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## **A Trade-Off Proposal for Funding Long-Term Care**

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# A Trade-Off Proposal for Funding Long-Term Care

Yung-Ping Chen

## I. Proposal in Brief

Long-term care can be a depressing subject. Most of us tend not to think about it. However, we cannot long avoid it as the 76 million baby boomers begin reaching older ages in a few short years. According to projections, in 40 years, those aged 65 to 84 (numbering 31.6 million in 2005) will more than double, and those 85 plus (about 5.1 million in 2005), who are more at risk of dependency, will more than triple (U.S. Census Bureau, 2004 and 2006). Heavy reliance on Medicaid, already the second largest budget item in most states, would not appear viable. If we could design better ways of paying for it, perhaps more of us would be inclined to plan. And plan we should.

Long-term care can be very expensive. According to a survey of long-term care providers, the average annual cost of nursing home care, in a private room, is approximately \$75,000 in 2007; the average yearly cost of assisted living is about \$32,600 for a one-bedroom unit; and the average cost of 40 hours per week of in-home care provided by a home health aide is about \$53,000 per year (Genworth, 2007). The prices of long-term care services have risen at rates higher than general inflation for many years (Scanlon, 2001). These expenses could bankrupt many elders in a period of months, especially those in more advanced ages, considering their meager income and savings. But at any one time only a relatively small proportion of elderly population need such care. and which individuals will need it cannot be readily foretold. Therefore, like the losses involving homes and automobiles, this contingency is best protected by

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insurance, a mechanism to spread risk among a large group of people. An insurance policy thus enables the insured to accept a small but certain loss (premium payment) as a means to avert a much larger loss should the insured event occur.

Yet, in actual practice, the role of insurance, private or social, in funding long-term care is rather limited; personal out-of-pocket payment and Medicaid pay some 70% of it (Congressional Budget Office, 2000). This system appears unstable at best and unsustainable at worst. It tends to impose heavy, and sometimes catastrophic, costs on those who need long-term care for extended periods of time; it severely strains Medicaid, which pays for the costs of care of those who are poor or who have become poor from spend-down, and whose funding is subject to changing budget conditions of state and federal governments. We need stable funding sources; new ways must be found.

Some analysts propose expanding Medicare to include long-term care or creating a new social insurance program for it. But, given the large resources needed to ensure continued solvency of current Social Security and Medicare programs, where may the new tax revenue come from? Others promote private long-term care insurance as a solution. Premiums for some of these policies are already tax-deductible as incentive, but many people still do not buy it (Scanlon, 2001).

These considerations help explain why, alone, neither social insurance nor private insurance can solve the problem. A new funding model is needed. We could create a social insurance plan to cover basic long-term care, to be supplemented by private long-term care insurance and out-of-pocket payments. When these three sources fail to provide for some individuals, public welfare (Medicaid) will step in. These are the same sources of funds presently in use, but the proposed model would deploy them vastly differently.

It would be ideal, but unrealistic, to assume that new resources may be available for establishing a new social insurance plan and for buying private insurance. I therefore suggest that we apply the concept of tradeable benefits in using existing resources. Trading one benefit for another already exists under the “cafeteria or flexible benefit plan,” a type of employee benefit program in the private sector, allowing workers some choice in designing a benefits package by selecting different types or levels of benefits within a fixed amount of employer dollars.

In the spirit of tradeable benefit, we could create, in the public sector, a social insurance program for covering basic long-term care by using a small portion, say 5%, of Social Security benefits, exempting low-income individuals from the trade-off. This approach would enable people to exchange a small part of their income protection for long-term care protection.

But why the trade-off? At least for two reasons. First, exchanging some income protection for some long-term care protection will strengthen one’s total economic security, defined to encompass both income security and health care security (including long-term care).

Second, giving up a small amount of Social Security benefit for some basic long-term care benefit is akin to paying the premium (a small but certain loss) for an insurance policy in order to avoid a large potential loss.

