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An estimated 6.6 million Americans age 65 and older need long-term care. By 1990 the number will increase to 9.3 million, bringing more pressure to bear on Medicaid and increasing the demand for alternative sources of financing.



Financing Long-Term Care

An estimated 6.6 million Americans age 65 and older need long-term care. As the baby-boom generation ages and individuals live longer, the desire and need for long-term care will become even greater. It is projected that the number of elderly in need of long-term care will increase to 9.3 million by the year 2000, to 12.9 million by 2020, and to almost 19 million by 2040.

As individuals live longer, they become more susceptible to developing chronic health conditions that require medical assistance over extended periods of time. Care for debilitating chronic conditions, or long-term care, is not covered by Medicare or most Medicare supplement (Medigap) insurance policies. Long-term care is expensive, and can rapidly deplete a lifetime's savings. Nearly two-thirds of the persons who enter nursing homes become impoverished in just over three months.

Long-term care financing is one of the most serious challenges confronting the United States. The elderly and their families have few alternatives for reducing their out-of-pocket expenditures for long-term care. Most elderly lack the financial resources to pay for long-term care, and private insurance is virtually nonexistent. A new type of prepaid health plan is beginning to provide this care, but is in a very early stage of development. Residential communities for the elderly that include long-term care services are expensive and may not be accessible for many persons.

Medicaid, which pays for the poor's health care, has become the only mechanism for financing long-term care. But the Medicaid program primarily covers services rendered in institutional settings, rather than home- or community-based services. It also creates a variety of market anomalies because of its reimbursement system. In addition, Medicaid coverage poses a problem in that one must become impoverished to become eligible. Yet, unless financing mechanisms change, more pressure will be brought to bear on the program.

◆ Introduction

Financing long-term care is one of the biggest challenges facing our society. The population is aging, with the fastest growth in the age group with the greatest potential for needing long-term care—persons over age 85. The elderly have few alternatives for reducing their out-of-pocket health care costs if they become chronically ill. Many elderly face catastrophic expenses and either spend all their wealth on long-term care or transfer financial assets to others in order to qualify for Medicaid.

This *Issue Brief* evaluates demographic changes and health care expenditures of the elderly and the risks associated with chronic health conditions. Existing financing mechanisms are explored, as are alternative approaches to long-term care financing. The financing of long-term care is the most fundamental issue discussed. Other concerns, such as the supply of nursing home beds and the reimbursement practices of Medicare and Medicaid, are raised but require analysis beyond the scope of this *Issue Brief*.

Long-term care refers to health and social services that are provided to the chronically ill and functionally impaired. Long-term care includes an array of services provided informally by family, friends, and volunteers (perhaps 60 to 80 percent of all long-term care) and also includes formal services provided, often through institutions, over extended periods of time. These include skilled-nursing care (such as changing catheters or administering medications), physical and occupational therapy, personal care services (e.g., assistance with bathing, dressing, walking, eating, and using a toilet), counseling, case management and coordination, homemaker services (light housekeeping, meal preparation, and shopping), and chore services (heavier tasks needed to maintain a home). Some services can be provided in a variety of settings, including hospitals, clinics, hospices, nursing homes, adult day care centers, and the home.

◆ The Economic Status of the Elderly

Americans are living longer, but retiring earlier. In the past two decades, life expectancy for the elderly (age 65 and older) has increased. Today's 65-year-olds can expect to live two and one-half years longer than the 65-year-olds of 20 years ago. Labor force participation among men age 65 and over declined from 33.1 percent in 1960 to 16.3 percent in 1984.¹ Retirement planning has come to play an increasingly important role in individuals' and families' decision making.

Individuals over age 65 have experienced measurable gains in financial well-being. Income among the elderly has risen, while poverty rates have declined. In the past 20 years, income among the elderly has risen faster than that of the non-

elderly, so that elderly and nonelderly families now have nearly equal levels of per capita income. In 1984, median income among families age 65 and older was \$18,215, about \$10,000 less than the median income for families headed by an individual younger than age 65. Median income among unrelated elderly individuals was \$7,296, approximately \$6,000 less than that for unrelated individuals age 64 or younger. By 1984, poverty rates for those age 65 and older had dropped nearly 23 percentage points from 35.2 percent in 1959 to 12.4 percent in 1984 (preliminary estimate). Since 1982, poverty among the elderly has been less than the overall poverty rate.²

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One Massachusetts study found that 46 percent of the elderly aged 75 years or older who had been living alone became impoverished within 13 weeks of placement in nursing homes.

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However, the elderly are not a homogeneous group. Age and family composition contribute to variations in personal resources. For instance, elderly with spouses are, on average, better off financially than elderly living alone. In 1982, 85 percent of all married couples had retirement income of \$10,000 or more; only 45 percent of all unmarried individuals reached this threshold. Median annual private pension income for couples (\$4,700) was nearly twice the benefit received by individuals (\$2,417), while median annual Social Security benefits were 53 percent larger for couples (\$7,750) than for individuals (\$5,050).³ Persons age 85 and older are almost twice as likely to be poor as those age 65 to 74. In 1983, 21.3 percent of persons age 85 and older had income below the poverty level, compared to 11.9 percent of persons age 65 to 74.⁴ Furthermore, in 1983, poverty rates among elderly couples were nearly one-fourth the level found among single elderly, and nearly one-third the rate among elderly families headed by females with no husbands present (chart 1).

