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Chapter Author: Alan M. Garber

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5 To Comfort Always: The Prospects of Expanded Social Responsibility for Long-Term Care

Alan M. Garber

> But whoever has the greatest number of the good things I have mentioned, and keeps them to the end, and dies a peaceful death, that man, my lord Croesus, deserves in my opinion to be called happy.
>
> Look to the end, no matter what it is you are considering.
>
> Solon's response to Croesus, who asked, Who is the happiest man? Herodotus, *Histories,* book 1

Longevity is a cornerstone of modern conceptions of the good life. Although the desire for a long life is not unique to modern times, the expectation that most people will live beyond sixty-five years of age is a phenomenon of twentieth-century industrialized nations. Mortality rates at the turn of the century, when life expectancy was about fifty years, implied that only about four of ten newly born American children could expect to survive to age sixty-five. By 1989 nearly eight of ten could expect to reach sixty-five (National Center for Health Statistics 1992). Yet if the happiness of a life is judged by its end, these impressive gains in longevity are a mixed blessing. Even if they have financial security, none who live to advanced ages can escape the risk that they will suffer years of discomfort, disability, and dependence before they die. Those whose final years are marked by infirmity do not keep to the end the "good things" that Solon identified as part the happy life—among them sound body, health, and "freedom from trouble." They suffer from the disabling effects of diseases and injuries that medical treatment can neither cure nor fully relieve.

Thus of the three aims of medical care in the old maxim, "To cure seldom, to relieve often, to comfort always," only comfort is achievable. Long-term care is the chief means of providing such comfort. Individual, family, and soci-

Alan M. Garber is Health Services Research and Development Senior Research Associate at the Palo Alto Department of Veterans Affairs Medical Center. He is also associate professor of medicine at the Stanford University School of Medicine and a research associate and director of the Health Care Program of the National Bureau of Economic Research.

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ety have long shared responsibility for long-term care, in a shifting and uneasy balance. Different views about both the feasibility and appropriateness of an expanded public role in providing and financing long-term care are at the center of American debates about long-term care policy, which is only one contentious aspect of broader deliberations about reforming health care. Long-term care carries special significance, though, because the people who use long-term care are often helpless, always dependent upon others, and unlikely to return to full health and function. For many of them, long-term care is a necessity, and for others, it ameliorates the effects of mental and physical decline.

Notwithstanding differences in the goals of care, in important respects long-term care is similar to other health services. Like hospital and physicians' services, it is designed to ease the burden of illness. The federal government insures a substantial fraction of the care, which is also expensive—the average cost of a year in a nursing home is about $20,000 in the United States, and is higher if Medicaid-financed stays are excluded. But long-term care fundamentally differs from other health services. The population that uses it is more sharply circumscribed, limited mainly to the severely disabled elderly. And although survival is sometimes difficult or impossible without it, long-term care is never lifesaving in the same sense that, say, emergency surgery following an automobile accident can be. Nonmarket services play an important role in long-term care, which is a close substitute for nonhealth services, such as housing and food. Much of the care is basic and humanitarian—such as shelter, food preparation, and assistance in walking and personal hygiene.

It is the mode of financing, however, that most clearly sets long-term care apart. Private long-term care insurance developed slowly and never became popular. The near absence of private insurance has been blamed as the fundamental shortcoming of long-term care financing, while the wide dissemination of insurance is regularly cast as the culprit responsible for uncontrolled growth in expenditures for physicians' and hospital services. The wider adoption of private long-term care insurance has the potential to bring to long-term care the very problems that health care reform is designed to solve, and it is unlikely to address all the real and apparent deficiencies of long-term care financing. The recognition that the failure of private insurance is not accidental must temper any hope that private insurance can be the sole means of reducing risk and improving access to long-term care. Nevertheless, I will argue that it is a promising approach to better risk protection for those persons in situations in which it is most appropriate.

The central conceptual questions confronting policies toward long-term care financing are common to all social insurance: how should any (government) policy balance insurance, savings, and redistributional features, and how should it relate to private activities? I briefly discuss below the political consequences of redistributive policies, but most of my comments address the mix between savings and insurance, and public and private financing. I will argue that the most successful policies to improve access to long-term care empha-

size increased private savings. Savings alone will not be enough; because a small fraction of the elderly account for most long-term care expenditures, the savings required to self-finance such care might result in undesirably large bequests for many of the elderly. Furthermore, the poor and near-poor elderly lack the assets and income needed to save for long-term care or to purchase insurance. Finally, increased savings, or indeed any reform of financing long-term care, is not a panacea, and some of the most vexing problems of long-term care have little to do with financing. The poor quality of some nursing homes, for example, has less to do with financing than with the inability to monitor the quality of care and the weak incentives some nursing homes have to improve quality. Policies designed to encourage individual savings will not solve every problem yet, I will argue, should be central to reform efforts. Expanded insurance, for example, is unlikely to be successful as the principal mode of financing long-term care; the costs would be insupportable if insurance were not coupled with savings features, and an insurance approach that controlled costs might deter the development of promising alternatives to traditional forms of long-term care. Financing universal long-term care insurance from public dollars hardly seems feasible today, and circumstances will not be more favorable in the coming years.

5.1 The Basic Facts of Long-Term Care

5.1.1 What It Is

The constellation of services that compose long-term care range from limited home-based assistance to comprehensive care in an institution. The services are frequently targeted at the specific physical and/or mental limitations of the patient but, in contrast to most medical care, are rarely aimed at a specific disease. They aid in coping with the irreversible consequences of one or (more often) multiple diseases, rather than curing them. Although not all long-term care is of indefinite or even prolonged duration—nursing home admissions can be brief, particularly when they aid in convalescence from an acute illness or operation—even patients who use long-term care for brief periods usually need it because chronic diseases and disabilities delay or impede their recovery from an acute condition.

Long-term care is traditionally delivered either in institutional (inpatient) or community settings. Institutional services are most prominent and account for the bulk of expenditures. This category includes skilled nursing (certified by Medicare to provide an appropriate range of medical, nursing, and rehabilitative services), intermediate care (offering a narrower range of professional services), and custodial facilities (basic housing and related services for persons whose disability is severe and irreversible), along with a variety of other institutional arrangements, such as hospices (for terminal care) and board and care homes, which provide meals but no professional services. In 1985 about 1.3 million, or 4.6% of all Americans sixty-five years of age and older, could be

found in a nursing home at any time (National Center for Health Statistics 1994, 193).

Community-based long-term care encompasses a diverse set of services, including home health care from a visiting nurse or physical therapist, respite care, home meal preparation or delivery, day care programs, and a host of other services. Many such formally designated home health services are covered by insurance programs. The number of elderly Americans receiving some form of paid home health services approached one million in 1992 (Strahan 1993).

Modern developments have blurred the distinctions among these categories of long-term care, and even distinctions between long-term care and acute medical services. For example, social/health maintenance organizations (SHMOs) add nursing home and related long-term care services to standard medical care benefits offered by prepaid capitated health plans. Besides applying capitation to long-term care, this approach allows the health maintenance organization (HMO) to internalize long-term care, reducing the distortion in trade-offs between covered and noncovered services. Congregate living arrangements, such as life care communities or continuing care retirement communities, combine housing and other services with features of long-term care insurance. These facilities charge high prices for entry, along with monthly fees that are typically higher than condominium fees but may also pay for board and long-term care services if the member requires them. The services, and housing, are matched to the needs of the member, so in some of the communities the person may move from a fully independent existence in an apartment, then to a facility that provides limited support services, and finally to a nursing home, all without leaving the congregate setting. Although other forms of senior housing rarely offer the full array of services of a life care community, most facilities provide some assistance, such as meal preparation, whether or not they explicitly incorporate insurance features. Such arrangements can make assisted living more attractive. Unlike typical nursing home admissions, which remove the disabled elderly from friends and often spouses, the continuum of care available in some life care communities makes it possible to remain in a nearby building despite deterioration in one's health. Furthermore, they can better integrate home health and institutional services.