The trade-off principle may also be applied in the private sector. We may induce more purchase of private long-term care insurance by linking it to life insurance or annuity contracts. For example, a person could buy a policy that combines life insurance with long-term care coverage. Such a combination policy pays long-term care benefits to the insured, if needed, by commensurately reducing life insurance benefits. This way, the policyholder is trading off some or all of the life insurance benefits for long-term care benefits.

Applying the trade-off idea could overcome several consumer reservations about private insurance. For example, people dread the thought of "use it or lose it" (losing all the premiums paid if they do not need long-term care) and even when they use it, they can gain (receive benefits) only when they lose (become disabled). A combination policy could allay this anxiety because the insured will not lose it if they do not use it, as just explained.

Moreover, a combination policy could induce people to buy it while younger when the premium for long-term care is less and when they are more apt to need life insurance. Purchasing a long-term care policy at earlier ages can ameliorate the problem of high premium costs of the policy when bought at older ages.

## **II. Proposal in Greater Detail**

How to finance long-term care costs is a major issue. As noted, in 2000, some 70 percent of long-term care costs at approximately \$123 billion, was financed by private payments and by Medicaid, shared about equally. Medicare and private insurance combined paid less than 30 percent. As also noted, this financing pattern can impose heavy costs and may even bankrupt many persons and families; it can severely strain state government budgets nationwide because of the growth in Medicaid. Long-term care financing clearly needs reform.

In the debate on how to reform long-term care financing, some favor the social insurance plan, some urge the private insurance approach, and others argue that both are needed. However, all these proposals face the same question of how to pay for it—with insurance premiums or from a payroll tax, personal income tax (on everyone or only on the elderly), corporate income tax, excise taxes (on cigarettes, wine, beer, and distilled spirits, gasoline, and other petroleum products), estate or inheritance tax, consumption tax, or a combination?

Should people be expected to pay for long-term care by risk-pooling through private long-term care insurance, or from personal savings such as an individual retirement account (IRA), home equity, or a new medical IRA? Can we rely on the federal and state governments to fund Medicaid increasingly for the bulk of the long-term care bill? Should we require employers to provide for long-term care and other health care costs for their employees? How about self-employed or nonelderly people who need long-term care?

With fiscal resources severely constrained at both the federal and state levels and with many persons unwilling or unable to pay more taxes or purchase private long-term care insurance, new long-term care benefits seem beyond reach. Yet, the nation urgently needs solutions to long-term care financing, especially in anticipation of the aging of baby boomers.

### **A Trade-Off Principle**

To resolve the dilemma, I propose that we consider trading off some pension income and personal savings for long-term care protection through a compulsory social insurance program, supplemented by voluntary private insurance mechanisms and private payments (Chen, 1993).

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 (1) Social Security benefits or (2) federal or state and local government employee retirement benefits. In the private sector, the trade-off may be with (1) private pensions, (2) Individual Retirement Accounts (IRAs), (3) employment-based savings mechanisms such as 401(k) accounts or Keogh plans, or (4) home equity. Therefore, the concept of trade-off is ideologically and politically neutral in that it favors neither social insurance nor private insurance; it can apply to either social insurance or private insurance.

The suggested method to pay for long-term care does not imply that the trade-off will cover all long-term care needs. The implementation of trading off

a small portion of Social Security for some basic long-term care coverage would still leave much room for private insurance. With their basic coverage financed, individuals may elect to have greater protection by buying additional private long-term care insurance.

### ***Existing "Three-Legged Stools"***

Reflecting shared private and public responsibilities as an ideal or a model, the current pattern in the United States for financing retirement income and acute health care benefits for the elderly is to use a "three-legged stool" (representing social or government effort, group or corporate effort, and individual or family effort), plus a safety net.

Retirement income uses Social Security for a floor of protection, supplemented by occupational pensions and personal savings, with Supplemental Security Income as a safety net. Acute health care is provided by Medicare and is supplemented by Medigap policies and by individual payments for noncovered expenses, with Medicaid as a safety net.