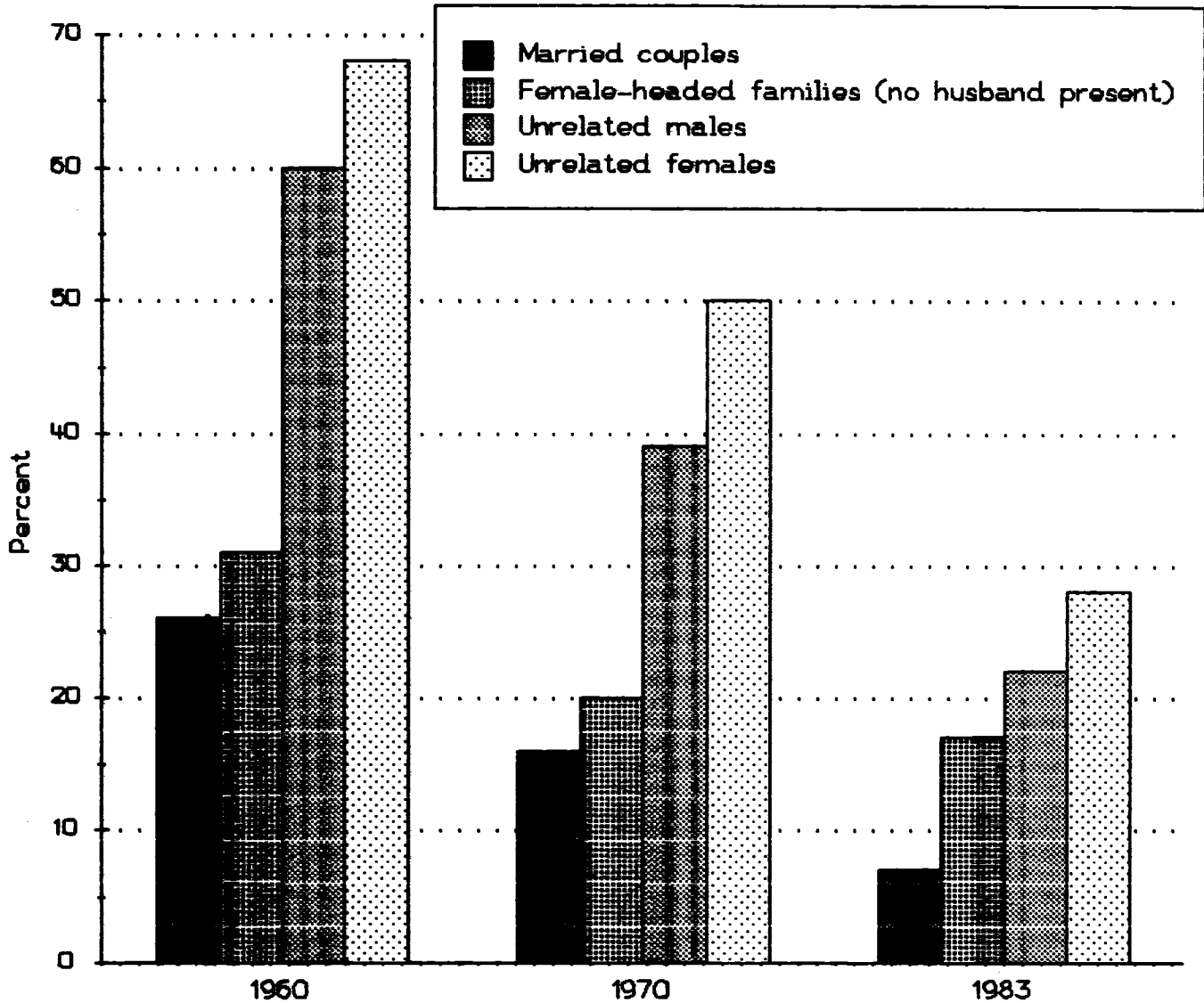
¹ For more information on the retirement decisions and wealth of the elderly see Employee Benefit Research Institute, "Complementing Social Security: Pensions, Earnings, Welfare, and Wealth," *EBRI Issue Brief* 45 (August 1985).

² U.S., Department of Commerce, Bureau of the Census, "Money Income and Poverty Status of Families and Persons in the United States: 1984," *Current Population Reports*, series P-60, no. 149 (Washington, DC: U.S. Government Printing Office [August 1985]), Table 15, p. 21.

³ *EBRI Issue Brief* 45, pp. 5-6.

⁴ G. Lawrence Atkins, "The Economic Status of the Oldest Old," *Milbank Memorial Fund Quarterly/Health and Society* 63, no. 2 (1985), p. 398.

Chart 1
**Percent of People Age 65 and Older with Income
 Below the Poverty Line in 1960, 1970, and 1983**



Source: Council of Economic Advisors, *Economic Report of the President*, 1985.

Compared to the nonelderly population, the elderly are also at greater risk of chronic and degenerative health problems that may lead to institutionalization and eventually to impoverishment. Recent studies have examined the financial risks associated with senile dementia such as Alzheimer's disease.⁵ One such Massachusetts study surveyed elderly individuals

⁵ Senile dementia is a particularly debilitating condition afflicting an estimated 50 percent of the American elderly that reside in nursing homes. About 15 percent of the elderly not residing in nursing homes are also afflicted. Economic costs in the U.S. associated with senile dementia were estimated at nearly \$39 billion in 1983 according to the National Institute on Aging.

and families with heads of household age 75 or older. This study found that 46 percent of the elderly age 75 years or older who had been living alone became impoverished within 13 weeks of placement in nursing homes.⁶

◆ Demographics of the Elderly

The elderly have been the fastest-growing age group in the United States, increasing both in absolute terms and as a percentage of the total population. At the turn of the century, 4 percent of the population, or 3.1 million people, were elderly. By 1980, the elderly had grown to 11.3 percent of the population, or 25.5 million persons. By the year 2030, the number of elderly is projected to double again and to represent 20 percent of the U.S. population.

