering Choices for Consumers*, Issue Paper #2006-13 (Washington, DC: AARP Public Policy Institute, 2006).

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41. U.S. Census Bureau, "Table 1. Annual Estimates of the Population by Sex and Five-Year Age Groups for the United States: April 1, 2000 to July 1, 2005 (NC-EST2005-01), May 10, 2006, available at: http://www.census.gov/popest/national/asrh/NC-EST2005/NC-EST2005-01.xls.

42. Qualified State Long Term Care Partnership programs.

43. Nelda McCall, ed., *Who Will Pay for Long Term Care? Insights from the Partnership Programs* (Chicago, IL: Health Administration Press, 2001).

44. Iowa was grandfathered by the 1993 law, but did not implement a Partnership program. Kevin J. Mahoney et al., "The States," in *Who Will Pay for Long Term Care? Insights from the Partnership Programs*, ed. Nelda McCall (Chicago, IL: Health Administration Press, 2001).

45. Julie Stone-Axelrad, *Medicaid's Long-Term Care Insurance Partnership Program* (Washington, DC: Congressional Research Service, 2005); and Enid Kassner, *Long-Term Care Insurance Partnership Programs*, fact sheet (Washington, DC: AARP Public Policy Institute, 2006).

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"dollar-for-dollar" coverage up to a specific amount, or to buy a greater level of coverage and get full asset protection.

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51. U.S. Congressional Budget Office, "Table 15. Estimated Budgetary Effects of Title VI, Subtitle A—Medicaid" in Cost Estimate, S. 1932: Deficit Reduction Act of 2005, January 27, 2006, http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf.

52. Health Insurance Portability and Accountability Act of 1996 (HIPAA).

53. H.R. 2682, Long-Term Care and Retirement Security Act of 2005 (introduced 5/26/06); an identical bill, S. 1244, was sponsored by Charles Grassley (introduced on 6/14/05). Two others bills in the 109th Congress also included tax deductibility for long-term care insurance: H.R. 6211, sponsored by Stephanie Herseth (introduced 9/27/05), and S.1602 sponsored by Charles Grassley, Evan Bayh, and Hillary Rodham Clinton (introduced 7/29/05).

54. In contrast, under current law, long-term care insurance premiums may be counted toward the medical expense deduction by people who itemize their deductions; this allows people with total medical expenses that exceed 7.5 percent of their adjusted gross income to deduct the amount of expenses above 7.5 percent. For people who are self-employed, the full amount of long-term care insurance premiums is deductible regardless of whether they itemize. If an employer offers long-term care insurance as a benefit the employer's contribution toward the premium is deductible for the employer and not considered taxable income for the employee.

55. Internal Revenue Service, 2007 Federal Tax Rate Schedules, http://www.irs.gov/formspubs/article/0,id=164272,00.html.

56. It is similar but not identical to a price reduction because of: the need to file a tax return to obtain the "discount," possible uncertainty about what an individual's marginal tax rate will be, and issues of timing (a person might, for example, not receive a tax refund until many months after paying a premium.

57. Internal Revenue Service, 2007 Federal Tax Rate Schedules.

58. Since fewer than 5 percent of tax filers use the current deduction for medical expense (and therefore could potentially use it for long-term care insurance if they purchased it), a large number of people would gain the opportunity for deducting long-term care insurance premiums under this proposal. Cohen and Weinrobe, *Tax Deductibility of Long-Term Care Insurance Premiums: Implications for Market Growth and Public LTC Expenditures*.

59. Tax Policy Center, "Distribution of Individual Income Tax Returns and Earnings, by Statutory Marginal Tax Bracket, 2005," (2007), http://www.taxpolicycneter.org/TaxFacts/TFDB/TFTemplate.cfm?Docid=455.

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61. Joint Committee on Taxation, "Estimated Budget Effects of the Revenue Provisions Contained in The President's Fiscal Year 2004 Budget Proposal, Fiscal Years 2003-2013," March 4, 2003, http://www.house.gov/jct/x-15-03.pdf. See also: Joint Committee on Taxation, Description of Revenue Provisions Contained in the President's Fiscal Year 2004 Budget Proposal (Washington, DC: Government Printing Office, 2003), http://www.house.gov/jct/s-7-03.pdf.