Perhaps the most important form of long-term care, "informal" (nonmarket) home services, is measured poorly and does not appear in national income accounts. The National Long-Term Care Survey, which was administered to a random sample of Americans sixty-five years of age and older, revealed that 19% of Medicare recipients had functional impairments expected to last at least three months (Macken 1986), of whom 90% received some form of assistance from family members (Rivlin and Wiener 1988). Spouses and children (usually adult daughters) of the disabled elderly may spend many hours each day preparing meals, helping them to eat, bathe, and walk, and even helping them to the toilet. Family members who provide such care often reduce their own hours of paid work or leave the labor force. A study of informal home health services for terminally ill cancer patients reported that family members

provided ten hours of care daily, and that one-third of the caregivers who worked at the outset of the care episode dropped out of the labor force. Even if the patient received hospice care as an outpatient, though, the terminal illness caused about 22% of the caregivers to leave their jobs. In this study, caregivers who continued working lost $605 per episode of illness, and those who left the labor force lost $2,582 (Muurinen 1986). Because few hospice patients live long, the income forgone for the care of the disabled elderly who are not in the final stages of a terminal illness is likely to be far greater. When such support is no longer available or sufficient, whether through the death of a spouse, the exhaustion of a daughter, worsening disability, or supervening illness, nursing home admission often results.

5.1.2 Utilization

Discussions of long-term care policy often focus on the more than one million elderly Americans in nursing homes and, to a lesser extent, the million or so who use paid home health services. But about four million elderly Americans receive informal assistance for chronic impairments. Although they may not generate expenditures for long-term care, they are at risk of doing so. Limited evidence suggests that the (age-adjusted) functional status of the elderly is improving along with life expectancy. As the baby boom grows older, however, there will be a dramatic increase in the number of people who have reached the ages at which disability is common. The cohort effect is so large that it is likely to overwhelm any improvement in age-adjusted disability rates, stimulating an increase in the use of both formal and informal long-term care.

Most research on long-term care utilization has focused on its most expensive component, nursing homes. Three questions relevant to long-term care insurance predominate in the literature: who is likely to enter a nursing home, what is the distribution of utilization, and to what extent do other (lower-cost) forms of long-term care substitute for nursing homes? A smaller literature addresses the issue that may be most critical to long-term care insurance: how price sensitive is demand?

Predictors of Utilization

Important predictors of institutionalization are advanced age, limitations in the ability to carry out one or more basic "activities of daily living" (ADLs), cognitive impairment, and the absence of a spouse or children who provide care (Wingard, Jones, and Kaplan 1987). As it happens, similar characteristics also predict mortality. Although the frail elderly may live with functional impairments for many years before they die, disability is associated with increased mortality. And as death nears, utilization of long-term care increases. As is well known, utilization of hospital and physicians' services increases in the last year of life. The same appears to be true of nursing home utilization, as Anne Scitovsky (1988) reported in a study of Palo Alto residents. In analyses of the National Long-Term Care Survey and the National Nursing Home Survey, Thomas MaCurdy and I (1992) found a similar pattern: in the final year of

life, the very old use nursing homes much more heavily than do survivors of the same age and sex. Entry to a nursing home, then, is commonly an event that occurs in the last stages of life. These observations account for one of the difficulties in identifying people likely to enter nursing homes: those who appear to be at very high risk of institutionalization often die before they are admitted or soon thereafter. One of the most important randomized trials of interventions designed to prevent institutionalization focused on a group of elderly individuals whose disabilities were thought to place them at extremely high risk of entering a nursing home; instead, very high death rates caused nursing home utilization in the control group to fall short of expectations (Kemper 1988).

Distribution of Utilization

The skew in the distribution of nursing home utilization, combined with its substantial cost, would seem to make long-term care insurance highly attractive. A sizable minority of Americans who reach age sixty-five can expect to enter a nursing home sometime before they die (Kemper and Murtaugh 1991; Dick, Garber, and MaCurdy 1994). Most admissions are brief, but a small fraction of the people who enter account for most nursing home care. Keeler, Kane, and Solomon (1981) were among the first to explore the mix of long- and short-stayers in nursing homes; they found that long-stayers were far more likely to have diagnoses of mental disorders and senility, while short-stayers tended to have diagnoses of fractures and cancers. According to our analyses of more recent national cohorts of the elderly, although fewer than 1% of Americans are in nursing homes at age sixty-five, 35% can expect to enter a nursing home (Dick, Garber, and MaCurdy 1994). Our results, presented in table 5.1, show that most admissions are brief. A smaller minority, however, will have very long stays. The 90th percentile of nursing home utilization is seventeen months for men and twenty-nine months for women.

Substitution and Price Sensitivity

Of fundamental importance to long-term care policy are two questions about utilization: how well do noninstitutional services prevent or substitute for institutionalization, and how price sensitive is the demand for nursing home care? If home services are close substitutes for nursing home care, they might enable people to remain in the community and delay, if not prevent, institutionalization. Institutionalization is viewed as both an expensive and unattractive living arrangement.[1] The right set of services, delivered at the right time, might fore-

1. Most estimates of the cost of nursing home care include expenditures for nursing home care but not savings that result from entry, which primarily accrue from reduced housing expenses. This approach may be valid for short stays but not for prolonged institutionalization. The typical nursing home patient was living alone before admission; if she is permanently institutionalized, by definition she no longer uses housing outside the nursing home. Savings on housing expenses partially offset nursing home costs. Furthermore, many patients require around-the-clock observation or care, which likely costs far less when delivered in an institution than in the community.

Table 5.1 Simulations of Nursing Home Utilization Rates

	Mean	5%	10%	25%	Median	75%	90%	95%
Number of nursing home admissions	1	0	0	0	0	1	2	2
Male	1	0	0	0	0	1	1	2
Female	1	0	0	0	0	1	2	2
Total nursing home utlization (months)	7	0	0	0	0	2	23	50
Male	6	0	0	0	0	2	17	37
Female	9	0	0	0	0	3	29	61
Nursing home utilization for those with at least 1 admission (months)	21	1	1	2	6	27	66	88
Male	16	1	1	1	4	20	50	71
Female	25	1	1	2	9	34	75	101
Spell length of 1st nursing home admissions (months)	14	1	1	1	3	14	48	69
Male	11	1	1	1	2	9	34	54
Female	17	1	1	1	3	18	57	83
Age at death (months after 65th birthday)	208	43	67	129	204	284	350	380
Male	186	38	61	115	183	252	317	352
Female	224	48	75	142	225	309	366	398

Source: Dick, Garber, and MaCurdy forthcoming.

stall nursing home admission. If effective, lower-cost substitutes for nursing home care were available, one might think that the elderly and their families would take advantage of them, especially because many of them would initially bear the full cost of nursing home admission. Of course, the cognitive impairment that is common among the disabled elderly might make it particularly difficult to locate appropriate home health services. But a review of the best-designed trials of home health care suggests an alternative explanation: home care does not serve as a close substitute for nursing home care. The review concluded that home care services have no impact on mortality, functional status, or nursing home utilization (Hedrick and Inui 1986). People who are admitted to nursing homes may simply need so much assistance that it is prohibitively expensive or infeasible to provide the services at home. The Channeling Demonstration was perhaps the most prominent trial of the impact of intensified community-based care on rates of institutionalization. It did not test home care directly, but rather the assignment of a case manager to the patients in the intervention group. The case manager was given the responsibility for ensuring that patients would receive the full range of home services that might benefit them, with a view toward improving function and avoiding institutionalization. Case management increased the utilization of home health services, patient satisfaction, and overall costs, but did not prevent institutionalization, death, or the deterioration of other aspects of health (Kemper 1988; Thornton, Dunstan, and Kemper 1988; Wooldridge and Schore 1988).