The older population itself is aging. Individuals over age 85 represent the fastest-growing age group in the population. The number of Americans age 85 and older is projected to increase from 2.6 million in 1980 to 13.3 million by 2040, or from 9 percent of the elderly population to 20 percent. Of the 13.3 million persons age 85 and older in 2040, slightly more than 30 percent may require some type of personal care assistance.⁷

Substantial advances in medical technology have increased the elderly's life expectancy and changed their prevalent causes of death. Better control of high blood pressure, improved surgical and medical treatment of heart disease, and early cancer detection as well as changes in lifestyle (e.g., decreased smoking and more exercise) have been major factors. Reduced incidence of heart disease and stroke has been especially significant in extending the lifespan of the elderly. In 1960, the life expectancy of a 65-year-old woman was 15.8 years, compared to 19 years in 1983. The average life expect-

tancy of a 65-year-old man was 12.8 years in 1960, compared to 14.5 years in 1983.⁸

Living longer has meant that chronic conditions have become major causes of death, disability, and functional dependency. These conditions can afflict individuals for years, impairing their ability to function and necessitating high use of health resources to manage—but not cure—the conditions. Although chronic conditions may include episodes of acute care, the focus of long-term care is to manage chronic problems while maintaining as much of the individual's independence as possible.



More than 70 percent of those who require help with personal care are over the age of 65.



The elderly, especially those over age 85, are at the greatest risk of needing long-term care. The likelihood of needing long-term care services increases with age. In 1977, there were about 13 nursing home residents per 1,000 persons age 65 to 74 and about 216 per 1,000 persons age 85 years and over.⁹ Nearly one-third of the population over the age of 85 requires help with personal care, compared to less than 1 percent of the population under age 45. More than 70 percent of those who require help with personal care are over the age of 65. Of the elderly in need of personal care, 2.6 percent were age 65 to 74 while 31.6 percent were age 85 and over.¹⁰

Most persons requiring long-term care reside within the non-institutionalized community, but the likelihood of needing institutionalized care increases with age. The 1977 National Nursing Home Survey found that 0.3 percent of all nursing home residents were age 45–64, 1.4 percent were age 65–74, 6.4 percent were age 75–84, and 21.6 percent were age 85 or older. This survey in conjunction with the 1977 National Health Interview Survey indicated that of those needing personal care assistance in the 65-to-74 age group, 40 percent resided in nursing homes. For those age 85 and over and in

⁶ U.S., Congress, House Select Committee on Aging, *America's Elderly At Risk*, Committee Print, 99th Cong., 1st sess., July 1985. The survey was conducted by Harvard Medical School and sponsored by the House Select Committee on Aging. The committee sponsored a similar study conducted by Blue Cross and Blue Shield of Massachusetts. That study, which surveyed persons age 66 and older, found that 63 percent of those living alone would be impoverished within 13 weeks of institutionalization, while couples had a 37-percent risk.

⁷ Beth Soldo and Kenneth G. Manton, "Health Status and Service Needs of the Oldest Old: Current Patterns and Future Trends," *Milbank Memorial Fund Quarterly/Health and Society* 63, no. 2 (1985): 286–319; Ira Rosenwaike, "A Demographic Portrait of the Oldest Old," pp. 187–205; and Joan C. Cornoni-Huntley, Daniel J. Foley, Lon R. White, Richard Suzman, Lisa F. Berkman, Denis A. Evans, and Robert B. Wallace, "Epidemiology of Disability in the Oldest Old: Methodological Issues and Preliminary Findings," pp. 350–376.

⁸ U.S., Department of Health and Human Services, Public Health Service, National Center for Health Statistics, *Health United States, 1984*, Pubn. No. PHS 85-1232 (Washington, DC: U.S. Government Printing Office [December 1984]), Table 11, p. 53.

⁹ *Ibid.*, Table 55, p. 116.

¹⁰ Pamela Doty, Korbin Liu, and Joshua Wiener, "An Overview of Long-Term Care," *Health Care Financing Review* 6 (Spring 1985): 69–78.

need of personal care assistance, 61 percent resided in nursing homes.¹¹

◆ Utilization and Health Care Expenses of the Elderly

On average, the elderly's health care utilization and, consequently, personal health care expenditures are much greater than those of the nonelderly. The elderly averaged 1.75 more visits to physicians' offices per person in 1981, and nearly twice as many hospital discharges per 1,000 persons in 1982, than the population as a whole. The elderly's average hospital stay in 1982 was 2.6 days longer than the national average.¹² The elderly spend nearly three times the amount the population as a whole spends on health care, per capita. In 1984, health care expenditures by those age 65 and older exceeded \$119 billion, while the expenditures of those under age 65 were \$267.5 billion. For the elderly, the largest expenditure category in 1984 was hospitals (\$54.2 billion), followed by nursing homes (\$25.1 billion) and physicians (\$24.8 billion); all other care accounted for \$15.8 billion (chart 2).

Nursing home care represents the elderly's second-largest expenditure category, but is their largest source of out-of-pocket expenditures. Among the 1.3 million elderly persons in nursing homes, about half are covered by Medicaid. More will eventually exhaust their financial resources and become eligible for Medicaid. Private out-of-pocket expenditures financed 50.1 percent of all nursing home care in 1984. Private insurance plans financed only 1.1 percent. Medicaid purchased 41.5 percent of all nursing home care, while Medicare's portion was 2.1 percent (chart 3).