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63. Christopher M. Murtaugh, Brenda C. Spillman, and Mark J. Warshawsky, "In Sickness and in Health: An Annuity Approach to Financing Long-Term Care and Retirement Income," *The Journal of Risk and Insurance* 68, no. 2 (2001): 225-254. See also: Brenda C. Spillman, Christopher M. Murtaugh, and Mark J. Warshawsky, "Policy Implications of an Annuity Approach to Integrating Long-Term Care Financing and Retirement Income," *Journal of Aging and Health* 15, no. 1 (2003):45-73.

64. We set the range of 10 percent to 20 percent for the proportion of people who could afford a TLC at retirement based on the following. In 2000, among people age 65-69 in the top income quintile (of people of all ages)—who constituted 10.8 percent of 65-69 year olds—the median net worth excluding home equity was $237,925 (Figure 12), approximately the amount needed to buy at TLC with inflation protection ($250,000). Thus, at least 5.4 percent of 65-69 year olds had this level of financial assets. In addition, some people in the other quintiles also had assets at this level. Furthermore, some people in this age group may have had more assets at retirement that they could have used for a TLC annuity, but instead used them to purchase a different annuity or other expenditure.

65. Indeed, few retirees purchase annuities; see Barbara A. Butrica and Gordon B. T. Mermin, *Annuitized Wealth and Consumption at Older Ages* (Washington, DC: Urban Institute, December 2006).

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90. The Uniform Medicaid Benefits proposal, while not commenting on the financing of its "floor," is accompanied by a new federal catastrophic program (see next section) that would substitute federal funding for a significant portion of obligations now borne under Medicaid. The Consumer-Controlled Benefit limits state requirements to programs designed to redistribute existing long-term care spending—away from nursing homes and toward home-and-community-based care, rather than increasing total spending. Although a few states have done this effectively (as the proposal notes)—and the proposal explicitly has the federal government assume some risk if costs increase—this feature might lead states to be cautious in the scope of benefits they provide. Note that the Consumer-Controlled Benefit proposal differs from recently enacted provisions in the Deficit Reduction Act. The proposal requires states to make home care available but allows them to restrict benefits; the Deficit Reduction Act allows states to include home care in their state plans and allows them to limit the number of people served (i.e., establish waiting lists) as well as determine the benefits.

91. Mark Merlis, *Medicaid and an Aging Population*, fact sheet (Washington, DC: Georgetown University Long-Term Care Financing Project, 2004).

92. National Governors Association, Policy Position HHS-27: Medicaid Reform Principles, March 5, 2007.

93. Anne Tumlinson and Jeanne Lambrew, "Linking Medicare and Private Health Insurance for Long-Term Care," working paper no. 6, Georgetown University Long-Term Care Financing Project, Washington, DC, 2007.

94. In the Federal Long Term Care Insurance Program, the monthly premium is $136.20 for a policy with a maximum lifetime benefit of $109,500 providing $100 daily benefit for 3 years, 30-day elimination period, and 5 percent compound inflation protection. The "premium calculator" does not allow computation of a 2-year policy, but $150 daily benefit for 2 years and $100 daily benefit for 3 years have the same maximum lifetime benefit. Federal Long Term Care Insurance Program, premium calculator, https://www.ltcfeds.com/ltcWeb/do/assessing_your_needs/ratecalc (accessed June 4, 2007).

95. The estimate is based on data from Social Security Administration, "Income of the Population 55 or Older, 2004" (released May 2006), http://www.socialsecurity.gov/policy/docs/statcomps/income_pop55/2004/sect02.pdf.

96. The proposal would give states the option of buying-in Medicare enrollees with incomes below the poverty level—that is, buying them a Medicare-approved policy and thereby obtaining the Medicare long-term care benefit for them.