As stated earlier, long-term care is now paid almost exclusively through personal savings (individual or family effort) and Medicaid (presumably, a safety net). How can we create a three-legged stool for long-term care in order to mobilize shared private and public responsibilities?

### ***A Three-Legged Stool for Long-Term Care***

A three-legged stool for long-term care could begin with a compulsory social insurance program to provide basic coverage for long-term care (financed by funds collected by the government and administered by either the government or private insurance carriers). We may call it "Social Security/Long-Term Care (SS/LTC for short)," as it is based on trading off some Social Security cash benefits for long-term care coverage. Such a floor of protection could be financed by trading off 5 percent of Social Security cash benefits with an exemption for low-income people. This program to exchange some Social

Security cash benefits for a basic level of long-term care protection could be phased in, using part of the cost-of-living increases.

This compulsory basic protection could then be supplemented, on a voluntary basis, with more long-term care coverage that could be linked to occupational pensions and/or personal savings, if necessary or desired. For both of these additional layers of coverage, private insurance may be used: the former would involve trading off some portion of occupational pensions from employers, including TIAA-CREF (Teachers Insurance and Annuity Association-College Retirement Equities Fund), and state and local government employee retirement programs; the latter would involve exchanging some portion of IRAs, Keogh plans, or other employment-based savings vehicles, such as 401(k) plans, or home equity for long-term care insurance. These supplemental long-term care protections would be analogous to Medigap policies, which augment Medicare.

Lastly, as a true safety net to help pay for long-term care, Medicaid would then be restored to its original purpose of helping the poor.

In short, the basic coverage under the proposed SS/LTC could apply to long-term care needs ranging from home care to institutional care and all modes in between, including the health care cost component of residence in a continuing care retirement community or an assisted living facility. Benefits paid by private long-term care insurance policies would supplement the basic coverage, just as Medigap policies and private payments are augmenting Medicare, or occupational pensions and personal savings are enhancing Social Security.

Why does the proposal link long-term care financing to retirement pensions and personal savings? And why are social insurance and private insurance mechanisms proposed?

## **Arguments for Trade-off and for Insurance**

### ***Linking Long-Term Care Financing To Pensions and Savings***

One of the theoretical premises on which the principle of tradeoff is based recognizes that income security is not the same as economic security. Economic security is a broader concept. A person is concerned not only with the acquisition of income and assets but also with the retention and disposal of them. A true assessment of economic security, therefore, may be accomplished only when income, assets (more accurately, net worth, which is assets less liabilities), and consumption expenditures are comprehensively taken into account from the standpoint of supply and demand.

In that light, income and net worth represent the *supply* of financial resources, and consumption expenditures represent the *demand* on these resources. The basic question, then, concerns a person's ability to command goods and services with the financial wherewithal. Therefore, for example, although the elderly may have achieved an income level and a net worth level that are on a par with those of the nonelderly, one may not infer that their economic security level is the same as that of the younger people. The reason is the high demand on these resources by actual or potential health care expenditures. Of particular concern to older persons is the possibility of significant expenditures for health care, including long-term care. Without accessible and adequately financed health care of quality, few persons will be economically secure with the incomes they have. The strong linkage between financing of health care and long-term care on the one hand and income support for the elderly on the other should therefore be recognized in designing economic security programs.

Currently, three major government programs—Social Security, Medicare, and Medicaid—help address the economic security needs of the elderly. Although these programs also cover population subgroups under age 65 (notably the disabled and the poor), the major portion of these expenditures is for

the elderly. Even with this level of government effort, however, many of their needs are not being met, such as expenses not covered by Medicare.