On average, the elderly's out-of-pocket expenses for health care are large and are expected to increase. Out-of-pocket health care expenses excluding health insurance premiums for the elderly in 1984 averaged \$1,059 per person—21.4 percent of the elderly's median income. By 1990 it is expected to average \$2,583.¹³

◆ Public Financing of Long-Term Care

Medicaid

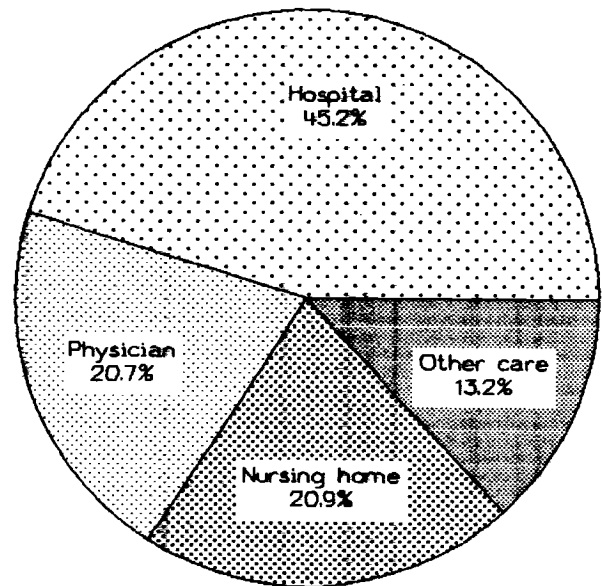
Medicaid is the major source of public financing for long-term care. Federal law requires states to cover services pro-

¹¹ Patrice Hirsch Feinstein, Marian Gornick, and Jay N. Greenberg, "The Need for New Approaches in Long-Term Care," in *Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives*, conference proceedings, pp. 7-12. U.S., Department of Health and Human Services, Health Care Financing Administration, Pubn. No. HCFA 03174 (Washington, DC: U.S. Government Printing Office [June 1984]).

¹² *Health United States, 1984*, Table 44, p. 99, and Table 50, p. 108.

¹³ House Select Committee on Aging, p. 20.

Chart 2
Distribution of Personal Health Care Expenditures Per Capita for People 65 Years of Age and Older, by Type of Service, FY 1984



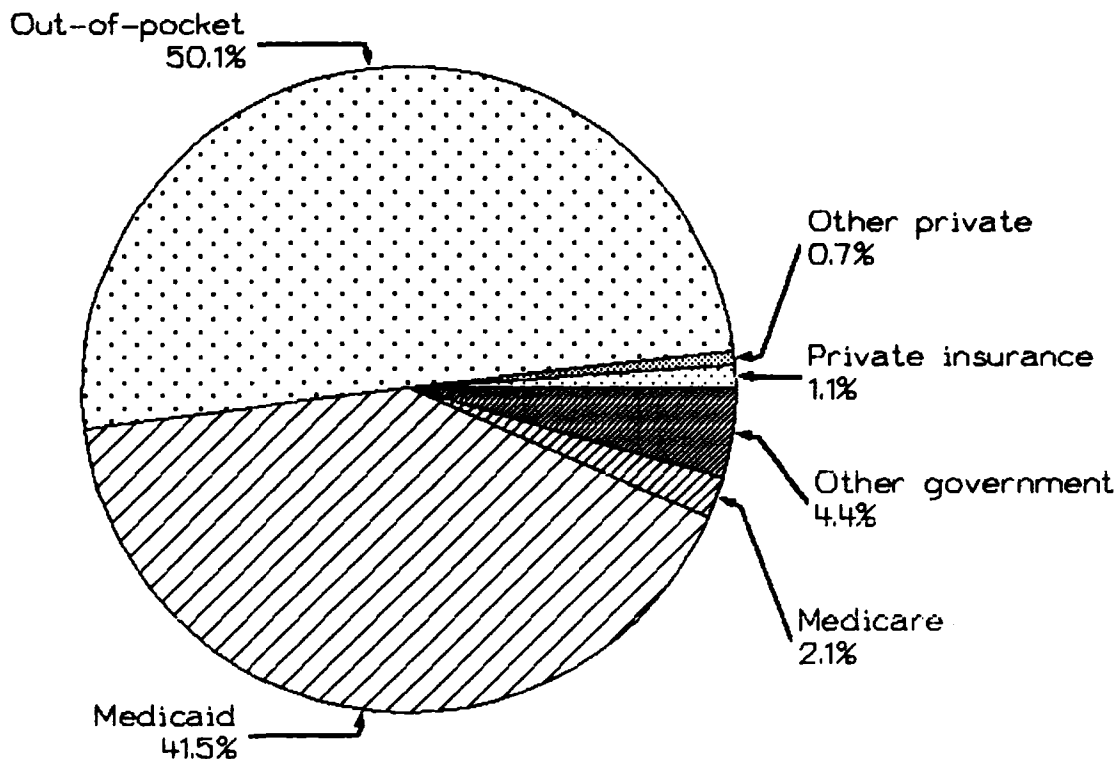
Source: Office of Financial and Actuarial Analysis, Health Care Financing Administration.

vided in skilled-nursing facilities (SNFs) for Medicaid recipients over age 21. In addition, states may cover SNF care for recipients under age 21, the service of intermediate care facilities (ICFs) and ICFs for the mentally retarded (ICFMRs), and institutional care for mental disease for persons under age 21 and for those age 65 and over.

Medicaid has been the fastest-growing component of many state budgets, and long-term care has been the fastest-growing portion of Medicaid spending. Between 1975 and 1980 Medicaid spending for long-term care rose at an annual rate of 17 percent, compared to 15 percent for all Medicaid spending. By 1983, Medicaid spending for long-term care was \$15.4 billion, or 48 percent of total Medicaid spending. Nursing home spending was the largest component of long-term care aggregate spending, accounting for over 36 percent of Medicaid expenditures. Nursing home expenditures are ranked within each state as Medicaid's largest or second-largest expenditure category.

