

Tax Policy Center
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The Future of Long-Term Care:
What Is Its Place in the Health Reform Debate?

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SUMMARY

As the population ages, demand for long-term care supports and services is growing. Today, 10 million frail elderly and adults with disabilities require such care. Nearly 80 percent is provided at home, much of it by family members and friends. In 2007, the cost of paid services was estimated at \$230 billion, while the economic value of informal care may have approached \$375 billion. As the Baby Boomers age, both demand for this care and its costs are expected to increase dramatically.

Today, most paid care is funded by government, through Medicaid and other programs. Less than 10 percent is financed by private long-term care insurance, and much of the rest is paid for out-of-pocket by families themselves.

Despite the considerable resources devoted to long-term services, many continue to receive poor quality care. As a result, policymakers are pursuing major changes in the way assistance is both delivered and financed.

As Congress and the Obama administration consider broad-based health reform, efforts to restructure long-term care are taking on greater urgency and policy experts have put forward several reform plans aimed at improving access to care. Some would make Medicaid more responsive to the needs of those who require long-term care services. Others would reduce the current reliance on Medicaid as the principal payer by expanding access to either social insurance or private coverage, or a combination of both.

BACKGROUND

In contrast to acute medical care, long-term care is aimed at assisting those with chronic illnesses manage their daily lives in relative comfort and security. Such care is provided to many different populations, from children with developmental disabilities to young adults with chronic injury or illness to frail older Americans. About 60 percent of those requiring care are over 65.¹

These services may include assistance with eating, bathing or toileting, cooking or eating. Long-term care may be provided at home, in nursing facilities, or in other settings such as assisted living facilities, group homes, and continuing care communities.

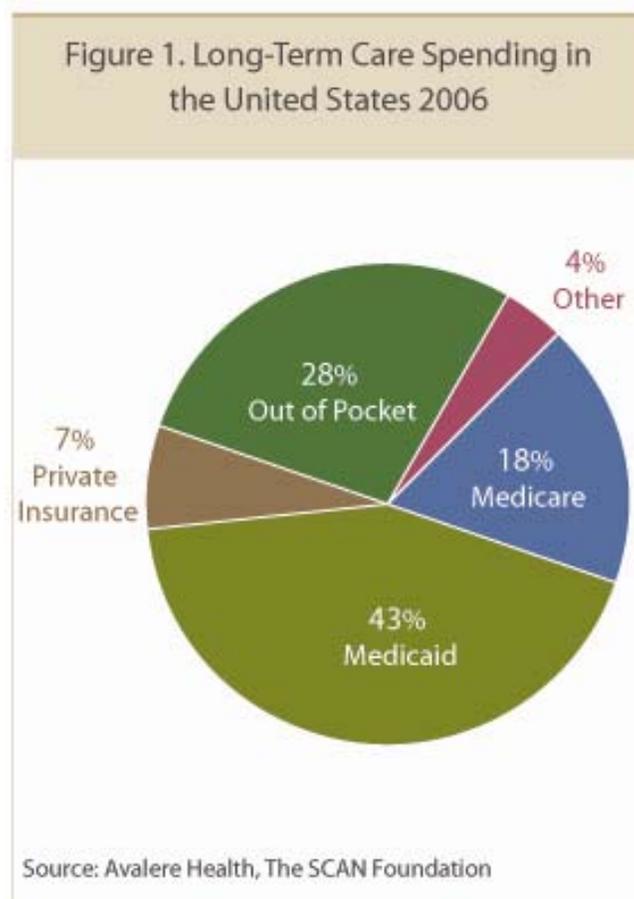
The growing demand for this care is in part the result of striking demographic changes. Life expectancy in the United States has increased from just 47 years a century ago to over 70 today. A woman turning 65 today can expect to live for nearly 20 years and be healthy for most of that time.²

Until recent decades, people rarely needed extensive personal care over a long period of time. Prior to the development of medical technologies such as antibiotics and insulin, or sophisticated treatments for heart disease and cancer, few lived long with chronic disease. A century ago, a person hospitalized with diabetes could expect to die within a month.³ Diseases of the very old, such as Alzheimer's, were rare in part because few lived to their 80s, the age at which this illness often presents itself.

Today, patterns of care are very different. Nearly 70 percent of those who turned 65 in 2005 will need some long-term services before they die. Those 65 and older will require assistance for an average of three years over their remaining lifetimes. Although a third will require no long-term services, 20 percent will need care for between two and five years, and another 20 percent will require this assistance for five years or more.⁴ Currently, about 10 million Americans need some form of long-term care.

