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Funding Long-Term Care

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Introduction

The aging of baby boomers is raising concern over their long-term care needs. How to pay for long-term care services is a major component of that concern. At present, out-of-pocket payment (from personal income and savings) and public welfare (Medicaid) combined account for 70% of the total cost of formal (paid) long-term care, with social and private insurance playing a minor role. This method of funding is unlikely to be sustainable because it tends to impoverish many people and thereby severely strains Medicaid budgets nationwide.

A better funding method could be found by (a), more widespread use of the insurance principle for both private- and public-sector programs, and (b), linking several sources of funds in each sector that already exist to generate resources to pay for both social and private insurance. Therefore, this paper proposes a new funding model, one in which social insurance and private insurance will pay for the bulk of the costs, supplemented by personal payment. When these three sources fail to provide for some individuals, public welfare (Medicaid) will serve as a safety net. These are the same sources of funds presently in use, but will be deployed vastly differently in the proposed model.

I. The Aging of the Elderly Population

In just over a decade, the baby boomers will begin to turn age 65. Over the next 40 years, the number of people aged 65 or older is expected to more than double.

More specifically, the new challenge in the next decades will be the aging of the elderly population. The age group 65–84 is estimated to increase by more than 50 percent in 20 years (from 30.5 million in 2000 to 47 million in 2020), and more than double in 40 years (to 62.9 million in 2040). More impressive is the 85 and older group, which is expected to grow by one-third in 20 years (from 4.3 million in 2000 to 6.8 million in 2020), and more than triple in 40 years (to 14.3 million in 2040).

The projected growth of those 85 and older invites concern because frailty is more common at advanced ages. It is difficult to forecast, though, because of

uncertainty about the effects of better health care and improved lifestyles on the incidence of dependency.

Declines in chronic disability rates among persons aged 65 and older were reported for 1982–1999. Even as the proportion of disabled elderly among the population declines, their absolute number is estimated to grow from 8.8 million in 2000 to 10.4 billion in 2020 and to 12.1 million in 2040. In other words, the implied growth in need for long-term care services is substantial because the projected decline in the disability rate will not be sufficient to offset the projected rise in the elderly population, especially those in the more advanced ages.

II. How Long-Term Care Expenditures are Paid Today

The uncertain need for long-term care services is a recognized risk that may carry with it substantial—even catastrophic—financial consequences to an individual or his or her family, but it actually occurs only to a relatively small and predictable proportion of persons in a population at any one time. Therefore, the most sensible approach to paying for this type of contingency is to use insurance mechanisms.

In practice, however, insurance is used in a limited way to fund long-term care by either the public or private sector. Combined, out-of-pocket payment and Medicaid defrayed 70 percent of the total expenditures, as noted earlier. Out-of-pocket payment—sometimes called self-insurance—fails to use the insurance principle of pooling risks. Self-insurance, by definition, is assuming the risk by oneself, rather than with others in a large group of persons exposed to the same type of risk.

Medicaid similarly lacks risk pooling, although some analysts regard it as a public insurance program. Labeling Medicaid—a welfare program—as insurance appears to use the term in a vernacular sense ("something to fall back on"), rather than in its actuarial sense, in terms of risk pooling among a large number of persons exposed to the same type of risk.

Traditionally, the bulk of long-term care services have been provided by informal (non-paid) caregivers of families and friends. During the last 30 years, increased labor force participation by women and changes in family patterns may have made such care less available. Despite these developments, informal

care is still highly important. Over the years, formal (paid) care has also become more prevalent.

The future demand for formal care may be expected to rise because these demographic trends would most likely result in a smaller pool of available informal caregivers. Persons in their 80s and 90s at present formed their families in the 1950s and 1960s when fertility rates were still high. For them, the supply of potential family caregivers would not have declined.

In contrast, when persons who reared their children in the 1970s–1990s arrive at ages when they will be more at risk of long-term care services, the supply of informal caregivers is expected to decline. These trends are similar in many countries in North America, Europe and Japan. It is therefore important to review how formal long-term care services are paid for at present.

III. Directions of Policy Reform: Sharing Public and Private Responsibilities

Heavy reliance on out-of-pocket payment and public welfare has spawned many calls for reform over the years. Reform ideas have revolved around social and private insurance. Expanding Medicare to include long-term care has been suggested. Creating a new long-term care program using social insurance has also been suggested. Private insurance has been considered an additional source of funding. There are tax deductions or credits to encourage the purchase of such policies. More tax incentives have also been proposed; however, tax incentives result in tax expenditures.

In short, in the debate on how to reform the way we pay for long-term care, all proposals face the same question of how to obtain additional funding. Many have come to realize that neither the public nor the private sector has the financial wherewithal to meet the high and growing long-term care costs. A significant challenge for policymakers is how to secure funding from both public and private sectors. New approaches are needed.