In states with Medicaid programs that encompass the medically needy, nursing home expenses are covered once health care costs become greater than an individual's Medicaid-recognized assets. Thirty-one states have incorporated medically needy programs into Medicaid. Over one-half of the people

Chart 3
**Distribution of Nursing Home Expenditures Per Capita for People
 65 Years of Age and Older, by Source of Funds, FY 1984**



Source: Office of Financial and Actuarial Analysis, Health Care Financing Administration.

covered by Medicaid in nursing homes were not on Medicaid upon entering but became eligible by "spending down" (depleting) their assets until medical costs exceeded net wealth.

The promise of Medicaid eligibility after depletion of one's assets provides strong incentives for transferring personal assets to others prior to needing long-term care. It is unknown how extensively assets are transferred to receive medical assistance, but tangential evidence suggests that it is not minimal. Attorneys advertise expertise in transferring or sheltering assets to assist families in qualifying for Medicaid. State laws governing asset transfers have grown increasingly strict, regulating asset valuation and lengthening the required waiting period between asset transfer and application for Medicaid benefits.

State and federal inheritance and gift taxes may also encourage the transfer of assets prior to needing long-term care. The

effect of Medicaid program incentives and state and federal gift and inheritance taxes are probably complementary, but the relative impact of each has not been studied.

The absence of private insurance alternatives to Medicaid for financing long-term care further encourages the elderly to seek ways to become Medicaid-eligible. Paradoxically, however, the Medicaid program may make it more difficult for private insurers to market coverage for catastrophic chronic-care costs. Misconceptions about the coverage now provided by private health insurance plans, Medicare, and Medicaid, and failure to recognize the risk of high health care costs associated with aging foster a public illusion that the probability of needing long-term care is small and that if it is needed, the financing will come "from somewhere."

The preeminence of Medicaid in financing long-term care has

also created some problems in service delivery. Medicaid coverage tends to be institutional rather than home- or community-based and has encouraged a delivery system that is biased toward institutionalization.

Medicaid's low reimbursement levels and cumbersome system of claims filing have also affected the nursing home market. Facilities that accept Medicaid patients have long queues for admission, while nursing homes that accept only private-pay patients generally have beds readily available. In some areas, however, nursing home beds may become scarce for private-pay patients as states restrict the overall number of new beds in the belief that this action will contain Medicaid expenditures. Flat-rate or cost-based reimbursement, moreover, has encouraged nursing homes that accept Medicaid payment to prefer patients who are the least sick or to over-provide billable services and supplies.¹⁴ These incentives have resulted in instances where too many services were provided to those less in need of institutional care, while not enough services were provided to those in greater need of care.

Medicare

Medicare was enacted in 1965 to finance acute care for the elderly and, subsequently, the disabled. Medicare does pay for some nursing home care, but the level and limits of coverage target post-acute care. Medicare pays only for nursing home stays that begin within 30 days of discharge from a hospital stay of three or more consecutive days. Furthermore, Medicare covers only care provided in skilled-nursing facilities and limits benefits to 100 days per benefit period (spell of illness). The first 20 days of Medicare-paid SNF care require no copayment; after 20 days a \$50-per-day copayment is required. In 1980, Medicare covered an average of 30 days of skilled-nursing care, much less than the average length of stay of 456 days for all nursing home care.¹⁵

Medicare also covers an unlimited number of home health care visits. To qualify for coverage, a beneficiary must be under the care of a physician, be homebound, and need part-time, skilled-nursing care (or physical or speech therapy) on an intermittent basis. The intermittent care requirement, however, has been interpreted by the Health Care Financing Administration as the need for home health care less than three days a week. Home health expenditures are less than 3 percent of Medicare's total costs but are growing rapidly.

From 1974 to 1980 the annual growth rate was 34 percent. Doty et al. have estimated that only one-third of this increase was due to price inflation; almost one-half was due to an increase in the proportion of beneficiaries utilizing home health services; 8 percent was because of an increased number of visits per person; 10 percent resulted from growth in the overall number of Medicare beneficiaries. Medicare home health care expenditures doubled from \$722 million in 1980 to \$1.5 billion in 1983, an annual compounded growth rate of 26 percent.¹⁶

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Since November 1983, Medicare also has covered a limited amount of hospice care (care for the terminally ill). Although this coverage is authorized as a three-year trial, provision of hospice coverage as a regular Medicare benefit is included in the budget reconciliation proposals currently before Congress.

Other Federal Programs

Many smaller federal programs together financed 5.6 percent (\$6.7 billion) of the elderly's total health care expenditures in 1984. These programs include nursing home and personal care for elderly veterans provided by the Veterans Administration; home-delivered meals, congregate meals, and some in-home support services financed under Title III of the Older Americans Act; social services financed under Title XX of the Social Security Act; a variety of programs financed through the alcohol, drug abuse, and mental health block grant, and programs funded through the Developmental Disabilities Assistance and Bill of Rights Act. Of this \$6.7 billion, nearly three-fourths (73.2 percent) went to purchase hospital services, followed by nursing home care (16.5 percent), other care (7.9 percent), and physician services (2.4 percent).¹⁷

◆ Alternative Financing for Long-Term Care

Recognizing the likely consequences of demographic trends, technological advances in medicine, and a general squeeze on social spending, there has been growing concern over whether resources are adequate to finance the enormous cost

¹⁶ Ibid.

¹⁷ Doty et al.

¹⁴ The inability to place Medicaid patients in nursing homes has prompted states to consider alternative reimbursement schemes. One fairly successful scheme implemented by the Maryland Medical Assistance Program makes payments based on one of four levels of care. Although capital costs are still reimbursed based on actual cost, patient reimbursement is an all-inclusive rate. Lack of placement is very costly since it usually means extending the hospital stay, which can be two to four times the daily rate at a nursing home.

