

Long-Term Care In The United States: An Overview

A complex system of public and private funding often leaves elderly persons at risk of financial catastrophe and inadequate care.

by Judith Feder, Harriet L. Komisar, and Marlene Niefeld

PROLOGUE: Elderly Americans are just about the only group of U.S. citizens whose health care is universally insured as an entitlement. However, elders who need long-term care have much less protection. Medicare, the federal program for the elderly and disabled, covers many of the costs of acute medical care but only tangentially covers some long-term care services. Medicaid, the federal/state health program, covers long-term care but only for people who are poor or who become poor paying for long-term care or medical care. Who gets what kind of services under Medicaid varies from state to state. This paper outlines the financing of the U.S. long-term care system and the policies that define it, pointing to the imperative for change to assure adequate services at an acceptable cost.

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ABSTRACT: Although long-term care receives far less U.S. policy attention than health care does, long-term care matters to many Americans of all ages and affects spending by public programs. Problems in the current long-term care system abound, ranging from unmet needs and catastrophic burdens among the impaired population to controversies between state and federal governments about who bears responsibility for meeting them. As the population ages, the pressure to improve the system will grow, raising key policy issues that include the balance between institutional and noninstitutional care, assurance of high-quality care, the integration of acute and long-term care, and financing mechanisms to provide affordable protection.

MORE THAN TWELVE MILLION PEOPLE in the United States, about half over and half under age sixty-five, need some kind of long-term care.¹ About a third of these people have care needs that are substantial. Medicare, the federal government's health insurance program, finances medical care for nearly all elderly Americans and some younger persons with disabilities. Support for their long-term care, however, falls largely outside Medicare's scope. Most long-term care is provided by families and friends in the community. Medicaid, the federal/state program that provides health insurance for low-income families, is the nation's primary safety net for long-term care financing. In 1998 Medicaid financed about 40 percent of the nation's total long-term care spending of \$150 billion and 44 percent of spending on nursing home care.²

Despite some recent improvements, long-term care continues to pose major challenges: People who need long-term care often do not get the care they need or prefer, and families' caregiving and financial burdens are often heavy. One in five adults with long-term care needs who live in the community report an inability to get the care they need, often with serious consequences.³

Policymakers continue to grapple with dissatisfaction in the scope, mix, quality, and financing of long-term care services. The availability of publicly supported long-term care varies from state to state. Despite the growth in home-care services, nursing homes continue to dominate the service system, and state and federal governments continually struggle to manage costs of the services they provide and wrangle over their respective financial responsibilities.

Changing demographics pose a further challenge. Current estimates suggest that the demand for long-term care among the elderly will more than double in the next thirty years.⁴ This growth will exacerbate concerns about balancing institutional and noninstitutional care, assuring quality of care, integrating acute and long-term care, and—perhaps most important—adopting and sustaining financing mechanisms that equitably and adequately protect people who need long-term care. Alongside policy toward Social Security

and Medicare, policy toward long-term care will increasingly shape quality of life for aging Americans.

This paper begins with an overview of the population who needs long-term care and the mechanisms used to finance that care, for both the elderly and the nonelderly populations. We then focus on the elderly—first examining changing patterns of service use and their policy implications, then examining policy issues that will become more problematic as the population ages.

Who Needs Long-Term Care?

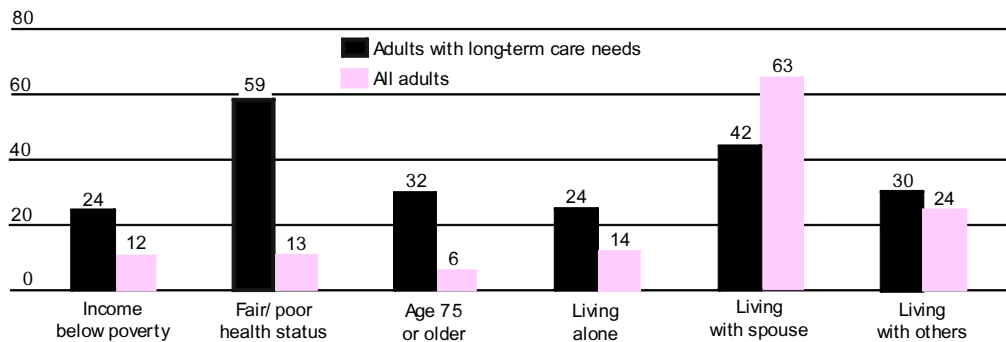
Long-term care refers to a broad set of paid and unpaid services for persons who need assistance because of a chronic illness or physical or mental disability. Long-term care consists primarily of personal assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs). ADLs are routine tasks of life, usually considered to include eating, bathing, dressing, getting into and out of bed or a chair, and using the toilet. IADLs are additional activities necessary for independence such as preparing meals, managing medications, and shopping for groceries. Long-term care also may include skilled and therapeutic care to treat and manage chronic conditions.

