# Long-term care: The public role and private initiatives

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*The ongoing effort of the U.S. Department of Health and Human Services to identify private financing mechanisms that can effectively assist the rapidly growing population of older persons in paying for long-term care expenses is discussed in this article. The focus on private strategies stems from the recognition that Federal and State sectors already pay almost one-half of all long-term care expenses, the proclivity of liberalized financing structures to raise total costs, and the tendency of public financing to dampen choice, flexibility, and access to care. In view of the improved economic situation of most older persons in our Nation today, the potential for market development of private financing options is thought to be excellent, particularly the market for long-term care insurance.*

## Introduction

In his State of the Union Address, February 4, 1986, President Ronald Reagan asked the U.S. Department of Health and Human Services to study and provide recommendations on ways that the private sector and government could work together to protect American families against the costs of catastrophic illness, including the sometimes devastating costs of long-term care. Secretary Otis R. Bowen, who has had a long-standing personal and professional interest in catastrophic health care costs, accepted this challenge.

In this article, the Department's ongoing, 2-year effort to identify private financing mechanisms that can effectively assist older persons in paying for long-term care expenses is discussed. The crux of the Department's work relates to two questions: "What works?" and "Who is responsible?" Thus, our work has considered not only which mechanisms seem to have the most potential, but also the appropriate roles and responsibilities of government and individuals.

This article is a progress report. The Secretary's *Report to the President on Catastrophic Illness Expenses*, which received considerable attention because of the Medicare acute catastrophic proposals, provided recommendations on the private financing of long-term care as well (U.S. Department of Health and Human Services, 1986a). However, the problem of establishing feasible and effective strategies for financing long-term care has by no means been "solved" by the Department's analysts, nor by others, and our work in this area continues.

As the range and breadth of related articles in this Annual Supplement issue of the *Health Care Financing Review* express, the problem is complex and, as a Nation, we are collectively struggling for solutions.

## Private financing strategies

The Department decided early on to eliminate options which would rely solely on expansion of Federal financing. The factors that led us to focus on private financing strategies included: the current and future economics of long-term care, particularly the recognition that Federal and State sectors are already significant payers of long-term care; the tendency of liberalized financing structures to raise total costs; the tendency of centrally financed solutions to preclude flexibility and individual choice; and the advantages of access to personal, rather than public resources, in obtaining competitive, quality care.

The focus on private financing options was not based on a belief that private options can solve all of the problems associated with long-term care costs. Indeed, we were certain they could not. The role of government in providing a safety net is a strong principle in our country. We expect the public sector will continue to provide a safety net for people who cannot provide for themselves—those individuals and families faced with long-term care expenses well beyond ordinary means as well as low-income persons.

## Demographics and demand

The urgency of developing financing strategies for long-term care increases in direct proportion to the growth of an aging society. In the next several decades, the number of older persons, particularly those over age 85, will increase rapidly. Persons over age 65 will grow from about 30 million persons today (U.S. Bureau of the Census, 1988), to more than 67 million by the year 2040 (Adler, Kitchen, and Irion, 1987). The number of persons over age 85 will quadruple.

Even looking at the near term—the year 2000, just 12 short years away—there will be about 10 million more Americans over the age of 65 than there were in 1980 (Social Security Administration, 1988a). The median age of the population will increase to 37 years, and retirees will live longer—women at age 65 will have a remaining life expectancy averaging almost 20 years, men nearly 16 years (Social Security Administration, 1988b).

These demographics mean that the number of disabled elderly persons is likely to increase dramatically, because the rate of dependency and need for long-term care services increase rapidly with age. Although less than 3 percent of persons 65-74 years of

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age need assistance with personal care activities such as eating, bathing, and dressing, about one-third of persons 85 years of age or over need such assistance (Doty, Liu, and Wiener, 1985).

Similarly, the rate of nursing home use also increases sharply with age, from about 1 percent of persons 65-74 years to 22 percent of those 85 years or over (Hing, 1987). If historic rates of institutionalization continue, the number of older persons in nursing homes will nearly double, to about 2.2 million residents by the year 2000 (Goss, 1988).