¹⁵ Doty et al.

of long-term care. Many consider the current system of financing long-term care inadequate because the financial burden can be very large relative to retirement income and accumulated wealth. At a cost of \$2,100 to \$4,500 a month, the expense of receiving care in a nursing facility can exceed retirement income, wiping out a lifetime's savings.

The problem, however, is that there is no obvious financing mechanism one can use to help meet long-term care costs in advance of the time they are incurred. Although a private insurance market exists for acute care not financed by Medicare, no comparable market for private long-term care insurance has been developed. A public mechanism—Medicaid—exists, but this is a means-tested program that was not intended to finance the long-term care costs of all elderly.

Approaches to financing long-term care could be purely public, like an extended Medicaid or Medicare program; purely private, by encouraging long-term care insurance; or a mixture.

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More than likely, long-term care financing will be addressed as a cooperative arrangement between the public and private sectors.

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A purely public approach could be organized in a manner that resembles Medicare. Coverage could be mandatory or voluntary and financed through premiums, general revenues, or both. One advantage of this approach is that participation would be among a broad population at risk of using long-term care; those at immediate risk of needing long-term care would not be the only ones selecting the insurance. To the extent that it is mandatory and/or financed through general revenues, the financial risk would be shared by all. Furthermore, the Medicare model might avoid the stigma of a means-tested welfare program. The disadvantage of this approach is that the benefits structured by the political process may be different from those individuals would choose, potentially producing expensive benefits that may not serve individuals' needs.

Purely private financing would have the free market determine the types of insurance available. The advantages of this approach are that the individual would be free to choose a policy that would complement his or her particular financial and family circumstances. The disadvantage of this approach is that individuals may not adequately assess the risk of needing long-term care. Alternatively, they may wait until retirement to purchase coverage, when the risk of needing long-term care is so high that premiums are prohibitive. If many

elderly were unable to afford the insurance, society would be faced with having to decide what to do about individuals who lacked adequate health care.

More than likely, long-term care financing will be addressed as a cooperative arrangement between the public and private sectors. Public involvement may take the form of assurances or assistance in developing widescale private markets. In addition, the public sector will probably continue to safeguard access to health care by poor elderly.

Financing Alternatives

Many financing alternatives have been suggested. The options receiving the most attention are private initiatives that include private insurance for long-term care, life-care communities, and social/health maintenance organizations (S/HMOs). Some attention has been focused on mechanisms to facilitate personal funding of long-term care, including converting home equity into cash and establishing individual retirement accounts (IRAs) for medical purposes—"medical IRAs." This is not an exhaustive listing of options, nor are the alternatives mutually exclusive. A brief description of the most widely discussed approaches follows.

Long-Term Care Insurance—Private insurance for long-term care is available, although not in all states, from at least 13 carriers; approximately 50,000 individuals are currently covered.¹⁸ These policies typically offer indemnity benefits in SNFs (ranging from \$10 to \$50 a day) for three to four years and may also cover custodial and intermediate care, as well as home health care. Premiums are commonly based on age and vary by the indemnity level and waiting period chosen.¹⁹

The feasibility of developing a private long-term care insurance market is a commercial concern for private insurers, as well as a policy concern for government. Numerous studies of

¹⁸ See Mark R. Meiners, "The State of the Art in Long-Term Care Insurance," U.S., Department of Health and Human Services, Public Health Service, National Center for Health Services Research, Pubn. No. NCHSR 84-67 (Washington, DC: U.S. Government Printing Office [April 9, 1984]); Meiners and Gordon Trapnell, "Long-Term Care Insurance: Premium Estimates for Prototype Policies," *Medical Care* 22 (October 1984): 901-911; "Private Financing of Long-Term Care: Current Methods and Resources, Phase I, Final Report" (Washington, DC: ICF Incorporated [January 1985]), submitted to Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

¹⁹ Fireman's Fund, which has the most experience underwriting this coverage, has 7,000 long-term care insurance policyholders. Based on seven years of experience, Fireman's Fund reports that the average policyholder age is 78, the average beneficiary age 83, and the average length of stay in a nursing facility 256 days. See ICF Incorporated.

existing policies, many sponsored by the federal government, as well as private market testing have been under way.²⁰ The Health Insurance Association of America has examined this issue and established broad guidelines for putting together a private insurance product.²¹

Estimates based on both existing and prototype policies suggest that many elderly could afford insurance coverage for long-term care. EBRI estimates suggest that long-term care insurance premiums may be less than 5 percent of 1984 cash income for 21 percent of families with a member over age 65 (chart 4).²² If families had purchased coverage at a younger age, premium levels would have been lower, both absolutely and as a percent of cash income. These prototype policies, it should be noted, do not adjust for any insurance-induced demand—that is, use of services that would not occur in the absence of the insurance coverage. If long-term care insurance increases utilization of services, premiums will increase.