Although the likelihood of needing long-term care rises with age, almost as many people who need such care are under age sixty-five as are above it—5.6 million persons under age sixty-five (including 0.4 million children) and 6.6 million elderly, in roughly 1995.⁵ About 13 percent (0.1 million nonelderly and 1.5 million elderly in 1996) reside in nursing homes. Of the remainder who live in the community, one-quarter (1.2 million ages eighteen to sixty-five and 1.5 million elderly) are severely impaired, needing personal assistance with three or more ADLs.⁶ Compared with the rest of the population, persons who need long-term care are disproportionately low-income, very old, and living alone or with relatives other than a spouse (Exhibit 1). They also incur substantial costs (out of pocket and Medicare financed) for acute care services.⁷

Virtually all elderly persons who need long-term care have health insurance through Medicare. Medicare covers disabled persons under age sixty-five, however, only after they have received Social Security disability benefits for two years. Only 33 percent of the home-dwelling population ages eighteen to sixty-four with long-term care needs have Medicare coverage (Exhibit 2). About half have either private health insurance (28 percent) or Medicaid (25 percent). Ten percent of the long-term care population in this age group are uninsured.

EXHIBIT 1**Characteristics Of Home-Dwelling Adults With Long-Term Care Needs, 1995**

Percent

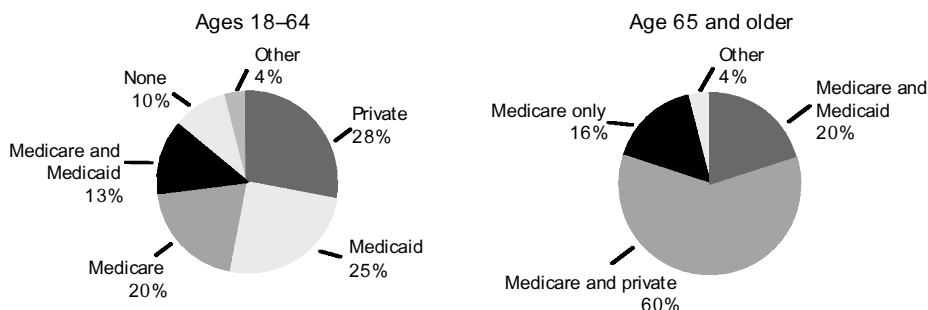


SOURCE: H.L. Komisar and M. Niefeld, "Long-Term Care Needs, Care Arrangements, and Unmet Needs among Community Adults: Findings from the National Health Interview Survey on Disability," Working Paper no. IWP-00-102 (Washington: Georgetown University, Institute for Health Care Research and Policy, 2000).

NOTES: Persons age eighteen and older. Long-term care need is defined as needing help with at least one activity of daily living (ADL) or at least one instrumental activity of daily living (IADL). ADLs consist of bathing, dressing, eating, getting in and out of bed or chair, using the toilet, and walking; IADLs consist of managing money, managing medications, shopping, preparing meals, light housework, using the phone, and getting to places outside of walking distance.