Studies like these, which indicate that home health services are poor substi-

tutes for nursing homes, suggest that the price elasticity of demand for nursing home care is small. Some policy positions assume that this is the case. Nursing home stays are feared and widely seen as unpleasant, a last resort for an individual whose condition is so hopeless and needs for care so great that neither family nor formal home care services can provide them. The major goal of insurance coverage for long-term care, according to this view, is redistribution of the costs of care, not increased utilization.

On the other hand, because it shares so many of their characteristics, nursing home care would seem to substitute for housing and personal health services. Furthermore, the price of nursing home care, especially relative to the opportunity costs of informal care, would seem at the very least to affect the timing of admission and sometimes its overall duration. The limited literature on the demand for nursing home care suggests that demand is moderately price-elastic. Chiswick (1976), in an analysis of regional data, estimated the surprisingly large price elasticity of -2.3. Thomas MaCurdy and I found that nursing home discharge rates were highly sensitive to changes in the daily subsidy implicit in Medicare rules (as Medicare payments phased out over the course of an admission), supporting the contention that demand is likely to be highly price sensitive (Garber and MaCurdy 1992). Price sensitivity may not characterize all segments of the elderly population; for example, in our work we dealt only with Medicare-covered nursing home admissions, which are deemed at the outset to be short-term rehabilitative stays. Individuals who are admitted to nursing homes for substantially longer, with irreversible limitations in their ability to carry out routine tasks, may not be able to alter their demand substantially in response to changes in price.

5.1.3 Financing

Comparison of the sources of financing for long-term care and for all other personal health expenditures, as displayed in table 5.2, reveals the unique pattern of long-term care: even though government payers account for a substantially greater proportion of expenditures for long-term care, the lack of private long-term care insurance means that the fraction of nursing home expenditures borne directly by the elderly as out-of-pocket expenditures is 43%. In contrast, out-of-pocket payments account for only about 20% of other health expenditures.

Some long-term care is mixed in other categories of health expenses. Foremost among these categories are home health services, which totaled about $9.8 billion in 1991. About 87% of home health care was reimbursed by third-party payers, primarily the federal government.

To understand how there could simultaneously be concerns that public insurance for long-term care is inadequate and that government expenditures for the same purpose are excessive, it is necessary to understand the basic rules under which the two major federal health insurance programs, Medicare and Medicaid, reimburse long-term care.

Table 5.2 **Sources of Payment for Nursing Home and All Other Personal Health Care (percentage of total expenditures, 1991)**

	Total, Billions 1991 $	Out-of-Pocket	Private Health Insurance	Other Private	Total Government	Medicare	Medicaid
Nursing home care	59.9	43.1	1.1	1.9	53.9	4.4	47.4
Personal health expenditures, excluding nursing homes	600.3	19.7	34.8	3.7	41.8	19.6	11.3

Source: Adapted from Letsch et al. 1992.

Medicare Coverage of Long-Term Care

Nearly all elderly Americans are enrolled in Medicare, which covers hospital and physician expenditures. Although it is primarily an acute-care insurance program, it pays for home health services and, under specific circumstances, nursing home care. Medicare coverage is designed to encourage nursing home use only as a substitute for hospital care, which Medicare would need to reimburse. It is not designed to ensure against prolonged institutionalization. According to a leading Medicare benefits guidebook, "inpatient services in a skilled nursing facility are an extension of inpatient hospital care, at a lower level of care than provided in a hospital but still requiring 'skilled' nursing or rehabilitation services" (CCH Business Law Editors 1994). To qualify for Medicare reimbursement, an admission must satisfy several restrictions. Medicare pays only if the nursing home is a certified skilled-nursing facility, the admission meets a prior hospitalization requirement, the nursing home stay is for the treatment of the condition that was treated in the hospital, the admission is certified by a physician, and a utilization review committee does not disapprove the stay.

If all of these conditions are met, Medicare will pay the full cost for the first twenty days of nursing home care during a benefit period. From day twenty-one through day one hundred, Medicare imposes a copayment. Often private supplemental "medigap" policies pay for some or all of the copayment, but seldom do they extend coverage beyond one hundred days, when Medicare coverage ends. These limits mean that Medicare pays at least part of the charges for a substantial fraction of short-term nursing home admissions, but accounts for a small fraction—4.4% in 1991—of nursing home expenditures.

Medicaid

Medicaid's role in long-term care reflects two defining characteristics: it is jointly administered by states and the federal government, and eligibility is based on need. Because the states have considerable discretion in administering the program, eligibility and coverage rules vary by state (Ruther et al. 1991). Most of the elderly who receive Medicaid benefits qualify on the basis of extraordinary health expenses, under the "spend-down" provision of many state Medicaid programs. For states that have such a provision, Medicaid eligibility is determined by an asset test and an income test; the latter requires income minus health expenditures to fall below 133% of the income level for welfare eligibility. One or a series of nursing home admissions usually account for the health expenditures for the middle-class elderly who spend down to Medicaid eligibility. That is why Medicaid pays for nearly half of all nursing home expenditures and, conversely, why nursing homes account for such a large fraction of Medicaid expenditures. National estimates of the fraction of nursing home admissions that lead to spend-down range from 14 to 18%, with about 17% of patients admitted to nursing homes spending down within six

months (Rice 1989; Adams, Meiners, and Burwell 1993). Although the popular image is one of catastrophic expenses suddenly leading the middle-class elderly to lose much of what they own before qualifying for Medicaid, the usual situation may be different. According to Sloan and Shayne (1993), most of the disabled elderly who spend down are already near poverty at the time they enter a nursing home. Furthermore, assets can be transferred as well as depleted.

By transferring assets to children and other relatives, the elderly can preserve wealth when they expect to face substantial out-of-pocket copayments for either medical or long-term care. Medicaid eligibility rules not only contain strong incentives for such behavior, but have several other consequences. For example, in several states, the asset limits place the spouses of the disabled elderly at risk of impoverishment. Joint assets are subject to the spend-down, so the spouses can lose liquid assets and their homes. Newspapers reported the spectacle of long-married elderly couples divorcing in order to protect the assets of the (relatively) healthy spouse. Thus the elderly who live in states with a medically needy category of Medicaid eligibility have free insurance against the costs of prolonged institutionalization, but qualifying for Medicaid is usually unattractive. Medicaid is also criticized as a long-term care insurance program because its expenditures for the elderly became unavailable for the care of the poor, particularly poor children, who are the program's intended beneficiaries.