The low rate of long-term care coverage among the elderly population may be related to four factors:

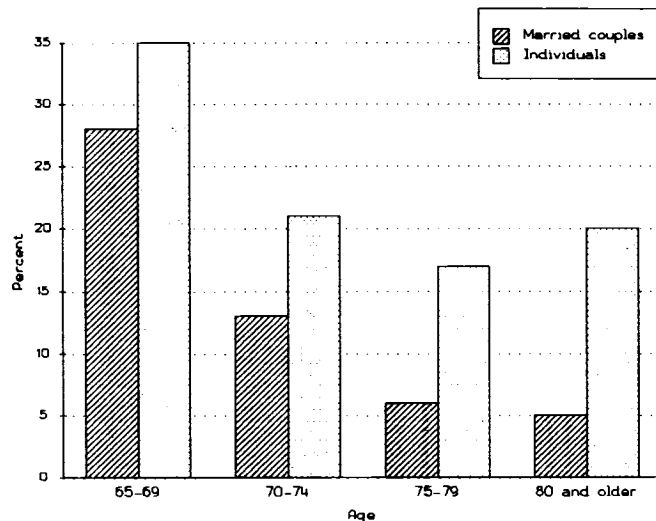
- for the most part long-term care insurance has been sold to individuals rather than to groups, making it more expensive;
- because of limited actuarial experience and the difficulty of defining some long-term care services, insurers have been very cautious in offering coverage—covering well-recognized, medically oriented benefits; using extensive screening to identify low-risk buyers; and providing partial indemnity rather than service coverage, with high deductibles;
- state regulations vary and in some places may inhibit the development of an affordable insurance product. In many states, long-term care insurance may be regulated as Medicare supplement (Medigap) insurance, mandating the coverage of specific benefits and imposing specific minimums for short-term losses relative to insurers' premium income. While these regulations are intended to protect the consumer, they tend to ignore differences in insurance policies and the event being insured. Long-term care insurance is substantially different from Medigap and may need regulation that accounts for these differences; and

²⁰ For examples see Meiners and Trapnell and ICF Incorporated. The Prudential Insurance Company of America recently released a test product to a random selection of AARP members in six states.

²¹ "Long-Term Care: The Challenge to Society" (Washington, DC: Health Insurance Association of America [1984]).

²² This is based on the estimated premium for a comprehensive prototype insurance policy. See Meiners and Trapnell.

Chart 4
Percent of Families for Whom Long-Term Care Insurance Premiums Would Be Less Than 5 Percent of Cash Income, 1984*



*Premiums are based on estimates (in 1984 dollars) of a prototype comprehensive policy developed by Mark Meiners and Gordon Trapnell. It assumes an annual premium for an individual age 65-69 of \$761; age 70-74, \$978; and age 80 and older, \$1,304. Premiums for married couples are assumed to be twice these levels. Source: EBRI analysis of the March 1985 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

- the existence of Medicaid as a "free" long-term care insurance policy may make it difficult to sell private policies.

Efforts to remove some of these barriers and facilitate development of private long-term care insurance, however, are under way. Insurance companies are gaining experience in offering this coverage. Federal legislation designed to assist private initiatives has been proposed. Finally, states are examining their insurance laws to be sure that the laws do not discourage the development of private insurance, since they expect private insurance to reduce Medicaid expenditures.²³

Life Care Community Centers—Sometimes referred to as continuing-care retirement communities, life care centers attempt to provide all services a relatively ambulatory elderly person would need from date of entry until death. A typical center has a campus appearance and contains an apartment complex, a dining facility, an activity center, and a nursing-care

²³ See Mark Meiners, "Long-Term Care Insurance," *Generations* 9 (Summer 1985): 39-42.

facility capable of providing skilled, intermediate, and custodial care. Individuals are provided the opportunity to live as independently as they can in surroundings that are secure and geared to an elderly community. For residents with medical problems, home health care or use of the nursing-care facility is provided; hospital care is provided outside the community center. Social activities are included and the centers often have a mechanism for self-governance.

Life-care residency is typically financed through entrance fees and monthly fees. Some centers affiliated with religious organizations, however, may require assignment of all assets at entry. The monthly fees usually do not cover all medical expenses.

Life care centers are not new in concept, but viewing them as a major means of financing chronic care is. Although many centers have existed for over 30 years, not much is known about them. For example, estimates of the number of care centers in 1979 range from 275²⁴ to 600.²⁵ Growing interest in life-care centers has accompanied concern about appropriate protection for residents, since few regulations govern either the financing or the health aspects of these centers. Several well-publicized business failures have heightened these concerns.

In any case, life care centers may not be affordable for many elderly. The cost for a single one-bedroom accommodation may range from nearly \$50,000 (with a monthly payment of nearly \$900) to more than \$80,000 (with a monthly payment of more than \$1,300). Monthly fees for the nursing-home care pose an additional cost.²⁶ Despite the expense, approximately 1 million to 1.3 million individuals over the age of 75 currently may have sufficient assets and income to enter life care centers.²⁷

Social/Health Maintenance Organizations—The S/HMO, a concept developed at Brandeis University, extends the HMO acute-care model of case management and prepaid financing to long-term care. The S/HMO is at financial risk for both acute and long-term care services, and therefore has every incentive to encourage the most appropriate utilization of services. Presently four S/HMOs are operating as three-and-one-half-year demonstration projects funded, in part, by the Health Care Financing Administration.

The financial success of S/HMOs relies on enrolling members that are similar to the population average in terms of their

chronic-care needs. However, since membership in S/HMOs is voluntary, adverse selection is likely to be a problem—that is, those in immediate need of care are most likely to enroll. Current experiments, however, should provide enrollment information that might be used in the private development of commercial S/HMOs.²⁸

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The illiquidity of home equity and the importance of a home as shelter create problems in converting home equity to finance large health care expenditures.

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Personal Resources—The most important asset of many elderly is home equity. However, the illiquidity of home equity and the importance of a home as shelter create problems in converting home equity to finance large health care expenditures. A forced sale can produce a low return. In addition, persons who sell their homes to finance health care may face major changes at a time when they are physically or emotionally incapable of coping with such change. Home equity conversion—converting home equity into income without requiring the family to leave their home—offers one option for overcoming these problems. Two basic types of home equity conversion are reverse mortgages and sale leasebacks.²⁹

Reverse mortgages provide a stream of monthly loan advances to the homeowner. Repayment of these advances is deferred until the homeowner moves or dies. In the meantime, the elderly homeowner retains the title. Appreciation in the home's value during the loan period typically belongs to the homeowner or family estate. Some reverse mortgages, however, allow the loan grantor to share in the appreciation.