Long-Term Care Financing

Although most people who need long-term care rely on unpaid help from family and friends, spending on long-term care is substantial.⁸ The primary sources of financing are Medicaid and out-of-pocket spending, which accounted for 40 percent and 26 percent, respectively, of national nursing home and home-care expenditures in 1998

**LONG-TERM
CARE SYSTEMS****43****EXHIBIT 2****Health Insurance Status Of Home-Dwelling Adults With Long-Term Care Needs, By Age, 1995**

SOURCE: H.L. Komisar and M. Niefeld, "Long-Term Care Needs, Care Arrangements, and Unmet Needs among Community Adults: Findings from the National Health Interview Survey on Disability," Working Paper no. IWP-00-102 (Washington: Georgetown University, Institute for Health Care Research and Policy, 2000).

NOTES: N = 5.1 million for both groups. For the nonelderly population, "Medicare" and "Medicaid" categories may include people who have other insurance. For the elderly, "Medicare only" and "Medicare and private" may include people who also have other public (non-Medicaid) insurance. "Other" includes Indian Health Service, Department of Veterans Affairs, and other public insurance programs.

(Exhibit 3). Two-thirds of long-term care spending is for nursing home care, 44 percent of which was funded by Medicaid and 31 percent through out-of-pocket spending in 1998.

■ **Medicare.** Medicare finances long-term care only tangentially through its limited skilled nursing facility (SNF) and home health benefits. Despite recent growth in spending on these benefits, much of the SNF and home care paid for by Medicare remains short-term rehabilitative care, often related to a hospital stay or outpatient procedure. Medicare covers SNF care for up to 100 days following a hospital stay of at least three days. For homebound persons needing part-time skilled nursing care or physical or other therapy services, Medicare pays for home health care, including personal care services provided by home health aides.

■ **Medicaid.** Medicaid is explicitly responsible for financing long-term care for persons with low incomes and persons who become poor (“spend down”) as a result of spending on medical or long-term care. Medicaid provided 44 percent of nursing home spending in 1998. Medicaid supports care, in part or in full, for about two-thirds of all nursing home residents.⁹ In addition, Medicaid allows states to cover personal care at home, regardless of whether skilled care is needed; Medicare does not.

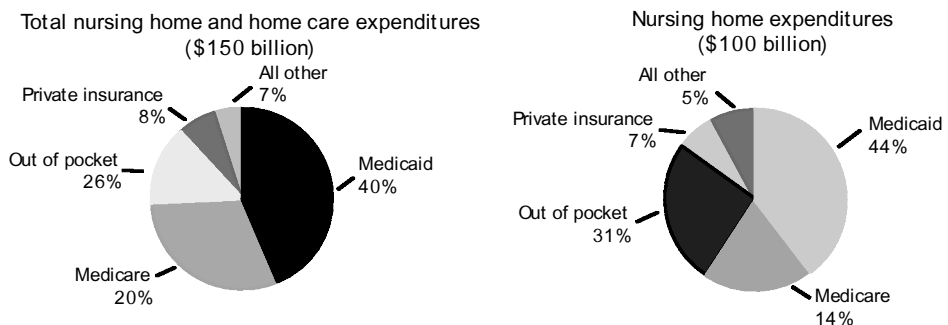
Federal rules entitle elderly and disabled persons to Medicaid benefits if their incomes and assets are low enough to qualify them for the federal Supplemental Security Income (SSI) cash assistance program—in 2000, income of no more than \$532 per month, and nonhousing assets less than or equal to \$2,000 for individuals.¹⁰ Most states allow people to become eligible under “medically needy” provisions if they spend down their income and assets on care. For nursing home care, even states without medically needy coverage

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UNITED
STATES

EXHIBIT 3

Long-Term Care Financing, By Payer, 1998



SOURCES: Authors' estimates based on data from Health Care Financing Administration, Office of the Actuary (February 2000); and B. Burwell, "Medicaid Long-Term Care Expenditures in FY 1998" (Cambridge, Mass.: MEDSTAT Group, 1999).

must cover nursing home residents with incomes of up to three times the SSI level. Institutionalized persons must contribute all of their income except a small personal needs allowance (ranging among states from \$30 to \$75 per month in 1996) toward the cost of care.¹¹ When one spouse lives at home while the other is institutionalized, the community-living spouse is allowed higher income and asset levels, which vary by state.

