

Long-Term Care Financing: Policy Options for the Future

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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

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will face fundamental policy and political challenges, not the least of which are considerable competition for strained public and private 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 resourc-

es 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,¹ 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 Life Care Annuity²) 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.

1. "Forced Savings as an Option to Improve Financing of Long-Term Care" by James Knickman.

2. The proposals are: "Medi-LTC: A New Medicare Long-Term Care Proposal" by John Cutler, Lisa M. Shulman, and Mark Litow; the Long-Term Care Partnership begun in four states in the 1990s and made an option for all states by the Deficit Reduction Act of 2005; and "The Life Care Annuity: A Proposal for an Insurance Product Innovation to Simultaneously Improve Financing and Benefit Provision for Long-Term Care and to Insure the Risk of Outliving Assets in Retirement" by Mark J. Warshawsky.

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 proposal³ 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 Long-Term Care Insurance Program proposal,⁴ 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

3. “Linking Medicare and Private Health Insurance for Long-Term Care” by Anne Tumlinson and Jeanne Lambrew.

4. “A Federal Catastrophic Long-Term Care Insurance Program” by Christine E. Bishop.

most people remain dependent 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,⁵ 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 im-

5. The proposals are: “Long-Term Care Policy Option Proposal: Consumer Controlled Chronic, Home, and Community Care for the Elderly and Disabled” by Marty Lynch, Carroll Estes, and Mauro Hernandez; and “A Federal Catastrophic Long-Term Care Insurance Program” by Christine E. Bishop.

mediately 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 address 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 net 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 drawn 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.⁶ 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, 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 Benefit⁷ 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. Essen-

6. The proposals are: "A Trade-Off Proposal for Funding Long-Term Care" by Yung-Ping Chen; the Community Living Assistance Services and Supports Act (CLASS Act) introduced by Senator Edward Kennedy in November 2005; a universal, mandatory public insurance system for long-term care similar to Germany's; and "A Proposal to Finance Long-Term Care Services Through Medicare With an Income Tax Surcharge" by Leonard E. Burman and Richard W. Johnson.

tially, 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 insurance 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.

7. “A Proposal to Finance Long-Term Care Services Through Medicare With an Income Tax Surcharge” by Leonard E. Burman and Richard W. Johnson.

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.



Georgetown University Long-Term Care Financing Project
Working Papers

- No. 1 **Medi-LTC: A New Medicare Long-Term Care Proposal**
John Cutler, Lisa M. Shulman, and Mark Litow
- No. 2 **The Life Care Annuity: A Proposal for an Insurance Product Innovation to Simultaneously Improve Financing and Benefit Provision for Long-Term Care and to Insure the Risk of Outliving Assets in Retirement**
Mark J. Warshawsky
- No. 3 **Forced Savings as an Option to Improve Financing of Long-Term Care**
James Knickman
- No. 4 **Long-Term Care Policy Option Proposal: Consumer Controlled Chronic, Home, and Community Care for the Elderly and Disabled**
Marty Lynch, Carroll Estes, and Mauro Hernandez
- No. 5 **A Federal Catastrophic Long-Term Care Insurance Program**
Christine E. Bishop
- No. 6 **Linking Medicare and Private Health Insurance for Long-Term Care**
Anne Tumlinson and Jeanne Lambrew
- No. 7 **A Trade-Off Proposal for Funding Long-Term Care**
Yung-Ping Chen
- No. 8 **A Proposal to Finance Long-Term Care Services Through Medicare With an Income Tax Surcharge**
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About the Project

The *Georgetown University Long-Term Care Financing Project* pursues analysis designed to stimulate public policy discussion about current long-term care financing and ways to improve it. The project is funded by a grant from The Robert Wood Johnson Foundation. More information about the project and other publications can be found at <http://ltc.georgetown.edu>.