Private Long-Term Care Financing

Most private financing comes in the form of out-of-pocket payments, medigap insurance, and private long-term care insurance. Out-of-pocket payments are considerable; the other sources of private financing are not. Medigap insurance usually covers Medicare copayments and deductibles, and may pay for some of the medical expenses that Medicare does not reimburse (such as physician fees that exceed the Medicare allowed charges, or expenditures that exceed maximum Medicare reimbursement) but infrequently covers prolonged nursing home admissions. Private long-term care insurance is designed for this purpose. It is a topic of perennial interest to insurers and policymakers, but for reasons I discuss below, the interest has not been reflected in sales of the policies (Van Gelder and Johnson 1991; Rivlin and Wiener 1988).

5.2 What Happened to Private Long-Term Care Financing?

The existing combination of private and public financing of long-term care has few champions. Current modes of financing provide the wrong kind of protection from risk, and, at least according to advocates of expanded long-term care services, the balance of federal coverage for health care of the elderly is too heavily weighted toward hospital and physicians' services. The most striking feature of long-term care financing, however, is not a small federal

role, but the near absence of private insurance coverage. Many proposals for reform call for federal initiatives to promote private insurance, or to create federal insurance that would complement private long-term care insurance. Whatever the mix of federal and private financing, though, the key issue is why private insurance markets have been slow to develop when public long-term care financing is so roundly condemned as inadequate.

Common explanations for why consumers have failed to purchase long-term care insurance include the availability of Medicaid as an alternative, high price, and restrictive benefits (Pauly 1990). Medicaid is likely to be an important substitute for private insurance; although eligibility requires asset transfer or depletion for the middle-class and wealthier elderly, Medicaid is essentially a compulsory insurance program that assures payment for extended nursing home stays. Indeed, private insurance is unlikely to be attractive to those who are not very well off, because they give up little to become eligible for Medicaid benefits. The wealthy, on the other hand, are likely to self-insure. Only people whose assets are neither too small nor too large would be candidates for private insurance. They might choose not to purchase because the policies provide too few benefits for the costs. Explanations for the limited penetration of private insurance and the unattractiveness of the policies that are available emphasize disincentives to insurers, such as adverse selection, moral hazard, and demographic uncertainty.

Affordability, never a precise concept, is especially imprecise in this context, depending as it does on the timing of purchase and liquidity of assets. Certainly the cost of an actuarially fair policy can be well beyond the means of an elderly widow who lives alone and suffers from multiple disabilities. And like a patient who tries to buy health insurance after falling seriously ill, she is unlikely to find an insurer willing to sell a low-cost policy. Another aspect of affordability is the ability to pay: older people tend to have substantial asset wealth and relatively little income. Many of their assets—particularly housing wealth—are illiquid, so it may be difficult to draw upon assets for direct payments for long-term care or for insurance. Reverse annuity mortgages and related programs have been developed to draw upon housing wealth to pay for living needs, but have not been very popular. Such mortgages may hold little appeal for the large fraction of the elderly who seem not to wish to reduce their housing equity (Venti and Wise 1990).

Insurers also face severe disincentives to marketing long-term care insurance. According to the conventional wisdom, which developed from limited survey evidence, the elderly do not purchase private insurance because they are unaware that Medicare does not cover long-term care. This explanation is puzzling, since insurers who thought the market would be profitable should have found it worthwhile to disseminate the information themselves. Furthermore, publications describing coverage rules are widely distributed. It seems more likely that the insurers had doubts about the profitability of the market. For the potential long-term care insurer, the informational asymmetries and

inefficiencies that have characterized health care insurance are magnified. Brochures for long-term care insurance show the consequences for buyers: many policies offer thin coverage and rigorous exclusions. Potential purchasers often eschew such policies because they question their value, not affordability.

Absent universal coverage, insurers and providers that bear risk, such as prepaid health plans, will find it difficult to overcome adverse selection unless they impose restrictions on coverage or limit sales to people too young to need long-term care. Poverty, lack of social supports, and functional disability are important risk factors for institutionalization. Although insurance companies may partially observe these characteristics, the beneficiary or family member who purchases the policy knows more about the health status and level of function. Any party that indemnifies, reimburses services, or directly provides care faces these same problems.

To minimize adverse selection, most insurers adjust premiums for observable risks. They also impose waiting periods, exclude coverage for preexisting conditions, or exclude from coverage common conditions that may be difficult to detect in early stages. Presumably a woman at age forty or fifty has little information about her future risk of nursing home admission, relative to others at the same age. At age seventy, she is much more likely than the insurer to know whether she is particularly likely (or unlikely) to enter a nursing home.

Mandatory universal insurance avoids adverse selection, but it does not inevitably reduce the magnitude of moral hazard. In health care, moral hazard is usually defined as a price effect, that is, by paying a substantial fraction of the cost of medical care, insurance coverage increases the quantity demanded. Housing, food, personal services, and other components of long-term care are of value to nearly all the elderly, not only those who are particularly disabled or who suffer from a specific disease. The broad value of such services makes it more likely that a price subsidy will increase demand for long-term care than for physicians and hospital services, which are targeted toward treating disease.

Even if the demand for care were inelastic in the short run, the adoption and diffusion of more costly new medical technology or the wider application of existing technology could increase long-run expenditures for the treatment of specific conditions. Thus, as the price to the consumer (the copayment) falls, the quantity demanded rises, and the long-run effects are likely to be magnified by technological change.

Traditional fee-for-service health insurance relies heavily on deductibles and copayments to reduce utilization. But this approach has fallen into disfavor, largely because most Medicare recipients reinsure for the copayments and deductibles, and because very extensive cost sharing appears to be necessary. If anything, even a small insurance-based subsidy for housing, for example, might be sufficient to increase demand. Payers do not rely on cost sharing alone. They also assess individuals on a case-by-case basis to determine their need for care, particularly for expensive procedures. In hospital settings this

process of determining "medical necessity" for a particular patient can be costly. Insurers adopt an analogous approach to long-term care, screening the enrollee for limitations in ability to carry out routine physical tasks and other factors to ascertain that a genuine "need" for long-term care exists. Such procedures are widely used and apparently have some value, but assessment of the need for long-term care services is at a primitive stage. It relies heavily on subjective reports by the family and the enrollee, who have incentives to obscure disabilities when seeking to buy insurance, and to emphasize impairments when they seek reimbursement. For many acute medical services, laboratory tests and other measures that are less subject to direct manipulation by the enrollee are available to help determine medical necessity. Comparable measures are seldom available for long-term care. Thus, despite the many instruments payers can employ to limit its effects, moral hazard is likely to remain a significant challenge to any mechanism for insuring or providing long-term care.

Some analysts argue that uncertainty about potential liability has deterred many potential insurers from offering long-term care policies. Insurers have had limited experience marketing and administering such policies, the argument runs, and there is substantial uncertainty about the length of life and trends in the disability of the elderly. Demographic projections are, of course, subject to uncertainty, and even the sign of the trend in age-specific disability is controversial. Many long-term care insurance plans allow individuals to pay premiums that vary with the age at initial enrollment, like renewable term life insurance. If the elderly live longer but age-specific levels of disability do not diminish, insurers will face unexpected liabilities. Furthermore, if spouses and children provide less care for disabled elderly in the future, the demand for paid long-term care services will grow. On the other hand, it should be possible to reinsure or otherwise mitigate the risk of larger-than-expected claims for long-term care. Furthermore, many insurers limit potential claims by setting a daily maximum payment and an upper limit on months of coverage.

If consumers expect government bodies to offer long-term care insurance in the near future, they may conclude that the public program will obviate the need for any private policy they buy. If this is an important reason for the reluctance of elderly Americans to purchase long-term care insurance, it is one that some insurers have already addressed. Some plans have arrangements to refund premiums if government policy creates insurance with similar coverage for all elderly Americans.