States have flexibility in designing their long-term care programs and controlling access. First, states determine their own eligibility levels. Second, although states must cover home health services, they have the option of providing personal care and may provide such care through programs that “waive” certain generally applicable federal requirements. Specifically, they can (and do) establish limits on the total number of persons enrolled (regardless of eligibility) and target programs to selected areas or population groups. Third, states can (and do) directly regulate the supply of nursing home beds. In addition, states control the rates paid to nursing homes for Medicaid beneficiaries, which can affect access.¹²

States’ different choices produce large variation in Medicaid long-term care spending.¹³ In federal fiscal year 1998 Medicaid spending on long-term care (for all ages) ranged from less than \$120 per state resident in five states to more than three times that level in the top four states and the District of Columbia.¹⁴

■ **Private insurance.** About 7 percent of long-term care spending is financed by private insurance—a combination of health and the relatively new long-term care insurance. Although the number of people buying private long-term care insurance is growing, as of the end of 1996 fewer than five million policies had been sold.¹⁵

■ **Out-of-pocket spending.** The fact that more than a quarter of long-term care costs are paid directly by patients reflects the financing structure described above: the absence of an insurance system, public or private, that spreads the financial risk of needing long-term care, and, in its place, a system that protects people only if they are impoverished. Given the high costs of long-term care—on average more than \$40,000 annually for nursing home care, and for the severely impaired (three or more ADLs), on average more than \$500 per month for home care (or \$6,000 annually)—persons needing to purchase such care face a substantial financial burden.¹⁶

Out-of-pocket expenses are only part of long-term care’s full burden on families. A 1996 survey of unpaid caregivers age fifty or older found that among caregivers who work or had worked, many made adjustments in their work schedules, worked fewer hours, or retired early or quit, and that 15 percent of respondents experienced physical or mental problems resulting from their caregiving.¹⁷

Use Of Long-Term Care By The Elderly

Although the pattern of service use among the elderly in the mid-1990s was largely similar to past patterns, surveys comparing the mid-1990s with the mid-1980s found two shifts: a reduced use of nursing homes and, if at home, a higher likelihood of receiving paid help. These changes are consistent with a policy goal of substituting home care for nursing home care. However, a closer look at experience calls into question whether paid home care has truly substituted for nursing home care, whether service levels are adequate, and whether greater support for home care will continue.

■ **Changes in service use.** A comparison of surveys shows that 4.2 percent of the elderly population resided in nursing homes in 1995, compared with 4.6 percent in 1985.¹⁸ This means that about a quarter-million elderly persons who, based on age and sex, would have been in nursing homes in 1985 were not in nursing homes in 1995. Nursing home residents and stays also looked different in 1995: Residents were older and more severely impaired, and stays were shorter and more likely to be financed by Medicare (13 percent in 1995, compared with 2 percent in 1985).

Survey data show changes in home-care use by the elderly over roughly the same period. The proportion of home-dwelling elderly persons with long-term care needs depending only on family and friends for assistance fell from 74 percent in 1982 to 64 percent in 1994, and from 66 percent to 50 percent among persons dependent in three or more ADLs.¹⁹ At the same time, elderly persons receiving paid care averaged fewer paid hours per week.

These patterns reflect changes in the health and long-term care system and its financing. Shorter hospital stays and technological advances have led some hospital care to be replaced by short-stay nursing home care, or acute care-related home health services. Less nursing home use may be related to increased use of supportive housing arrangements (assisted living).²⁰ But most residents are much less impaired than the typical nursing home resident, so it is unlikely that supportive housing substitutes for much nursing home care.

Perhaps far more important, financing for home care has expanded. A loosening of Medicare rules in the late 1980s expanded the delivery of home health care, both personal care and skilled care. Medicare spending for home health grew from just under \$4 billion in 1990 to more than \$18 billion in 1996.²¹ Although evidence suggests that the expanded service involved acute care-related as well as long-term personal care, spending growth went disproportionately to the small fraction of users receiving extensive home care (increased spending for Medicare home health users receiving 200

or more visits during the year accounted for about 60 percent of the total growth in spending between 1991 and 1994).²² There also is evidence that Medicare assisted a greater share of elderly beneficiaries with long-term care needs—between 1982 and 1994 the proportion of those with (paid or unpaid) home care who received Medicare-financed help during the previous week rose from 4 percent to 10 percent.²³ Medicaid spending for home care for low-income persons (of all ages) also rose during the 1990s, from \$4.8 billion in FY 1991 to \$10.5 billion in FY 1996 (and to \$14.8 billion in FY 1998).²⁴