## Paying for long-term care

In 1984, the last year for which separate figures for the elderly population are available, total health care expenditures for persons 65 years of age or over exceeded $119 billion (Waldo and Lazenby, 1984). The largest category was hospital care (45 percent), followed by nursing home care (21 percent). However, in terms of out-of-pocket expenditures, nursing home care constituted the single biggest health care expense for the elderly, accounting for about 42 percent of total out-of-pocket payments.

In 1986, national expenditures for nursing home care for persons of all ages totaled about $38 billion (Health Care Financing Administration, 1987). If the proportion of expenditures for the elderly remained approximately the same in 1986 as it was in 1984, then approximately $26 billion was spent on nursing home care for the elderly. By the year 2020, costs for nursing home care for all persons are expected to reach about $100 billion in 1987 dollars, assuming no benefit expansions in public programs (Rivlin and Wiener, 1988).

In 1986, almost one-half of all nursing home expenditures was paid by Federal, State, and local governments. The Medicaid program paid 41.1 percent, and an additional 6.4 percent was paid through Medicare, the Veterans Administration's programs, and other, non-Medicaid State programs (Health Care Financing Administration, 1987). Most of the remainder (51 percent) was paid directly out of pocket by older persons and their families. Private health insurance paid less than 1 percent of nursing home costs. It is this latter, private-sector portion that we think could be leveraged to become a significant factor in protecting the elderly from the financial burden of large out-of-pocket payments.

Although the number of older persons is increasing, the size of our future work force is decreasing. In 1987, there were 128 million Americans paying social security taxes and 38 million persons receiving benefits under the system, a ratio of 3.4 covered workers to 1 beneficiary. By 2030, projections indicate that there will be only 2 active workers per beneficiary (Social Security Administration, 1988b). The message: One should not look to additional social security taxes to finance increases in long-term care.

It also should be noted that the economic well-being of older persons today is better than ever. This reflects increased numbers of persons covered by better public and private pensions, increased earnings from assets, and wages earned in part-time jobs (U.S. Department of Health and Human Services, 1988a).

It may surprise many to learn that about one-half of the discretionary income of all Americans is earned by people over age 50 and that, after taxes, 20 percent of the incomes of those 65 years or over is discretionary (U.S. Department of Commerce, 1987). In general, the current economic picture indicates that older persons are in a better position than they were in the 1960's and 1970's to take advantage of private financing options, such as long-term care insurance, if these options are attractive and affordable.

Discretionary income also means that many older persons have the resources available to directly pay for modest amounts of long-term care needs, such as home health care services. According to data from the 1982 National Long-Term Care Survey, 88 percent of the disabled elderly living in the community have no out-of-pocket expenditures for formal home care services. Only about 3 percent spent more than 10 percent of income, and an estimated 1 percent (about 60,000 persons) spent more than 20 percent of income (U.S. Department of Health and Human Services, 1986b).

Unfortunately, a general picture of improved buying power does not extend to all elderly persons. An estimated 12 percent or so of elderly persons are living below the poverty line, and many others live close to that marker (U.S. Department of Health and Human Services, 1988a). These persons—many of whom are elderly women living alone, very old persons, and minorities—have few choices and will continue to need public assistance programs such as Medicaid to meet long-term care needs.

## Induced demand and total costs

Any extensive long-term care financing system, public or private, that replaces a portion of out-of-pocket expenditures, can be expected to induce a certain amount of demand for services and raise overall costs. Although the decision to enter a nursing home is generally considered a last resort, one may assume that the availability of financing resources will affect the decision process in some way. Thus, if financial barriers are removed, the use of nursing homes will increase to some extent. This effect will be more pronounced if people actively desire the service being financed, such as might be the case with home care service.

The impact of induced demand can be lessened by assuring that the user of the services substantially shares the cost, especially the initial costs. Financing approaches should be designed so that they help families facing heavy costs for care avoid financial devastation rather than shield the consumer from true costs. It is to everyone's long-term benefit if the financing system is kept fairly lean while still assuring access to critical services.

Ideally, the financing available would allow families to avail themselves of nursing home care when the

disabled person is too sick to be cared for at home or when providing the care places too great a strain on the resources of the family. The system should also encourage the availability of other services that support family caregiving, such as home, respite, and adult day care.