97. Christine Bishop, "A Federal Catastrophic Long-Term Care Insurance Plan," working paper no.5, Georgetown University Long-Term Care Financing Project, Washington, DC, 2007.

98. In the federal program, the premium for a 65-year old is $204.29 for a policy providing $150 daily benefit for 3 years, 30-day elimination period, 5% compounded inflation protection, and a maximum lifetime benefit of $164,250. Federal Long Term Care Insurance Program, premium calculator, https://www.ltcfeds.com/ltcWeb/do/assessing_your_needs/ratecalc (accessed June 4, 2007).

99. Estimated using results in Peter Kemper, Harriet L. Komisar, and Lisa Alecxih, Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect? *Inquiry* 42, no. 4 (winter 2005/2006):335-350. The results are for a somewhat broader population—based on a need for assistance with 1 or more ADLs or substantial cognitive impairment—than would be eligible for the proposed catastrophic benefit.

100. Yung-Ping Chen, "A Trade-Off Proposal for Funding Long-Term Care," working paper no. 7, Georgetown University Long-Term Care Financing Project, Washington, DC, 2007.

101. 2007 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, http://www.ssa.gov/OACT/TR/TR07/.

102. Estimated based on data from Lynn Fisher, Nicole Pascua, and Anne DeCesaro, *Income of the Aged Chartbook, 2004*, SSA Publication No. 13-11727 (Washington, DC: Social Security Administration, Office of Policy, 2006).

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104. The Retirement Security Project, *Automatic IRAs: Extending Savings Opportunities to 75 Million More Workers* (Washington, DC: The Retirement Security Project, February 2007), http://www.retirementsecurityproject.org/pubs/File/RSP_AutoIRAvpapersummaryfinal.pdf.

105. Alison Evans Cuellar and Joshua M. Wiener, "Can Social Insurance for Long-Term Care Work? The Experience of Germany," *Health Affairs* 19, no. 3 (2000): 8-25. Melanie Arntz, Ralf Sacchetto, Alexander Spermann, Susanne Steffes, and Sara Widmaier, "The German Social Long-Term Care Insurance—Structure and Reform Options," Center for European Economic Research (ZEW) Discussion Paper No. 06-074, November 2006, available at SSRN: http://ssrn.com/abstract=944780. Charlene A. Harrington, Max Geraedts, and Geoffrey V. Heller, "Germany's Long Term Care Insurance Model: Lessons for the United States," *Journal of Public Health Policy* 23, no. 1 (2002): 44-65.

106. If a person does not claim all of the monthly services to which they are entitled, they may receive a partial cash payment (equivalent to the unused percentage of the service benefit).

107. An employee's contribution also provides coverage for any family members who have no earnings or earnings below specified amount. Contributions for unemployed people are paid by the Federal Employment Agency. Pensioners pay the full contribution out-of-pocket. Since 2005, people without children pay more (1.1 percent instead of .85 for employees share). Arntz et al., "The German Social Long-Term Care Insurance—Structure and Reform Options."

108. Robyn I. Stone, *Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century* (New York, NY: Milbank Memorial Fund, 2000).

109. Cuellar and Wiener, "Can Social Insurance for Long-Term Care Work? The Experience of Germany."

110. http://www.taxpolicycenter.org/TaxFacts/TFDB/TFTemplate.cfm?Docid=45&Topic2id=50.

111. Len Burman and Greg Leiserson, *Two-Thirds of Tax Units Pay More Payroll Tax than Income Tax*, Tax Facts (Washington, DC: Tax Policy Center, Urban Institute and Brookings Institute, April 9, 2007), http://www.taxpolicycenter.org/UploadedPDF/1001065_Tax_Units.pdf.

112. Leonard E. Burman and Richard W. Johnson, "A Proposal to Finance Long-Term Care Services Through Medicare With an Income Tax Surcharge," working paper no. 8, Georgetown University Long-Term Care Financing Project, 2007.

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114. Organization for Economic Cooperation and Development (OECD), *Long-Term Care for Older People*, The OECD Health Project (OECD, 2005).

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About the Project

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