Private long-term care insurance may become an important source of financing despite the limited role it has played so far. Private insurance became more attractive in the late 1980s, when many plans eliminated prior hospitalization requirements for nursing home admission and promised benefits for a longer period. Exclusions for such conditions as Alzheimer's disease and for preexisting conditions became less common. Finally, a greater proportion of policies guaranteed renewability (Van Gelder and Johnson 1991). These fea-

tures undoubtedly contributed to their rising popularity. The Health Insurance Association of America reported that in 1988 the number of companies selling long-term care insurance was six times the number in 1984. By December 1988 an estimated 1.1 million policies had been sold. It may be several years before growing enrollment is reflected in the share of payments covered by insurance, especially if the purchasers are in relatively good health. Thus it seems likely that private long-term care insurance, which was unattractive to purchasers because it paid benefits only under a restrictive set of circumstances, will become an increasingly important means of financing nursing home care in the next decade.

Despite the prospect of continued growth, private insurance is unlikely to provide the majority of financing for long-term care in the near future. The costs due to adverse selection can be minimized if insurance is purchased during working years, so private insurance could have had an expanded role by the time baby boomers have aged. According to simulation estimates from the Brookings-ICF long-term care financing model, at most 58% of all the elderly early in the next century could be covered by private long-term care insurance purchased during working years. Insurance purchased after retirement would cover fewer people (Rivlin and Wiener 1988). Private insurance, unless subsidized, is also unlikely to finance care for low-income, high-risk men and women, like many Medicaid enrollees.

5.3 Limits to Expanded Public Financing of Long-Term Care

An expanded government role is the cornerstone of many proposals for reform of long-term care financing. Some of the proposals extend well beyond financing—they would broaden regulatory powers to monitor and improve the quality of nursing home care, for example. Poor quality of care is one of many problems that long-term care reform might address; it is difficult to detect because many patients are incapable of complaining or making their complaints felt, and concerned family members have few opportunities to assess quality. As important as such issues may be, financing is the centerpiece of most proposals that would expand federal involvement in long-term care. Federal financing would yield the most direct route to achieving universal coverage. The middle-class elderly, who stand to lose substantial assets if they need nursing home care, might find universal, federally sponsored insurance appealing, while the poor and near poor, who have less to lose in qualifying for Medicaid, would be little affected.

If the federal government takes an expanded role, it would most likely be as part of a "private-public partnership." A typical arrangement would have private insurance pay for the first year of nursing home care, and government programs pay for any nursing home care exceeding one year. All such proposals, even if they assume that much of the funding will remain private, need a mechanism for funding the federal share. Universal coverage would require

substantial redistribution, and just as funding issues frustrated the most ambitious recent health care reform plans, they may prove insuperable obstacles to large increases in the federal share of long-term care expenditures.

Who will pay for expanded coverage? In discussing this question, I first consider shifting some of the costs from the elderly to the working-age population, or to future generations, and then consider "budget-neutral" funding, meaning the generation that receives the coverage pays for its full costs through a combination of premiums and taxes.

5.3.1 Intergenerational Redistribution

The funding mechanisms for long-term care might either involve deficit spending (shifting the costs to future generations) or increased taxes on the current working-age population. I will not comment on the desirability or consequences of deficit funding to finance long-term care, except to say that neither today's political climate nor tomorrow's economic environment favor deficit financing for a new entitlement for the elderly.

Funding long-term care for current Medicare beneficiaries out of taxes imposed on the currently employed population would increase an already large subsidy that is unlikely to be maintained when current workers grow old. Despite high rates of poverty, the economic well-being of the elderly has improved absolutely and in relation to other demographic groups. For example, between 1970 and 1984 median incomes for families headed by persons between twenty-five and sixty-four years old barely changed, rising from $29,113 to $29,292 (in 1984 dollars). During the same period, median incomes for families headed by persons sixty-five years of age or older rose from $13,522 to $18,236 (U.S. Senate Special Committee on Aging 1985–86, 57). By 1992 the median income of married couples sixty-five years of age and older had reached $23,817 (Grad 1994, 36). According to Hurd (1990), in 1987 the mean household income of the elderly was about 63% of the income of households of all ages, and the average wealth in 1979 was $147,000 (including federal benefits; wealth was about $80,000 excluding Social Security, Medicare, and Medicaid). Census statistics placed 1988 median net worth at $73,000 for households whose head was age sixty-five and older, about twice the median net worth for all households (U.S. Senate Special Committee on Aging 1991). As the recipients of indexed Social Security benefits and rising Medicare payments who also live longer than previous cohorts, the elderly receive far more in benefits than they contributed to Medicare and Social Security. According to one set of estimates, a new retiree in 1990 could expect to receive $4 in Medicare payments for every $1 paid in taxes and premiums (Center for Health Economics Research 1994, 21).

Though they are far more likely to be ill and require health care than other segments of the population, the elderly have already attained near-universal coverage for hospital and physician services. In 1989 about three-fourths of them had both Medicare and private supplemental insurance. About 6% had

both Medicare and Medicaid. Fewer than 1% lacked health insurance, as compared with about 16% of the rest of the population (National Center for Health Statistics 1992). Their health insurance does not completely protect them from risk, for Medicare is not fully comprehensive; it does not cover prescription drugs, and although its hospital and physician benefits are extensive, they are subject to a ceiling. In a study of the disabled elderly, Liu and colleagues estimated that catastrophic health care expenses were about as likely to be due to acute care as to nursing home care. They calculated that about 9% of disabled elderly persons with an income between $500 and $1,000 per month would have acute-care expenses exceeding 15% of income, and that about 8% and 3% of them would have comparable out-of-pocket expenses for nursing home care and drugs, respectively (Liu, Perozek, and Manton 1993). Thus universal health insurance does not guarantee comprehensive protection from financial risks that result from poor health. Nevertheless, other broad segments of the population completely lack coverage, and it seems unlikely that incremental federal dollars would first go to expand benefits for the elderly.

Working in favor of funding long-term care from tax receipts today is the size of the current cohort of working-age Americans relative to retirees. The size of the cohort, however, also makes it unlikely that any such policy will be sustainable.

The support ratio captures the salient demographics in simple terms. The elderly support ratio (one hundred times the ratio of persons age sixty-five and over to working ages) is projected to rise from about twenty-one (currently) to forty (in 2030), as the total support ratio (elderly and children under age twenty as percentage of the size of the working-age population) increases from 70 to 90. As the support ratio rises, only large and sustained productivity gains will make it feasible to rely on current taxation to finance programs for the elderly. The demographic shift coincides with the financial crises that both Medicare and Social Security face early in the next century.[2]

If current trends continue, even if there is no expansion of long-term care benefits, the shift in the age composition of the population will dramatically increase health expenditures. Between 1950 and 1990 the number of Americans sixty-five years of age and older rose from 12.2 million to 31.0 million; by 2030, according to census projections, their number will more than double again, to 69.8 million. In 1990 the elderly were about 12.5% of all Americans; by 2030 they will be just over 20% of the population. In 1987 per capita health expenditures were $5,360 for Americans sixty-five years of age and older and

2. The trust fund crisis will first affect Medicare Part A; the Hospital Insurance Trust Fund, which funds Part A, will only be able to pay benefits for about seven more years. The Old-Age and Survivors' Insurance Trust Fund is projected to be able to pay benefits for about another thirty-six years with the reallocation to the Disability Insurance Trust Fund that Social Security Trustees recommend (Social Security Bulletin 1994). Medicare Part B, which is funded from the Supplementary Medical Insurance Trust, is financed on a year-to-year basis, so is not directly subject to the depletion of trust funds. It is funded by a combination of premiums that enrollees pay and general tax revenues. Premiums cover less than one-third of program costs.