## Preserving choice and assuring quality

The term "long-term care" refers to a wide range of medical, health-related, and social services that may be required by a disabled person. The amount and kind of services needed by an individual do not depend simply on a person's condition. Rather, they depend on the living arrangements available, the availability of family and friends, the presence of community services, and other nonmedical factors.

This diversity of health needs, intermingled with social needs for housing, meal services, transportation, and assistance with household management, makes centrally developed and regulated approaches less likely to be appropriate, since choices are generally constrained. Public programs, which must achieve uniformity and equity, have much more difficulty in offering both choice and cost control.

Private financing options, which give individuals more control of their resources, may also foster more competition and better quality in the delivery system. Given the diversity of settings and services, it is difficult to closely monitor the quality of noninstitutional services. However, if families have access to private financing, they can simply take their business elsewhere if services are not up to par.

## The role of government

The government's role in long-term care financing should focus on the traditional responsibilities of government—providing for those who have no private resources to pay for needed services. In addition, one of the most valuable contributions that government can make towards a society planning for its health care is to provide leadership and public education on the Nation's long-term care needs.

Even though the situation is improving, substantial numbers of older persons do not fully appreciate their vulnerability with respect to catastrophic nursing home care costs. The government could do more to help families understand the importance of considering long-term care needs as part of their retirement planning and assess the alternatives available. The government should also encourage the private sector, employers, and insurers to assess critical gaps in coverage being offered for long-term care needs.

This Department is working on a public information effort with several major business and professional organizations, including the American Medical Association, the American Hospital Association, the Health Insurance Association of America, the American Council of Life Insurance, the Society of Professional Benefits Administrators, and the American Association of Retired Persons. As a first step, the *Medicare Handbook* is being revised to include the message that long-term care benefits are not covered by the program and skilled nursing and home care benefits are limited to post-hospital, short-term needs (Health Care Financing Administration, 1989).

Future work will explore the possible use of news and other communications media to carry the message by means of special regional forums, existing Federal networks such as senior centers, and business groups such as Chambers of Commerce. The effort would target employers and working-age persons, as well as retired persons.

## Development of private financing systems

The Secretary's *Report to the President on Catastrophic Illness Expenses* contained a number of recommendations in the long-term care area (U.S. Department of Health and Human Services, 1986a). Most proposals focused on ways to encourage the development and availability of long-term care insurance and incentives for increased savings for long-term care expenses. Similarly, in the congressionally mandated *Report to Congress and the Secretary by the Task Force on Long-Term Health Care Policies* (Task Force on Long-Term Health Care Policies, 1987), several tax incentive proposals were presented that would help expand the number of persons purchasing private long-term care insurance. A major thrust was to lower the age at which coverage would be obtained. Also favored were tax code changes to allow persons access to pension funds prior to retirement for the purchase of long-term care insurance.

It would be difficult to estimate the cost of these and related tax incentive proposals because there is so little data on which to base the estimates. The Department of Health and Human Services has been working with the Department of Treasury in its study of proposals involving use of the tax code. Treasury officials have indicated that a report for the President on the tax implications of long-term care proposals will be complete by late 1988 (VanAmringe, 1988).

## Private long-term care insurance

Considering the extensive focus in both the public and private sectors on the potential of private long-term care insurance, a few comments on this particular option are in order. As is pointed out in other articles in this issue of *Health Care Financing Review*, the long-term care insurance market is still in its infancy. The critical question is, can it become a viable alternative? I think it can, if and when the market matures to a point that products reach a large number of people with affordable premiums.

Group, employer-based health insurance benefit plans allow the majority of our citizens to obtain

protection against acute care illness expenses. We believe the same strategy holds potential for long-term care expenses as well. To foster the growth of long-term care insurance, we must work to lower the cost and expand the number and variety of products on the market while encouraging the gradual evolution of employer-based, group insurance.