Since the mid-1990s, however, Medicare policy has changed once again. The Balanced Budget Act (BBA) of 1997 created incentives for home health agencies to limit the volume of care—in particular, for patients needing the most care.²⁵ Spending growth dropped sharply.²⁶ However, the impact on patterns of use is not yet known.

■ **Policy implications.** A lower probability of nursing home use and an expansion of Medicare home health are consistent with but by themselves not evidence of a policy preference for home care over nursing home care for people in need of services. Changes in patterns of care raise a number of important policy questions regarding the adequacy of care and the policy process that shapes it.

Although some data are available to reveal changes in service use, experts emphasize the absence of data and analysis to show that impaired persons who might previously have entered nursing homes are actually receiving adequate care.²⁷ Concern about adequacy of service stems from evidence on Medicare's limited reach among the impaired population and of care needs that go unmet. Near the height of Medicare's home health expansion, in 1994, only 10 percent of impaired elderly persons who received assistance at home reported receiving Medicare-financed home care during the prior week.²⁸ (A smaller proportion, 3 percent, received Medicaid-financed home care.) Further, average weekly hours of paid care per recipient fell between 1982 and 1994, especially among those with home care financed from "program sources" (such as Medicare, Medicaid, and private insurance). This decline suggests that although Medicare may have come to serve more people, its benefits are more limited than those Medicaid may previously have provided.²⁹

Concern about the limited use of paid services is compounded by evidence on how many elderly persons go without care. Results from a national survey indicate that nearly one-fifth of home-dwelling elderly with long-term care needs, in roughly 1995, reported needing help, or more help, with ADLs or IADLs.³⁰ Respondents attribute these unmet needs to finding services too expensive, having difficulty finding help, or being ineligible for help from an agency because of income or medical eligibility criteria. Among community-

“Medicare and Medicaid policy resembles a fiscal tug-of-war, rather than a concerted effort to address people’s needs.”

dwelling elderly with long-term care needs, persons reporting unmet need are disproportionately severely impaired, living alone, and poor or near-poor.

A second concern is the way in which current Medicare and Medicaid long-term care policy is being made. The Medicare home health expansion largely reflected the withdrawal rather than the introduction of policy guidance. No decision was made to rely upon Medicare to finance an expansion of long-term care, and many question the targeting of its benefits (based on a need for skilled care without regard for personal care needs) as well as the efficiency of its delivery system (reliance on agencies).³¹

Similarly, the retractions in service stimulated by the BBA’s changes in home health payment policy may be poorly targeted. Although the policy change was intended to promote efficiency, it may replace incentives to provide what may have been too much care with what may be too little.³² In reviewing recent evidence, the Medicare Payment Advisory Commission (MedPAC) concluded that some beneficiaries who require costly home care are facing difficulties obtaining services.³³ There is little professional consensus on norms of care under Medicare’s home health benefit—an issue that reflects both the design of the benefit (skilled over personal care) and the complexity of evaluating the “appropriate” amount of personal care. In the absence of such norms, a shift to incentives for agencies to spend as little as possible would seem to put the patients who need the most care at greatest risk.

Medicare and Medicaid policy resembles a fiscal tug-of-war, rather than a concerted effort to address people’s needs. Medicare’s expansion of home health benefits offered states an opportunity to “shift” responsibility to Medicare—that is, allow the program to finance care that states might otherwise provide. Analysis suggests that some states (with relatively high Medicaid home-care spending) adopt policies to assure that Medicare revenues are “maximized”—explicitly shifting financing for some services from the Medicaid program, for which states share financial responsibility, to the fully federal Medicare program.³⁴

What will happen to these and other home care services as Medicare shrinks? Medicare’s expansion may have filled needs for home care in states with more limited Medicaid coverage. It is not clear that Medicare’s retraction will be offset by Medicaid growth.