$1,286 at younger ages. Thus there will be dramatic growth in the age group that uses about four times as much health care as the general population.

In fact, the age shift may have greater effects than these figures suggest. Population growth will be concentrated at advanced ages, when health expenditures are greatest. About half a million Americans in 1950 were the "oldest old," people eighty-five years of age and older. By 1990, 1.2 million were eighty-five years and older, and by 2040 there are projected to be 13.2 million Americans in this age group (U.S. Bureau of the Census 1993). Above sixty-five years of age, expenditures continue to rise with advancing age; per capita expenditures were $3,728 at ages sixty-five to sixty-nine and $9,178 at eighty-five years and older. Simple actuarial projections of health expenditures, based on recent rates of growth in per capita expenditures by age, imply that health expenditures for the elderly will grow to untenable levels early in the next century, and will exceed $1 trillion by 2030 (Garber and MaCurdy 1992). Every serious health care reform plan proposes to avert the deepening crisis in health expenditures by slowing the growth of spending for hospital and physicians' services. Unless and until expenditure growth is held to "acceptable" levels, there will be substantial political resistance to adoption of any *new* benefits, including long-term care.

Even without broader coverage, long-term care expenditures will grow dramatically. Nursing home utilization and expenditures rise at an even steeper rate with age than overall health expenditures. Per capita nursing home expenditures increase more than twenty-fold between ages sixty-five and eighty-five, averaging $165 at ages sixty-five to sixty-nine and $3,738 at eighty-five years and older; they are about $46 for Americans between ages twenty and sixty-four (Waldo et al. 1989). Over the past decade or so, age-specific nursing home utilization appears to have declined slightly. However, the effects of the shift in the age distribution of the American population will expand the number of nursing home residents, even if the trend toward lower risk of institutionalization continues.

Why might the risk of institutionalization continue to decline? New evidence suggests that age-specific disability rates are declining. In a controversial 1980 article and subsequent writings, James Fries proposed that there is a natural limit on the attainable life span, and that more and more people will live to the maximum life span. Thus survival curves will approach the rectangular, rather than developing a longer and thicker tail of very old survivors. Along with the rectangularization of survival, Fries claimed, will come a compression of morbidity: people will spend less time sick and disabled before they die. His claims were hotly debated. It seemed obvious that, just as medical care might diminish morbidity and improve function, it would also keep alive people who either had disabilities or were likely to acquire them. For example, improved treatment of congestive heart failure might enable people with the condition to live longer, albeit with severe activity limitations. Many authors questioned whether there was evidence of compression of morbidity (see, for

example, Verbrugge [1984] and Poterba and Summers [1987]). Poor data made it difficult to test Fries's hypothesis in any convincing way; most of the evidence was indirect, and there was little longitudinal data with appropriate measures of functional status or morbidity. A recent publication by Manton, Corder, and Stallard (1993), based on analysis of three waves of the National Long-Term Care Survey, offered some of the most convincing evidence that age-adjusted functional status has indeed improved over time. Although their data covered only a seven-year period during the 1980s, Manton and colleagues showed that fewer nondisabled elderly became disabled (on an annualized basis) between 1984 and 1989 than between 1982 and 1984. Furthermore, people with disabilities were less likely to acquire new disabilities in the second time period. These intriguing results have yet to be confirmed using other data, but even if they are correct, the decline in morbidity seems unlikely to be sufficiently large to offset the increases in the demand for both medical care and long-term care that will result from the aging of the baby boomers.

Thus, even if general funds could pay for long-term care of the elderly today, any such approach offers only a temporary solution, since the burden of subsidizing the care of elderly baby boomers will be heavier and will fall on a smaller population of working adults.

5.3.2 Can Current Beneficiaries Pay?

If redistribution across generations is infeasible, what are the prospects of financing from the population that currently receives benefits? One approach that might appeal to the elderly is to finance expanded long-term care benefits by reducing Medicare outlays for hospital and physician services; it is unlikely that they would choose to have nearly all Medicare dollars go toward conventional medical services, as they do now. However, many of the elderly believe, perhaps with good reason, that any savings resulting from a cutback in medical expenditures would be used to reduce Medicare outlays, not to fund new benefits. In any case, the results of efforts to reduce Medicare expenditures, including the Prospective Payment System (designed to limit hospital costs) and the Resource-Based Relative Value Scale (designed to reduce expenditures for professional fees), have been disappointing.

An alternative mode of intragenerational financing imposes a combination of taxes and subsidies on current Medicare beneficiaries. Such approaches preserve budget neutrality and exploit the large variance in the economic status of the elderly. A similar strategy resulted in the passage of a modest expansion of Medicare benefits in the late 1980s. That experience undoubtedly contributed to the caution with which Congress has approached health care reform under the Clinton administration.

The Medicare Catastrophic Coverage Act of 1988 was the culmination of an ambitious effort to extend Medicare benefits to long-term care and prescription drugs. During months of negotiations, the benefits were whittled away, until the package included in the act was greatly diminished in scope and expense.

It liberalized the dollar limits on payments for inpatient and physicians' services, and added a prescription-drug benefit, whose deductible was set so high that only a small minority of Medicare recipients would actually receive payments. It also included a slight expansion in long-term care coverage, raising the limit from 100 to 150 days of nursing home care per benefit period, and eliminating the requirement that hospitalization had to precede covered nursing home admissions. To preserve budget neutrality and to ensure that all the elderly would be covered, the act included a subsidy for the low-income elderly and a surtax for those with high incomes. According to a Congressional Budget Office report, in 1989, when premiums averaged $145, the program's benefits were worth $62 per enrollee. The maximum surtax, which made the total cost about fourteen times the expected value of the benefits, applied to anyone whose income exceeded $35,000. Although the act was criticized from some quarters because it did not go far enough in covering long-term care, the most devastating attack came from politically active elderly individuals who faced a large surtax to pay for benefits that most already received as part of private supplemental health insurance. Their protests, which embarrassed a number of congressmen and the leadership of the American Association of Retired Persons (AARP), led to the repeal of the act before its full implementation.

5.4 Making Long-Term Care More Broadly Available

Private solutions to financing long-term care remain largely unproven, and government approaches, at least for the foreseeable future, will have limited scope. Do these observations imply that there are no sustainable approaches to improving access to long-term care and to reducing the risk of catastrophic long-term care expenditures? I believe that the answer is no, but that the following considerations are essential to designing improved modes of financing long-term care.

Financing out of general tax revenues, or any means of transfer from working-age adults to the current elderly, will offer at best transient solutions. The large size and inadequate funding of existing entitlement programs and the rising support ratio are sufficient reasons. Resistance to any such approach will be particularly severe in the face of the improved economic status of the elderly and the worsening economic plight of the very young. Plans to use deficit financing, or to increase taxes on the working-age population, will face the general resistance to increases in taxes. They would also increase redistribution to an age group that already receives substantial benefits from government programs.

Initiatives to promote private long-term care insurance should emphasize purchase many years before disability becomes common. Many private long-term care insurance policies are structured like either whole-life or level-

premium term life insurance. They are relatively inexpensive for people who begin purchasing coverage at a time when the probability of a claim is very low and adverse selection is unlikely to be a significant problem. Adverse selection is a far more serious problem at advanced ages, when functional impairment is frequent, because methods to screen for risk factors for institutionalization are imperfect. There would be difficulties even if adverse selection could be overcome, since actuarially fair insurance would be prohibitively expensive for many of the at-risk elderly.