### ***Long-Term Care's Burden on Medicaid***

Medicaid has become a major payer for health care expenditures. Growing at a faster rate than federal and state-local government expenditures, Medicaid costs have risen significantly in recent years. Along with the disabled, the elderly are the most expensive group covered by Medicaid. A major policy concern is the rising proportion of Medicaid spending for long-term care for the elderly and the disabled. Medicaid is the second largest category of state spending nationwide, now exceeding state spending on higher education.

If current demographic trends and policy provisions continue, Medicaid costs will increase dramatically in the future as the proportion of the population age 85 and over increases. The escalating cost of providing long-term care for the elderly and the disabled currently enrolled in Medicaid will likely outstrip the ability of state governments to finance these services. Medicaid's fiscal pressures on state governments already have resulted in cutbacks and delays in reimbursements. It is doubtful that Medicaid can continue indefinitely as a major funder of long-term care.

### ***Rationale for Social Insurance and Private Insurance***

The most sensible approach to paying for long-term care is to use insurance mechanisms. Underlying every definition of insurance is the concept of risk-pooling or of group-sharing of losses when persons exposed to loss from a particular source combine their risks and agree to share losses on some equitable basis. Another way of conceptualizing insurance is to consider risk-pooling as risk transfer. The essence of insurance then lies in the willingness of risk-averse individuals to accept a small certain loss in preference to a large uncertain loss. An insurance system effectively transfers from the insured person for whom the insured-against event did not occur to the insured for

whom it did. Insurance is a financial mechanism societies have used to spread the risks of substantial financial loss among a large group of people. Long-term care is a risk that should be pooled. Although private long-term care insurance policies have been in use for some years, even with some expansion in the purchase of such products in recent years, the percentage of older persons with these policies is insignificant.

Private payments fail to utilize insurance protection. The other major payer—Medicaid—similarly lacks risk-pooling. Medicaid has been perceived as a public insurance program. It is an insurance program in the vernacular sense of “falling back on something,” not in the actuarial sense of insurance in which a group of persons exposed to the same risk are banding together to share the risk by paying a share of the cost through the payment of premiums. By contrast, Medicaid is paid out of general revenues.

On the other hand, the retirement income system and the provision of acute health care for the aged seem to suggest the viability of a goal or an ideal of shared responsibility between private and public sectors through the use of social insurance and private insurance.

Provisions for income security for the aged were initiated in this country with the passage of the Social Security Act of 1935. The predominant public opinion before the Great Depression was that Americans could, by and large, provide for their own old age by individual savings or by family assistance, aided by private philanthropy and public charity when all else failed.

A social insurance plan was designed to prepare people for some degree of financial independence in old age. As an ideal or a model, Social Security was to provide income as a floor of protection to be supplemented by other financial accumulations through personal savings and private pensions. Should economic dependency in old age occur, despite earlier attempts to prepare against it, public assistance or welfare would render the needed payments to

prevent destitution. Such a system of shared responsibility among individual, group, and government efforts was intended to foster self-reliance and collective assistance simultaneously.

This ideal or model seems well-suited for financing long-term care. Not only does the social insurance approach pragmatically blend the conflict between beliefs in individual efforts and in collective assistance but it also offers a mechanism for pooling risks.

### ***Social Contingencies and Social Protection***

The trade-off principle also finds support from what is known as “contingency analysis.” Arguing that our current social protection policies do not adequately recognize the contingencies that face growing numbers of older persons and that it may now be in order to consider some reallocations of responsibility among different societal sectors—public and private, formal and informal—for assuring well-being in old age, Hudson (1993) examined the questions of (a) what is truly contingent (i.e., risks or negative outcomes) about advanced age and what is not, and (b) how much protection should be provided against what set of events. He observed that social insurance seems to provide the best protection against events or risks that are likely, nonvariable, and potentially not severe, such as retirement income, but the least protection against events or risks that are more severe, less predictable, highly variable, and unevenly distributed contingencies, such as chronic functional limitations requiring long-term care.

Based on his observations that massive public funding of retirement income seems to preclude the development of a needed insurance for long-term care, Hudson (1993) lends support for trading off some pension income for the creation of a basic long-term care coverage, using social insurance.