We recognize that there are impediments to the development of more affordable products. One problem often raised by the insurance industry is the uncertainty about the tax status of interest earned on long-term care insurance reserves (the monies that insurance companies put aside to pay future benefits). This is a technical problem, albeit an important one, but it is one that can be resolved either through a general Internal Revenue Service ruling or by legislation.

Another problem often cited is lack of employer interest in long-term care products. This was emphasized at the Secretary's National Conference on Retiree Health Benefits, held in Washington, D.C., in June 1987 (U.S. Department of Health and Human Services, 1988b). Business leaders discussed the legal, accounting, and statutory changes which are acting as barriers to development of employer-based, long-term care benefits, even if structured as employee-paid benefits. In particular, the lack of attractive prefunding alternatives for companies was stressed.

Despite these problems, I see positive signs that the situation is changing, with growing interest in long-term care insurance both on the part of individuals and among employers. This is heralded by the development of the first generation of group long-term care policies, by the dramatic increase in the number of companies offering individual policies, and by the number of policies offered in each State.

In 1986, the Department asked the Washington Business Group on Health (WBGH) to sound out its members on their views of long-term care benefits. They reported that virtually no companies were interested in providing or assisting development of such services (WBGH, 1986). Significant change was indicated when WBGH conducted a followup survey (Levin and Frobom, 1987). The WBGH polled 150 of the Fortune 500 companies and found that more than 38 percent had plans actively under way to develop long-term care insurance. An additional 26 percent of the companies polled indicated that long-term care services would be an important agenda item in the upcoming year. And, in fact, by the end of 1987, three major American corporations announced they would be offering long-term care insurance to employees, with at least one of the employers planning to contribute to the premium.

On the supply side, just a year ago there was no company in the country known to offer a group long-term care policy. At the end of 1987, however, the Health Insurance Association of America (HIAA) advised us that there were four companies marketing group policies (HIAA, 1987). Nationwide, the number of individual long-term care policies is estimated to be more than 400,000, double what it was 2 years ago (Task Force on Long-Term Health Care Policies, 1987). In a recent comparative analysis of long-term care insurance policies, *Consumer Reports* found 70 companies had entered the field, many with several different types of policies (Consumers' Union, 1988). HIAA also reports that every State now offers at least some choice in terms of individual long-term care policies and that many States now offer an average of 10-12 different policies from among which to select (HIAA, 1988).

It is not appropriate to view private insurance as a single solution. The Nation needs a pluralistic approach of options that offers choice, flexibility, and diversity and provides a mixture of private sector financing vehicles.

According to a recent report on long-term care financing from the Brookings Institution, commercial long-term care insurance and other private financing options have only limited potential for either reaching a significant portion of the elderly or offsetting out-of-pocket or Medicaid expenditures (Rivlin and Wiener, 1988). The estimates presented in this report may caution against too much optimism. However, I think they are more reflective of the limitations of our ability to make accurate 30-to-40 year projections than of the true potential of insurance.

I disagree with this assessment for several reasons. First, I doubt that the current system will continue forever as it is now. Second, I know that people do not buy only what they can "afford"; they buy what they want and what they cannot risk or afford being without as well. Third, I think that it is not just the group over age 65 that will be interested in long-term care insurance; younger people will buy insurance for their parents, if not for themselves.

An estimated 60-65 percent of the elderly of all income groups have purchased medigap policies, sometimes (inappropriately) several (U.S. Department of Health and Human Services, 1986a). I think that the long-term care market can achieve the same market penetration if allowed to develop without undue regulation and that effective incentives could be developed to make it happen sooner. A number of risk options can be estimated and a series of plans provided to cover each option. The private sector need not be bound by the "one size fits all" approach that is so common among Federal entitlement programs.

## Conclusion

There is a lot more we need to know, and know quickly, in order to assure that our future long-term care system is responsive, effective, and desirable. The Department will continue to foster work in long-term care and wants to work with insurance companies, actuaries, and State Medicaid program directors, as well as the traditional academic community, to improve data on long-term care needs, financing, and the economic status of persons who need long-term care, including issues related to "spend down" of assets. Meanwhile, I salute the community of persons

who have been involved in research and demonstration efforts to understand more about our present system; many examples are highlighted by the articles in this special issue of the *Health Care Financing Review*.

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