IV. The Trade-Off Principle

This paper proposes a new funding model in which social insurance will provide a basic layer of protection to be supplemented by private insurance and personal payment. Assuming acceptance of this model, where might the funds for a new social insurance program and for the purchase of private insurance be found? Many people seem unable or unwilling to devote new resources for meeting long-term care costs. At least part of this may stem from the fact that people, in general, tend to compartmentalize or categorize their total resources (financial and non-financial assets as well as income) into different expenditure items such as food, housing and the like. Once compartmentalized or categorized, resources will only be available for designated purposes or accounts.

Merging resources could then increase the total utility of existing resources for meeting various costs. In order to merge or combine resources together, it is necessary to create linkages in both public and private sectors. Therefore, this paper suggests the use of the trade-off principle.

The trade-off principle can be applied in both the public and private sectors. In the public sector, long-term care coverage may be provided in a trade-off with Social Security cash benefits or with federal or state and local government, employee retirement benefits. In the private sector, private long-term care insurance coverage may be provided in a trade-off with life insurance or annuity; private pensions; individual retirement accounts or IRAs; employment-based savings mechanisms such as 401(k) accounts or Keogh plans; or home equity conversion, such as reverse mortgages. Therefore, the concept of trade-off is ideologically and politically neutral in that it favors neither social nor private insurance; it can apply to either or both.

While the trade-off is suggested to generate new funding for long-term care when government resources are not available and when individuals are either unable or unwilling to devote new dollars for it, the suggested method does not imply that the trade-off will cover all long-term care needs. Far from it—implementation of the trade-off principle in the public sector would still leave much room for private-sector initiatives such as personal insurance and personal saving.

V. Observations of Cognitive Psychology/Behavioral Economics

The policy prescriptions suggested above that promote widespread use of insurance mechanisms and create linkages between sources of funds are undergirded by these two basic ideas: risk aversion to potentially large financial losses and fungibility of income and assets. However, risk aversion and fungibility are the concepts that may be challenged by cognitive psychology/ behavioral economics concerning observations of how people make choices.

Traditional economic theory assumes that people seek to maximize the satisfaction from making market decisions about consumption, saving and investment. Satisfaction is the utility they derive from these activities. Economics thus assumes utility-maximizing rationality on the part of consumers, savers and investors. But, cognitive psychologists note that people do not always behave in a logical, consistent manner to maximize utility, either as an individual or on behalf of a firm or an organization.

For the purposes of this paper, two behavioral tendencies or biases—loss aversion and mental accounting—are of particular interest in understanding (a),

the lack of utility-maximizing rationality in the use of insurance mechanisms and (b), the scarcity of funding for long-term care.

Loss aversion poses a barrier to utility-maximization rationality. Psychological experiments have suggested that people actually make decisions differently regarding the possibility of gains and the possibilities of losses. People feel the pain of a loss more acutely than the pleasure of a gain of equal size. As a consequence, they feel far worse about having made losing choices than they do about not having made winning choices. Therefore, loss aversion—not risk aversion—is important in influencing decision-making. People often delay making a decision about risk because they might regret the consequences of the decision.

Mental accounting creates another barrier to utility-maximizing rationality. Mental accounting means that people tend to separate a whole into its components. Instead of looking at the totality of the circumstance, including other risks and making decisions related to it, as the utility theory would suggest, people tend to judge financial risks in isolation. Mental accounting may be behind the decision of individuals and businesses that often make insurance purchase decisions on a case-by-case basis, rather than considering their entire financial and risk positions.

Based on cognitive psychology, the challenge behavioral economics poses to the standard assumption of utility maximization rationality in economics also poses a challenge to the ideas presented in this paper. Therefore, it is necessary to identify and confront the particular behavioral phenomena that result in the problems observed in funding long-term care.

Limited use of insurance seems to result from loss aversion. And the lack of resources appears to be a consequence of compartmentalization of budgets. If loss aversion predominates over risk aversion, then promoting more use of public and private insurance will lose much of its persuasive power. And, if non-fungibility is the rule by which people make their purchasing, saving and investing decisions, then the idea of trade-off will probably be ignored.

It is necessary, therefore, to remove these impediments. To remedy loss aversion, one could attempt to reduce the problem of "use it or lose it", relative to the stand-alone long-term care insurance policy, by linking it to life insurance or annuity. To overcome the non-fungibility consequence of mental accounting, the

budget category could be broadened, by merging long-term care needs into retirement income needs. These ideas will be outlined in the following sections.