Medicaid is targeted to the poorest population; many persons who are not very poor nevertheless cannot afford paid help. Further, states have always varied in the generosity of their Medicaid home-care benefits and will undoubtedly vary in their willingness to fill the possible service gaps. Hence, Medicare changes will likely reduce access to care for some persons with long-term care needs.

Current And Future Policy Choices

Both the outcomes and the process of U.S. long-term care policy have serious shortcomings, and the consequences of these shortcomings will increase as the population ages. Policymakers continue to face an array of complex policy problems regarding the balance between nursing home and home care, assurance of quality, integrating acute and long-term care, and affordable access.

■ **Improving the nursing home/home care balance.** Despite Medicare's home health expansion, Medicaid continues to dominate long-term care spending, and institutional care continues to dominate Medicaid services, accounting for three-quarters of Medicaid long-term care spending in FY 1998.³⁵ States have struggled for years to reduce nursing home use, by limiting nursing home care (through preadmission screening, limits on the supply of nursing home beds, and constraints on growth in Medicaid payments) on the one hand, and expanding home care (primarily through "waivers" of Medicaid requirements, allowing states to target benefits to limited geographic areas and to specific groups and numbers of beneficiaries) on the other. However, in most states policy initiatives have had a modest impact on the allocation of resources between nursing homes and home and community-based care.³⁶

The continued emphasis on nursing homes over home care reflects in part a reluctance to expand support for home care as an add-on to, rather than a replacement for, current institutional care. Although home care can (and does) substitute for nursing home care, enhanced public support for home care will likely expand the total number of persons receiving care. Many who would resist going to nursing homes may welcome care at home. Indeed, improving quality of life for individuals and families struggling to maintain care at home is as much a goal of home care as is reducing nursing home use. Nevertheless, the result is that broader support for home and community-based care will raise, not lower, costs.

A few states—most notably, Oregon, Washington, and Wisconsin—stand out for efforts to avoid this outcome by explicitly limiting the use of nursing homes—that is, moving people and dollars out of nursing homes and into home and community-based care. However, control over spending levels not only required limits on nurs-

ing home use; it also required limits on the availability of home care that in some cases created waiting lists for care. Also, despite fairly dramatic reductions in nursing home use (especially in Oregon), total long-term care spending continued to rise.³⁷ All told, it may be difficult to achieve a better balance across services without expanding overall investment in long-term care. Willingness to make that investment, however, is at best uncertain.

■ **Quality assurance.** Despite reform of nursing home regulation more than a decade ago, recent reports to Congress indicate that about a quarter of the more than 17,000 nursing homes nationwide still have serious deficiencies.³⁸ About 40 percent of those homes have had repeated deficiencies.³⁹ Such poor performance is attributed to insufficient attention to and support for federal and state enforcement activities.⁴⁰ Both levels of government have stepped up activities as a response to public criticism, but concerns remain.

Nursing home payment policy also can influence quality of care. Although higher payment does not ensure higher quality, payment rates can be too low to support adequate quality. The BBA repealed requirements limiting states' flexibility in setting nursing home rates. To date, states have not responded with major changes in nursing home payment, but inaction may be a reflection more of economic prosperity than of comfort with payment methods and rates. In the coming years decisions on how much and how nursing homes are paid (by Medicare as well as Medicaid) will be critical in establishing incentives or disincentives to provide high-quality care.⁴¹ Although nursing home quality assurance is problematic, assurance of quality outside the nursing home has barely begun. Assuring the quality of care at home has historically been regarded as challenging because of the numerous sites of care, potential isolation and vulnerability of persons receiving care, and the lack of information on the relationship between services and outcomes. Supportive housing arrangements raise another set of quality assurance issues. Board-and-care homes for low-income persons receive barely more than subsistence payments and fall outside both federal and many states' regulatory scope. Assisted-living facilities, although better paid, fall outside about half the states' regulatory frameworks and offer providers a potential escape from nursing home regulation.⁴² Enhancing the effectiveness of quality tools and extending their reach will remain a considerable challenge for policymakers.