Financing long-term care by redistribution among the elderly is unlikely to be politically feasible. As the history of the Medicare Catastrophic Coverage Act illustrates, even an immensely popular and modest expansion of benefits will meet with severe political resistance if voters perceive that its costs are too high. A comprehensive long-term care benefit, particularly if it began covering nursing home care early in an admission, would be more expensive than the provisions in the Medicare Catastrophic Coverage Act. The surtaxes needed to finance the program would not go unnoticed. Attempts to fold long-term care into a more general health care reform effort, as we recently witnessed, may make the change more acceptable politically, if only because they obscure the relationship between program costs and benefits. But unless long-term care benefits are financed by reductions in other benefits, or real efficiencies result from the general reform effort, resistance will be substantial.

Is reform likely to bring new efficiencies that reduce the size of the surtax needed to finance expansion of covered benefits? Some have argued that health care reform can reduce administrative waste, eliminate inappropriate care, and promote more efficient practice patterns. Even if these claims are valid in the context of hospital and physician services, they are unlikely to apply to long-term care. Fee-for-service insurance, coupled with tax subsidies, is widely blamed for inefficiencies and overutilization in the existing market for health care. Yet insurance-induced distortions, apart from any implicit in the Medicaid program, cannot have had comparable effects on long-term care. In fact, many reform proposals seek to duplicate traditional fee-for-service private health insurance in the long-term care market, making cost reductions and efficiency gains particularly unlikely.

Moral hazard may be a far more significant problem in developing insurance for long-term care than for physicians' and hospital services. Projections at the time Medicare was passed grossly underestimated future expenditures. In 1967, its first full year of operation, total Medicare expenditures were $4.2 billion. By 1991 Medicare expenditures reached $120 billion (Helbing 1992). If only changes in the size and composition of the beneficiary population, along with general price inflation, had affected Medicare outlays, expenditures would have grown far more slowly. Typical projections assume that there is no behavioral response to the price subsidy implicit in health insurance, so insurance does little to increase demand for hospital or physicians' services. If only

patients who develop respiratory failure benefit from assisted ventilation in an intensive care unit, for example, a reduction in the price the patient pays for such services is unlikely to increase demand substantially.

The long-run elasticity of demand, however, can be much greater than such an example suggests. Subsidized care, with the associated increase in ability to pay for high-technology services, inexorably led to the development of new and expensive modes of health care. In the absence of widespread health insurance, many of these technologies would never have left the laboratory, or they would have been sold at lower prices. Unlike many forms of conventional medical care, long-term care often substitutes for goods and services that any elderly person might consume, such as housing, personal services, and food preparation. Innovations in housing arrangements for the elderly have increasingly blurred the distinction between housing and nursing home care; many continuing care retirement communities, for example, are designed to provide a comprehensive set of services beginning with pure housing and sometimes food services, sometimes with medical insurance, and directly providing graded levels of long-term care. Because the criteria used to determine the "need" for long-term services are less precise and more easily manipulated than, say, the diagnosis of a heart attack, the close substitutability of housing and other services means that long-term care insurance is likely to increase utilization substantially, and that the distortions will be larger than for conventional medical insurance.

A long-term care insurance program that covers noncatastrophic expenditures will be costly. The usual arguments about the drawbacks of first-dollar insurance coverage apply with force here. Many elderly Americans can expect to use formal long-term care, and a majority will receive informal long-term care at some time. Most will make limited use of such services. Publicly and privately financed insurance to cover such expenses will be subject to the costs that result from moral hazard, and adverse selection will raise the costs of privately provided insurance that is sold to the elderly. Such insurance offers little risk reduction at high cost.

Any public insurance program for long-term care is likely to be most successful if it mandates universal participation and restricts coverage to catastrophic long-term care benefits. Even for those who use it heavily, long-term care is usually less expensive than hospital and physicians' services. A small fraction of people admitted to nursing homes have stays lasting a year or longer. Although nursing home charges vary greatly within and between regions, the mean cost of an admission, even if it lasts a year, is small in relation to the wealth of many of the elderly. A program that financed only greatly prolonged nursing home stays would cost substantially less than a marked expansion of benefits for conventional medical services, or for first-dollar coverage of nursing home stays, and many of the elderly could afford to pay for the period before coverage began with a combination of savings and private insurance.

Like all other forms of long-term care insurance, the catastrophic coverage would be subject to both adverse selection and moral hazard. In every respect, however, catastrophic coverage would be much less vulnerable to such problems than would, say, first-dollar or first-day coverage. The linkage of the insurance coverage to the duration of prior use (i.e., the lack of coverage until a year or so of institutionalization) would mean that only persons who could expect to have very extensive and lengthy nursing home utilization would benefit; presumably many of these people could be identified ex ante.

Not all of the elderly would be able to pay for catastrophic insurance out of current income. Below some income and/or asset threshold, individuals could continue to be covered in the current Medicaid program, whose expenditures would fall as a large fraction of the elderly who "spent down" to qualify for Medicaid become eligible to receive catastrophic coverage under the new program. All of the usual issues about phasing in a benefit that is means tested arise here: the disincentives to save, the desired degree of progressivity, and methods to ensure the quality of care delivered under the safety net (Medicaid).

The popularity of private insurance to supplement Medicare suggests that it will be difficult to preserve the cost-sharing features of catastrophic long-term care insurance. Most Medicare recipients obtain medigap policies, which pay all or part of the deductibles and copayments, thereby eliminating the features that were designed to prevent overutilization of covered services. Tax deductibility of premiums for private policies exacerbate their overpurchase. If private supplementary insurance promoted overutilization of long-term care, long-term care coverage with provider incentives (such as capitation) would be an alternative means of controlling expenditures.

Increased savings will be necessary to ensure adequate funding for long-term care. A savings-based approach to financing long-term care has several advantages that insurance market reform lacks. One is the development of new alternatives to traditional forms of long-term care. Innovations such as continuing care retirement or life care communities offer a combination of housing, personal, and health services, and are designed primarily for the healthy elderly who would like to be able to stay outside institutions if they become disabled. Narrowly drawn insurance coverage would encourage traditional forms of long-term care at the expense of innovations, while broad coverage could lead to excessive moral hazard. Thus private savings mechanisms will often lead to more efficient outcomes than expanded insurance, which will lead to price distortions.

There are three major concerns with savings-based approaches: public policies designed to increase private savings for long-term care might be unsuccessful; if successful, they might lead to undesirably large bequests; and many low-income workers and the persistently unemployed would be unable to save enough money. The major form of tax-advantaged savings for long-term care that was proposed during the 1980s, called the individual medical account (IMA), was patterned after IRAs. It never attracted widespread support, in part

because so few people participated in IRAs, which were clearly superior from the saver's point of view (funds from IMAs could be spent only on long-term care, whereas the proceeds from IRAs could be spent on anything). Increased savings could result in undesirably large bequests, and the wealth might not be readily annuitized if long-term care insurance markets are highly imperfect. Increased savings among those who are near poverty or already receive income support seems infeasible, and for this segment of the population Medicaid is likely to remain the principal means of financing long-term care.