VI. Creating Social Insurance for Long-Term Care: A Social Security/Long-Term Care Plan

Applying the trade-off principle in the public sector, one could fund a social insurance program for providing basic coverage for long-term care by diverting a small portion of a retiree's Social Security cash benefits for this purpose. This trade-off can be called a "Social Security/Long-term Care (SS/LTC) Plan", in which retirees would trade off a small portion of their current benefits to join SS/LTC. SS/LTC would then exempt low-income Social Security beneficiaries from the trade-off. Closest to the suggested SS/LTC is a proposal to tax Social Security benefits for long-term care.

How to Start SS/LTC

The new plan could be implemented using a Long-term Care Trust Fund, like those for Social Security and Medicare programs. To illustrate, assume that the SS/LTC plan had become law in January 1996 and would build up a trust fund using the increase in the cost-of-living adjustments (COLA) to phase in the system, as described below.

The new plan would divert a portion of the COLA into the LTC Trust Fund starting January 1, 1996. Each year thereafter, the rate would rise by one percentage point to the ultimate level of five percent, beginning in January 2000, and continuing into future years. Long-term care coverage would begin on January 1, 2000, in an arrangement similar to how Social Security began. (Social Security started collecting payroll taxes on January 1, 1937. It began paying the first monthly Social Security benefits on January 1, 1940, two years in advance of the starting date under the original legislation.)

Basic Long-term Care Coverage

What might be the expected long-term care coverage from the suggested SS/LTC? Assuming the program is administered by the government in a manner similar to that used for Medicare, administrative costs would indeed be essentially negligible, with mandatory participation. This new program may

induce higher demand; nursing home use, therefore, may be expected to increase by 10–20 percent. This increase in cost could be offset by setting the daily coverage amount at about 85 percent of customary and reasonable charges.

The costs for nursing home and home health services may continue to rise for some time at a rate faster than average earnings' increase. Therefore, the five percent SS/LTC plan may provide one year of coverage only at 85 percent of customary and reasonable charges after a 90-day waiting period, two years of home health care, or a combination of these two benefits.

The idea of trading one type of benefit for another (in this case, Social Security for long-term care) has been applied in employee benefit programs in the private sector under the rubric of "cafeteria plans". Still, SS/LTC represents a shift in the entitlement paradigm and a change in the way one thinks about benefits under government programs. Therefore, the idea should be greeted with reservation, resistance or rejection.

Some Pros and Cons of SS/LTC

The SS/LTC plan has been subject to scrutiny by health policy analysts. For example, Illston and Weiner considered several positive points about the plan. First, they acknowledged that, according to opinion polls, the public might be willing to trade off some Social Security benefits for long-term care coverage. Second, they recognized that the plan would not introduce new taxes on workers, thus removing concerns about generational equity. Third, they believed that because its funding is linked to a percentage of Social Security benefits, and is therefore income-related, the plan would be an improvement over Medicare Part B premiums, which are deducted at a flat rate from Social Security checks. But they thought the major drawback to this idea was that it would not raise enough money to cover all long-term care costs, echoing Weiner's earlier criticism. However, SS/LTC has never proposed to be the sole payer for long-term care. Instead, the plan was suggested to provide basic coverage, to be supplemented by private insurance and personal payment.

Some critics have cited the repeal of the Medicare Catastrophic Coverage Act (MCAA) as evidence that SS/LTC will not work because the elderly are asked to pay for their own long-term care. In my view, the critics have over-emphasized the fact that MCCA required the intended beneficiaries to pay for their own benefits.

The critics have de-emphasized or overlooked the fact that MCCA did not really provide meaningful long-term care benefits, which seemed to have been implied by the term "catastrophic" in the law's title. Moreover, to the extent that MCCA provided enhanced benefits to the Medicare coverage, they were, for the most part, covered by the Medigap policies, which many of the elderly had already owned, and with which they were mostly satisfied.

Therefore, the protest against the legislation reflected the fact that the elders were dissatisfied with having to pay for some benefits for which either they or their former employers had already paid. They were not, in my opinion, rebelling against the arrangement that called on them to pay for the benefits themselves.

VI. Private Insurance for Long-Term Care: Trading Benefits

As noted earlier, private long-term care insurance has been regarded as a potential source of funding. This section explores how this potential may be realized. Despite the fact that private long-term care insurance policies today are much improved than those in the past, covering almost all forms of assistance, including home care and assisted living, as well as nursing home, this market has not flourished.

Among many reasons for the unwillingness of people to buy long-term care insurance, the following are the most important which inform the suggested solution in this paper. On the demand side, some people resist buying long-term care insurance because it provides no benefit if they do not need services; they dread the so-called "use it or lose it" syndrome. Another reason is the high costs of private long-term care insurance policies for older people. On the supply side, insurance companies are concerned about moral hazard (greater use of services induced by insurance) and adverse selection (buyers are those who suspect they will need long-term care services).