In a sale leaseback plan, the home is sold to an investor; the former homeowner retains the right to rent the home for life. Each month the investor pays the former owner and in exchange receives a rent payment. Upon the former homeowner's death or change of residence, all rights associated with

²⁴ Howard E. Winklevoss and Alwyn V. Powell, *Continuing Care Retirement Communities: An Empirical, Financial, and Legal Analysis* (Homewood, IL: Richard D. Irwin, Inc. [1984]).

²⁵ Frankel, "Life Care Communities: Housing for Both the Active and the Infirm Elderly," *Journal of Property Management* (March-April 1979).

²⁶ ICF Incorporated, Table 9, p. 41.

²⁷ ICF Incorporated, Tables 30 and 31, pp. 74–75.

²⁸ For more information, see Jay N. Greenberg and Walter N. Leutz, "The Social/Health Maintenance Organization and Its Role in Reforming the Long-Term Care System," *Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives*, pp. 57–65. The S/HMO demonstration projects began in January 1985.

²⁹ Employee Benefit Research Institute, "Reverse Annuity Mortgages: A Viable Source of Retirement Income?," *EBRI Issue Brief* 12 (September 1982).

the house belong to the investor. Appreciation during this rental period also belongs to the investor, as does the responsibility of maintenance and taxes.

Only a few private- and public-sector programs facilitate home equity conversions;³⁰ participation in these programs is negligible, perhaps because of the attitudes many elderly have toward sale of their homes and because of regulatory uncertainty. Moreover, potential lenders may be reluctant to enter reverse mortgage contracts without mortgage guarantee insurance. Mortgage guarantee insurance would insure that lenders are not put in the position of requiring the elderly to sell their homes when the loan term has expired. This insurance is not widely available. Finally, uncertainty about federal taxation may foster reluctance to enter a sale leaseback arrangement. Homeowners may be unwilling to relinquish their homes under contracts that are unfamiliar to them; home equity conversions are relatively new and extremely complicated.

In any case, home equity conversion may have little potential for helping the elderly to purchase long-term care services. A \$50,000 home, for example, may produce an annuity value of between \$195 and \$475 per month, depending on the conversion plan used.³¹

Establishing tax-preferred savings instruments such as IRAs for medical purposes has been proposed as another solution. This approach would allow an individual to defer paying taxes on contributions and on interest earned in the account. Some proposals, such as the Health Care Savings Account Act (H.R. 3505), introduced by Rep. D. French Slaughter (R-VA), would provide a tax credit for making contributions to the account. In this particular proposal, disbursements from the account would not be considered as income for tax purposes as long as the disbursements are for eligible medical expenses and the individual is eligible for Medicare.

Since "medical IRAs" would be less liquid than regular IRAs, the tax advantages would have to be relatively great to foster their widespread use. EBRI tabulations of the May 1983 EBRI/U.S. Department of Health and Human Services Current Population Survey pension supplement indicate that participation in regular IRAs is not widespread: only 17 percent of workers had IRAs in 1982.³² Increased tax advantages

could outweigh disadvantages associated with restricting "medical IRA" withdrawals to the purchase of health care. However, for the savings to amount to a meaningful sum, individuals must assess the risk of needing long-term care early in their financial planning.

◆ Conclusion

On average, the financial well-being of the elderly has improved significantly over the last 20 years. The incidence of poverty among the elderly has declined, and the elderly are living longer. But while medical technology and changes in lifestyle are extending life expectancy, the likelihood that the elderly will need chronic health care is growing. Increases in the elderly population imply an increasing demand for long-term care services and an increasing need to use health care resources efficiently.

The ability of some older individuals to finance long-term care is limited by the type of wealth usually held and by the source of income. Most elderly receive retirement income from fixed annuities and most of their wealth is in the form of homeowner equity. Although financial instruments to convert home equity to cash income are available, few elderly have been willing to relinquish ownership of their homes, even if they retain a lifetime right to continued residence.

In fact, there are strong incentives for the elderly to divest their wealth before long-term care is needed. Federal and state gift and inheritance taxes and the existence of Medicaid provide incentives to bequest wealth before death. Even if assets are not transferred, chances are still good that they will be expended, forcing the individual to apply for medical assistance through the Medicaid program.

Historically, the net result of Medicaid-financed long-term care has been to direct long-term care services and resources to institutional care. Medicaid regulators recently began evaluating alternatives to the institutional and reimbursement biases inherent in Medicaid practices. Over the last few years, state demonstration projects have experimented with expanded home- and community-based services, case-management, and prospective rate setting.

The problems of efficiently financing long-term care exist now. Pressure on long-term care resources will continue to grow as the population continues to age. Solving the problems of financing long-term care and efficiently providing long-term care services will require innovation and the attention of everyone affected—government, providers, and the growing ranks of potential consumers.

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³⁰ Bruce Jacobs and William Weissert, "Home Equity Financing of Long-Term Care for the Elderly," in *Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives*, pp. 82-94.

³¹ ICF Incorporated, "Private Financing of Long-Term Care: Current Methods and Resources, Phase II, Final Report," (Washington, DC: ICF Incorporated [January 1985]), pp. 15-24; submitted to Office of the Assistant Secretary for Policy Evaluation, U.S. Department of Health and Human Services.

³² Emily S. Andrews, *The Changing Profile of Pensions in America* (Washington, DC: Employee Benefit Research Institute [1985]), Table IV.5, p. 82.

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