## Objections and Reservations

Many objections to and reservations about SS/LTC exist. Some deem it unnecessary, others view it as undesirable, and still others think that it is unworkable.

*Unnecessary:* Because cost-containment is an indispensable component of health care reform, some have argued that the achievement of a more efficient acute care system would free up sufficient resources to allow funding of long-term care as well as universal coverage. More specifically, there are those who believe that a single-payer system with strict government control of costs would result in enough money to provide all health care services including long-term care. They therefore believe that SS/LTC is unnecessary.

However, even if one agrees with this argument, how much and over what period of time these savings may be expected are important questions. Are these savings to be dedicated in advance to fund long-term care and the presently uninsured? Can long-term care needs and the needs of the uninsured be met by cost-containment savings that may arise only gradually and piecemeal? Savings from containing costs may be substantial eventually, but how are the long-term care costs to be met in the interim? How would current expenditures be reallocated to cover long-term care and the currently uninsured? With savings from cost-containment, some may opt for paying a smaller national total for health care and long-term care. How are these attitudinal differences to be resolved?

*Undesirable:* Some have argued that SS/LTC would have the potential disadvantage of weakening the long-term finances of the Social Security trust fund, or requiring higher Social Security taxes, neither of which seems to be a very attractive option, at least in the political sphere.

This view reflects a misunderstanding of the proposal, however. Under SS/LTC, Social Security beneficiaries (except low-income ones) will be diverting

part of their benefits to fund the proposed program. This procedure does not weaken the trust fund because the suggested diversion is similar to the manner in which Medicare Part B premium is deducted from the Social Security payments due beneficiaries. Of course, because the diversion will reduce the "take home" Social Security benefits, people may be displeased with the SS/LTC plan, but that is a separate problem, one that differs from the solvency issue.

Many consider the suggested trade-off as a cut in Social Security benefits or a tax on them. Such benefits are already too low for many people, they argue, and Social Security payments should be raised, not reduced. Others assert that there are more than sufficient funds available in the United States today to pay for both adequate retirement incomes and long-term care and that we should pursue a "struggle" to win these benefits for the broadest possible portion of our population. Although they concede that in the end we may not succeed and may be driven to compromise measures such as SS/LTC, it is a poor strategy, they believe, to propose any distressing compromise at the outset of "our fight." There is, in addition, the contention that SS/LTC represents yet another entitlement program. Maintaining that any public measure to assist in long-term care expenses should be in the form of public assistance or welfare, some people join in believing that SS/LTC is undesirable, though they are motivated by entirely different reasons.

The interpretation that the plan calls for a cut in Social Security is an important issue. While it is true that the cash benefit is lowered, it is not lost or taken away from the beneficiary. *Rather, it is in exchange for another form of benefit.* It should be recognized that by accepting a smaller cash benefit under Social Security one is receiving protection for long-term care, thereby gaining a higher level of economic security—getting a greater value of protection. Moreover, low-income Social Security recipients would be exempt from the trade-off.

With regard to any objection to a mandatory social insurance program, one view of why social insurance was instituted may be helpful. It is argued that social insurance is not so much a method for helping the careless and the poor as it is a means of protecting the prudent and the rich, since participation in the program is *mandatory*. Why would it be in the interest of society (or the general public) that each person be forced to take part in preparing for his or her retirement? It has been suggested that the strongest argument is probably based on the self-interest of those who would have saved on their own volition. For there are those who would not prepare on their own, and when these improvident members of society need assistance, it is the provident ones who would be taxed to help them. Therefore, SS/LTC may be said to help the rich, because the burden on them would be less when the non-rich are also required to share in the payment.

*Unworkable:* Some people feel that there may not be any incentive for the poor and the rich to accept or welcome SS/LTC. The poor can use Medicaid and the rich can self-insure; neither would desire the plan. Further, those who contemplate divestment or transfer of assets in order to qualify for Medicaid would not be interested in it either.