To substantially reduce the degree of these reservations, the trade-off principle may be used to enhance the willingness of individuals to purchase long-term care insurance, by linking it to life insurance or annuity products. Also, it may be possible to increase the ability of individuals to purchase long-term care insurance by linking it to occupational pensions from employers. This includes Teachers Insurance and Annuity Association-College Retirement Equities Fund and government employee retirement programs at federal, state

and local levels, or by linking it to individual retirement accounts (IRAs), Keogh plans, or other employment-based saving vehicles, such as 401(k) plans and home equity conversion plans (e.g., reverse mortgages).

Linking long-term care benefit to life insurance or annuity products already exists in the market. Upwards to 15 life insurance companies are marketing this type of combination product. Out of all the long-term care policies sold in 1996, about six to seven percent were life insurance policies with a rider for long-term care. Companies' products vary to suit their respective markets. There are many varieties such as a fixed annuity or a variable annuity with long-term care benefits, or a universal variable life insurance policy with a long-term care rider. But the underlying concept is the same, that of combining long-term-care protection with income protection through life insurance or annuity.

For example, for a single premium of $100,000, a 65-year-old woman could buy a life insurance policy that provides an initial death benefit of $190,000. The death benefit, by definition, is payable on the death of the insured. The death benefit can also be used by the insured prior to death to pay for long-term care expenses, such as nursing home or home health care for at least 50 months—at lesser of actual cost or 2 percent of a death benefit of $3,800 monthly.

This arrangement is akin to the critical illness rider attached to a life insurance policy. If the insured is diagnosed as having a critical illness and if 100 percent is paid on diagnosis, then nothing is payable on subsequent death. However, if only 25 percent is paid on critical illness, then 75 percent of the face amount is payable on subsequent death.

In short, with a rider for long-term care, a life insurance policy pre-pays the death benefit for long-term care expenses. If the insured does not need long-term care, then the funds in the insurance policy continue to grow. Stated differently, unused long-term care benefits will pass to the beneficiaries of the policy. Under this arrangement, in essence, the policyholder trades off some or all of the death benefit for long-term care.

Tying long-term care insurance benefits to life insurance products could possibly resolve much of the issues troubling both the demand and supply sides of the market. Not willing or able to recognize the value of insurance protection, some people inaccurately consider paying the premium wasteful. Providing a long-term care rider to a life insurance policy would overcome this concern. The

cash value of the life insurance policy will continue to accrue if the policyholder does not use long-term care services.

Closest to the idea of a combination product suggested here is a proposal of long-life insurance, which combines nursing home, home health and deferred annuity benefits. The idea of trade-off has also been incorporated in other studies.

Providing a long-term care rider to a life insurance policy would reduce, if not eliminate, this moral hazard problem: there would be a built-in resistance to over-using long-term care benefits because that would reduce the eventual insurance proceeds. The adverse selection problem would be limited because such a combination product would appeal to both healthy and not-so-healthy people. The high cost issue could also be moderated because people could buy long-term care insurance coverage at younger ages.

Moreover, if a long-term care rider could be provided under group life insurance policies, then the ability and willingness of workers to participate would be even more enhanced. The method to combine long-term care benefits with life insurance or annuity products could be adapted to serve organizations that market both retirement income products and long-term care policies, such as Teachers Insurance and Annuity Association-College Retirement Equities Fund (TIAA-CREF).

Some may argue that the idea about tying a long-term care rider to a life insurance policy may appear to unduly promote sales of life insurance. However, a recent study has reported that life insurance is essentially not correlated with financial vulnerability at every stage of the life cycle. As a result, roughly two-thirds of poverty among surviving women and more than one-third of poverty among surviving men results from a failure to insure survivors against an undiminished living standard. This finding may lend support to the viability of tying long-term care to life insurance.

Finally, linking long-term care benefits to life insurance or annuity products can cope with the problems caused by loss aversion and mental accounting, as discussed earlier.

X. Conclusion

With improved longevity there is in all likelihood a growing need for long-term care services by the aging baby boomers in the next few decades. The costs could be immense. It is unlikely that our society can meet that demand, given the present mix of long-term care funding, which relies primarily on out-of-pocket personal payment and public welfare.

Since insurance is the best method to protect against this type of risk and because neither the public nor the private sector alone has sufficient resources to pay for long-term care, this paper proposes a new model in which insurance—both public and private—will play a key role. Given constrained government resources and unwillingness or inability of individuals to pay for long-term care, this paper further suggests a trade-off principle to be applied in both the public and private sectors in order to implement the new funding model.