■ **Integrating acute and long-term care.** People in need of care are clearly frustrated by the challenge of coordinating different types of services across different programs—specifically, Medicare, which finances acute medical care, and Medicaid, which finances long-term care. Better integration across services and programs

could reduce this burden and improve both the quality and the efficiency of care. However, there is much more rhetoric than reality to “service integration.” Its promotion, especially through reliance on capitation (a single payment per user to cover all services) rather than fee-for-service, reflects a continued quest for cost containment, at least as much as it does a pursuit of high-quality care.

To date, experience with capitation, even for acute care for the elderly, is limited. Medicare managed care now covers about 17 percent of beneficiaries.⁴³ Limited evidence on its performance, relative to fee-for-service, has raised quality concerns—generally, regarding outcomes for persons with chronic conditions; specifically, regarding reduced use and worse outcomes related to home health care and rehabilitation facilities.⁴⁴ Medicare also has promoted the development of new managed care arrangements that include long-term care, which have recently been adopted as provider options. Although demonstration projects provide some evidence of more efficient service delivery, there is concern about the ability to replicate these models and attract enrollees.⁴⁵

Medicaid managed care focuses on acute care for the low-income population under age sixty-five.⁴⁶ A capitation payment including acute and long-term care for the elderly requires the “integration” of Medicaid and Medicare and a negotiated arrangement between the state and federal governments. Both the states and the federal government have been cautious in pursuing these arrangements—states, uncertain about the capacity of organizations, including commercial managed care plans, to take on responsibility for long-term care; the federal government, generally unwilling to allow states to require beneficiaries to participate in managed care and concerned about giving states control over the use of Medicare dollars.

Although states have been cautious in assuming that managed care can be applied to long-term care, interest in the concept reflects factors other than efficient delivery of high-quality care. Capitation, especially combining Medicare with Medicaid dollars, offers states financial advantages: the opportunity to control dollars that the federal government now manages and, through fixed capitated payment, to limit liabilities for service. Pursuit of those advantages without evidence that care is truly managed would place the most vulnerable beneficiaries at considerable risk.

■ **Expanding insurance for long-term care.** Theoretically, there is little rationale for failing to finance long-term care as we finance acute care—that is, relying on insurance to spread its risk. We typically rely on insurance to deal with costs that are potentially catastrophic and unpredictable. Long-term care satisfies both criteria. Purchasing extensive personal care, at home as well as in nursing

homes, is a catastrophic expense. Further, the probability that a given person will need long-term care is uncertain. For example, although 39 percent of persons at age sixty-five are likely to use some nursing home care before they die, almost half will require less than a year of care, while about a fifth will require five years or more.⁴⁷ Public discussion all too often assumes that a need for long-term care is an inevitable part of aging and that saving is therefore the right strategy to address it. With costs so varied and unpredictable, savings will be inadequate and inefficient. Insurance makes more sense.

The U.S. long-term care system, however, does not provide insurance against the risk of long-term care costs. As described above, the private insurance market is small, and (public) Medicare explicitly limits coverage for long-term care. Medicaid provides support that is critical to persons who need long-term care, but that support is available only after all other resources have been exhausted. Thus, even with Medicaid, risks are concentrated, not spread.

Some argue that with supportive public policies—notably, subsidies through the tax system—the private insurance market could spread the risk of long-term care costs, thereby reaching a much larger portion of the population and greatly reducing burdens on the public sector.⁴⁸ Recent estimates by the American Council of Life Insurance are that private insurance could grow to finance 29 percent of nursing home costs in 2030, ten times their estimate of 3 percent today.⁴⁹ However, reliance on private insurance to address future long-term care needs raises critical policy questions.

The first question is the adequacy of protection. Observed inadequacies are numerous: market practices that make policies unavailable to those most likely to need long-term care; benefits that cover only a portion of the costs of care and are not guaranteed to keep pace with rising costs or changing practices of care; and the possibility of unanticipated premium increases (even with policies that promise the same premium for the life of the policy). These features of private insurance, which reflect insurers' incentives to limit risk, create a barrier to risk spreading that is also apparent in the private individual health insurance market. The nation's continued dissatisfaction with this market should generate skepticism about the wisdom of following a similar path for long-term care.