Specific mechanisms for promoting savings are beyond the scope of this discussion. Increased savings will likely require an increase in the average age of retirement and may require substantial behavioral change. It seems clear, however, that insurance for long-term care will remain flawed. Increased savings, when feasible, and particularly when coupled with catastrophic insurance, may offer the greatest flexibility and limit both risk and moral hazard.

5.5 Conclusions

Veneration of the elderly—a central tenet of both Eastern and Western religious and cultural traditions—obliges family and society to maintain and enhance the well-being of those who are old, particularly if they need assistance. Modern industrialized societies rely heavily on social welfare programs for this purpose. The United States lacks universal health insurance for the rest of the population, but it subsidizes insurance for physician services and provides all of the elderly with hospital insurance under Medicare. Federal and private programs to insure long-term care for the elderly are considerably less well developed than Medicare, though. There is little private insurance, and Medicaid is only available to the poor, the near poor, and those who spend down. How can our humanitarian impulses to ensure access to long-term care be reconciled with the financial, demographic, and political barriers to expanding or transforming the government role?

All of the mechanisms for expanding access to long-term care by changes in financing are problematic. There are three major forms of financing: direct private payments, private insurance, and government payments. Direct private payments lack risk protection, and preparing for such payments will require sizable precautionary savings. Private and public insurance can generate substantial inefficiencies, stemming from moral hazard, poor information, and the high cost of monitoring. Adverse selection is also likely to affect any insurance program that falls short of universal participation. Any broad mandate or government program could overcome adverse selection, but would have large and politically unpopular redistributional components.

Long-term care is currently financed by a mix of all three approaches, although private insurance has had a limited role. Its role is likely to grow, especially if long-term care insurance plans are marketed to younger populations, who are less likely to be subject to adverse selection. The federal role in fi-

nancing long-term care is unlikely to expand substantially, unless funds are taken from other programs for the elderly, like Medicare and Medicaid. The rapidly approaching depletion of the Hospital Insurance Trust Fund, the already large general revenue contribution to Supplementary Medical Insurance, and changing demographic largely preclude the addition of a comprehensive long-term care benefit to Medicare, unless offsetting savings can be found. The costs would be high, the inefficiencies great, and the likelihood of funding budgetary shortfalls out of taxes or premium payments small.

These realities suggest that federal policy should emphasize increased savings, rather than direct federal payments for long-term care. Policy is most likely to succeed if it emphasizes ensuring that the disabled elderly can obtain humane care, whether it comes from family members, visiting nurses, or institutions. Some will be able to rely on spouses and children for assistance, but many will eventually need formal services. Efforts to prepare should begin long before this contingency is likely to arise. Government programs should promote such efforts, because if today's workers become disabled when they are older, the federal government is unlikely to be able to shoulder a greater burden than it does now. Increased private saving and greater participation in private insurance, not a broader package of federal benefits, offer the surest protection against the financial consequences of old-age disability.

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Comment

John B. Shoven

Alan Garber's paper provides an excellent introduction to the economics of long-term or nursing home care. There are currently some serious shortcomings in our system of financing and delivering quality long-term care in the United States. Due to the aging of the baby boom generation, however, these problems are going to be magnified many times over within the next fifty years or so. Per capita nursing home expenditures grow extremely rapidly with age. In 1989, those between ages sixty-five and sixty-nine spent an average of $165 on long-term care, while those over eighty-five spent more than twenty times as much, at $3,738 per capita. Combine this with the fact that the over eighty-five population is projected to increase by a factor of five over the next fifty years, and the topic of this paper takes on immense importance.

Garber points out in the paper that private insurance is currently only a tiny factor in the financing of nursing home stays. At first glance, this is puzzling since the need for long-term care appears to be something that should be insurable. The majority of people will not need long-term care in their lifetimes, and even for those who do spend some time in a nursing home, the average total time spent is not long and the cost is not too great. However, there is a

John B. Shoven is the Charles R. Schwab Professor of Economics and the dean of the School of Humanities and Sciences at Stanford University.

sizable minority who will need care for several years, and for them the expenses can be overwhelming. As Garber points out, however, on further thought this market suffers severely from two of the classic insurance problems: adverse selection and moral hazard. Undoubtedly, these problems at least partially account for the reason that private insurance is not a big factor in this market.

There are other reasons why private long-term care insurance has failed to develop. First, to get around the adverse selection problem, insurance companies need to enroll people long before they might need care. However, with all of the talk of the government providing long-term care in the future, why should individuals give up current consumption for future benefits that may be unnecessary? Without checking the overall market for long-term care insurance, I simply examined the policy offered by Stanford University (provided by CNA Insurance, one of the largest participants in this market). In the policy offered at Stanford, there is absolutely no provision for what happens if the government is covering long-term care by the time the policy holder needs it.

Second, there often are no inflation adjustments in the policies or guarantees that the insurance company will be solvent in the distant future. The Stanford plan comes in three sizes, offering maximum daily benefits of $90, $120, or $150 (and also maximum nominal lifetime benefits). These all sound reasonable for today's prices, but if the potential enrollees think that they might need nursing home care sometime in the 2030s, these payouts might be totally inadequate. The Stanford plan mentions making adjustments (to both cost and payouts) with future inflation, but there are no specifics whatsoever. Third, the policies cannot be actuarially fair. The Stanford policy charges men and women the same amount; one visit to a nursing home where the population is between 75 and 80% women would hint that a single pricing policy cannot be in the interest of male participants. Fourth, a significant fraction of people are myopic, particularly about unpleasant events in the very distant future. And, fifth, the policies are very expensive. I calculated how much money one could accumulate if one put aside the long-term care premiums beginning at age thirty-five and earned a nominal return of 7.5% on the money. By age eighty (not far from the median age of entry into nursing homes), the account would have grown sufficiently to finance a twenty-six month stay at the policy's maximum daily benefit. But Garber's table 5.1 tells us that the average lifetime utilization of nursing homes is only seven months. Even for the 35% of the population who will spend some time in a long-term care facility, the average utilization is twenty-one months. Clearly, many people would rather take their chances than purchase a policy with the actuarial dice so poorly arranged.

Many of the problems of private insurance provision are fundamental and cannot be solved with either increased government regulation or increased private competition. It is probably safe to say that privately purchased insurance will never be a major factor in this market. Some of the problems, particularly the moral hazard problem, also apply to government-provided insurance. I per-

sonally find persuasive Garber's suggestion that the demand elasticity for nursing home care is substantial because the services provided substitute for meals and housing expenses. A high demand elasticity translates directly into a very large moral hazard problem in this market.

It is not at all clear that the solution for long-term care financing is to try to expand the role of either private or public insurance. If we had even more widespread insurance than we do now (and Medicaid is already a very large factor in this market, paying roughly half of the total bill in the economy), the moral hazard problem could become as severe as it is in the rest of the health care industry. That is, the age-specific demand for nursing home care could increase substantially if more people are put into a situation where they or their family don't pay the incremental costs of their usage. Given the demographic outlook for nursing home demand, we cannot afford to have even higher age- and sex-specific usage.

Garber ends the paper with an analysis of alternative policies for long-term care financing. None of them will easily deal with the rapidly increasing population over eight-five, of course. Expanding either public or private insurance seems both implausible and undesirable, given the moral hazard problem. The option that bears further exploration in my opinion is the combination of government provision of catastrophic long-term care insurance (for stays longer than one or two years) with individual saving responsible for shorter stays. The incentive to save will be viable only if the government refrains from financing noncatastrophic nursing home stays. Individual or family responsibility for these costs is a viable option only if the government refuses to help those who do not provide for themselves.

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