As pointed out earlier, Medicaid's fiscal prospect is dim. Cutbacks in Medicaid reduce supply, and choices regarding nursing homes are severely restricted. Medicaid may not long continue as a major funding source for long-term care. Serious questions ought to be raised by anyone contemplating its use. In any event, through the way it is financed, Medicaid was designed to serve as a safety net.

As to the rich, they are currently paying for their own long-term care, if they need it, and part (perhaps much) of the long-term care costs of the poor. The SS/LTC plan would have the effect of reducing the burden on the rich by requiring all but the poorest among the elderly to contribute to the risk pool for long-term care, as discussed earlier.

Resistance to private long-term care insurance is strong, however. It is widely known that currently and historically only a small minority of the elderly can afford private long-term care insurance policies. It is also common knowledge that there is still considerable skepticism about private long-term care insurance policies, though their quality has improved in recent years.

However, it is not commonly realized that one of the basic reasons for the high-cost and low-quality private insurance product is the fact that risk pooling has thus far been exceedingly limited. Consequently, insurers have needed to develop very large reserves by charging high premiums per policy because of the relatively large variances in a small pool of the insured...

It is important to note that if the risk pool is enlarged, then premium prices or the quality of these insurance products may be expected to improve for the insured. A hypothesis that accompanies the proposed SS/LTC is that the plan will have the salubrious effect of stimulating the development of better private long-term care insurance policies.

### **Concluding Remarks**

Responding to the high and potentially catastrophic costs of long-term care in an era of increasingly scarce public and private resources, we propose the establishment of a compulsory social insurance program called SS/LTC. Under it, present and future retirees would receive a lower Social Security benefit (say 5 percent less) in exchange for a basic long-term care protection (as an illustration, 1 year of coverage at 85 percent of customary and reasonable charges after a 90-day waiting period or 2 years of home care). It is possible that this basic protection could be supplemented with additional long-term care protection through voluntary private insurance mechanisms, using the same trade-off principle, if necessary or desired, as it applies to private pensions and personal savings.

The proposed SS/LTC may have the beneficial effect of promoting the development and sales of private long-term care insurance policies, which would then charge lower premium prices and/or offer better-quality products.

### **III. Relevant Issues**

The proposed SS/LTC suggests that Social Security recipients, except low-income ones, forsake a small portion of the Social Security benefits in order to fund a basic level of long-term care coverage in a social insurance program. SS/LTC also proposes that this basic coverage be supplemented by private long-term care insurance and private payments.

To implement this option, a number of formulations are possible with regard to the level of funding, eligibility rules, and the benefit structure. Among the questions that would need to be answered are the following (Chen, 2003):

- Who would be eligible for benefits and what would be the benefit triggers?
- What would be the daily level of payment and the elimination period?
- What types of services and what levels of those benefits would be covered?
- How much coverage can be provided for various levels of Social Security benefit transfer under SS/LTC?
- Would it be mandatory or voluntary and what are the implications of each approach?
- Would it pay benefits regardless of living arrangements (nursing home, assisted living, continuing care retirement community, or one's own home through home and community-based care)?

- Would the benefit be paid to service providers or to disabled persons themselves and what are the implications of each approach?
- How would the benefit paid under SS/LTC be coordinated with payment from private long-term care insurance policies?
- What might be the distributional effects of SS/LTC on different groups of people by income, race and ethnicity?
- How would SS/LTC deal with the geographical differences in the costs of long-term care services?
- How would SS/LTC deal with those already using long-term care at the effective date of SS/LTC?
- How should the "capped" entitlement of SS/LTC be managed, since its revenue is limited to the transfer of, say, 5 percent of Social Security benefits each year?
- Would the extent of long-term care coverage that could be afforded be the same from one cohort of births to the next?
- What might be various prototypes of SS/LTC that could be designed?

#### **IV. 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.

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