A second question is whether tax support for private insurance represents an equitable use of public resources. Tax subsidies are far more likely to reach persons already able to purchase long-term care insurance, rather than those who cannot afford it. Analysis by the Congressional Budget Office (CBO) suggests that the latter group will grow in the coming decades. Further, it suggests that even with

an expansion of long-term care insurance, Medicaid spending must increase—from \$43 billion estimated for 2000 to \$75 billion for 2020—to ensure even current levels of service to low- and medium-income people (Exhibit 4). Proponents of tax subsidies for private insurance argue that the need for public investment would be even greater in the absence of support for private insurance—the CBO estimates that without any private long-term care insurance, Medicaid long-term care spending would rise to \$87.8 billion in 2020. However, to accept that argument is to assume that investment in public and private support will go hand in hand. In practice, advocacy of subsidies for private insurance is more likely to obscure the need to strengthen direct public support. The result would be to target resources to the economically advantaged while leaving the disadvantaged at risk.

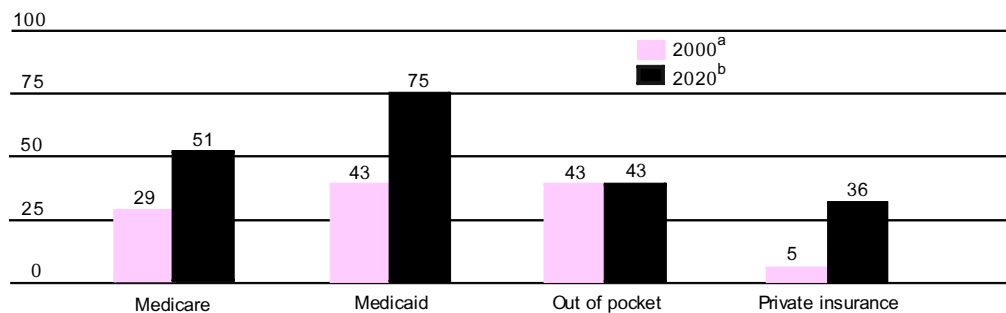
Expanded social insurance is an alternative to public support for private insurance. For example, Medicare could be expanded to include long-term care, entitling all Americans, regardless of income, to some insurance protection should they become greatly impaired. However, investment of resources to sustain the social insurance we have (Medicare and Social Security), let alone the social insurance we might have, is subject to considerable debate. Despite the nation's current prosperity and underlying wealth, our willingness to redistribute resources to reflect the aging of the population seems to be in question.⁵⁰

In these circumstances, better support for the economically disadvantaged—a more adequate means-tested safety net—should be our priority. We now expect people to impoverish themselves com-

EXHIBIT 4

Projected Spending On Long-Term Care For The Elderly, By Payer, 2000 And 2020

Billions of 2000 dollars



SOURCE: Congressional Budget Office, "Projections of Expenditures for Long-Term Care Services for the Elderly" (Washington: CBO, March 1999).

NOTE: For each year, total spending includes less than \$5 billion in spending by "other payers" (not shown).

^a Total spending: \$123.1 billion.

^b Total spending: \$207.3 billion.

pletely before providing them assistance with long-term care. That system seems excessively harsh. Further, it is geographically inequitable and will become more so as the population ages. Analysis of future population growth and resources reveals that growth in the demand for long-term care and the ability to finance it will vary greatly across states.⁵¹ To create a stronger, more fair safety net will therefore require not just more dollars, but more federal dollars.

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NOTES

1. H.L. Komisar and M. Niefeld, "Long-Term Care Needs, Care Arrangements, and Unmet Needs among Community Adults: Findings from the National Health Interview Survey on Disability," Working Paper no. IWP-00-102 (Washington: Georgetown University, Institute for Health Care Research and Policy, 2000); M. Adler, "People with Disabilities: Who Are They?" (Unpublished tabulations from the 1994 National Health Interview Survey, Phase I, November 1996); and N.A. Krauss and B.M. Altman, *Characteristics of Nursing Home Residents—1996*, MEPS Research Findings no. 5 (Rockville, Md.: Agency for Health Care Policy and Research, December 1998).
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