Moreover, while these services remain overwhelmingly “low-tech,” they are nonetheless extremely expensive. The average “private pay” rate for a single room in a nursing home exceeds \$75,000 per year. Home health aides cost an average of \$18 per hour.⁵

The overall cost of paid long-term care is significant—in excess of \$230 billion annually. In 2007, about 43 percent, or approximately \$100 billion, was paid by Medicaid, the joint federal-state health program for the poor. Less than 10 percent is financed by private insurance. Much of the remainder is paid out-of-pocket by those receiving care or by their families.⁶



However, it is important to note that most long-term care is informal unpaid assistance provided by family members, usually spouses or daughters. While this aid is often referred to as “free,” it is often physically, emotionally, and financially

burdensome. According to one study, the economic cost of informal care may have reached \$375 billion in 2007.⁷

These relatives and friends report they spend an estimated \$5,000 annually out-of-pocket on caregiving.⁸ In addition, they often cut their own work hours to free up time to provide care. This not only reduces their immediate earnings, it may also result in lower Social Security benefits, smaller pensions, and fewer defined contribution plan assets.

While costs to individuals are substantial, the largest single payer of long-term services and supports is Medicaid. This joint federal/state health program was created in 1965 principally to provide medical care to low-income women and children.

In 2007, however, while those over 65 and disabled adults represented just 28 percent of Medicaid enrollees, the program spent 67 percent of its budget on this population. Medicaid spent \$2,435 per child enrollee, but more than \$14,000 for each beneficiary 65 and older.⁹

Overall, Medicaid spent about one-third of its budget on long-term care alone. However, benefits vary widely by state. In 2004, states spent an average of \$304 per resident on long-term care services. But New York paid \$833, while California spent \$187 and Nevada spent just \$102¹⁰. By 2017, the Centers for Medicare and Medicaid Services projects spending on long-term care will more than double, from \$100 billion to more than \$225 billion.¹¹

Despite these high costs, recipients of long-term care face significant delivery issues. About 75 percent of the frail elderly and younger adults with disabilities receive care at home, an additional 10 percent in assisted living or other congregant care settings, and about 15 percent in skilled nursing facilities.

Those receiving care indicate a widespread preference for remaining at home. However, providing this care can be extremely difficult for family members. It often requires a high level of training in skills such as bathing or transferring a patient, and in handling emotional challenges. It often also requires business management skills since families are often responsible for hiring aides, paying their taxes, scheduling their replacements and the like. Today, few programs offer such training.

The inability of families to manage these care needs, and the frequent physical decline of caregivers themselves often results in recipients moving to institutional care facilities.

Historically, Medicaid has been a major driver of nursing home usage. In part, this is because Medicaid is required by law to pay only for care delivered in skilled nursing facilities. In recent years, through a series of state “home and community-based service” waivers, Medicaid has begun expanding coverage to include assistance for those staying at home.

However, institutional care remains the focus of the Medicaid long-term care system. In 2007, nearly three-quarters of Medicaid long-term care dollars for the frail elderly and adults with disabilities were still being paid to nursing facilities, although every state has a home care waiver program in place.¹²

Many states have been unwilling to make a full financial commitment to these programs, which often put them at risk for costs above a fixed level. Some states limit benefits. Others limit access. As a result, as many as 90,000 Medicaid beneficiaries were on home care waiting lists in 2007. Only five states spent more than 50 percent of their Medicaid long-term care budgets on community care, while nine spent less than 10 percent.¹³

A note on Medicare: The federal health program for seniors is not designed to pay for long-term care services. However, it does provide limited post-acute skilled nursing care and personal assistance. Normally, Medicare will only provide these services after a patient has been hospitalized for at least three days. It will pay full benefits for up to 20 days after discharge and partial benefits for a maximum of an additional 80 days.

It is difficult to know how much of this care is “long-term” and how much is “post-acute.” However, in 2006, Medicare paid an estimated 18 percent of skilled nursing facility, home health, and assisted living costs, or approximately \$40 billion.¹⁴ This represented about 10 percent of all Medicare expenditures.

This distinction between the two government payers is an artifact of both the politics and medical environment of the 1960s, when both programs were created. At that time, chronic illness was still often of short duration. Today, however, multiple chronic disease is common among the those over 65. Nearly 90 percent of those 65 and older suffer from at least one chronic illness, and 20 percent of those 75 and older suffer from five or more.¹⁵

Medical experts agree on the need to coordinate care for this population. However, this is extremely difficult in an environment that separates Medicare-paid acute care and Medicaid-funded long-term care for those very ill and low-income people who are “dual” eligible for both. Today, only a handful of small programs are attempting to coordinate care for this population.¹⁶

Finally, about 7 percent of long-term care costs are paid by private insurance. Approximately 7 million Americans have private long-term care insurance, according to industry estimates.¹⁷ However, sales have been flat for the past several years.¹⁸

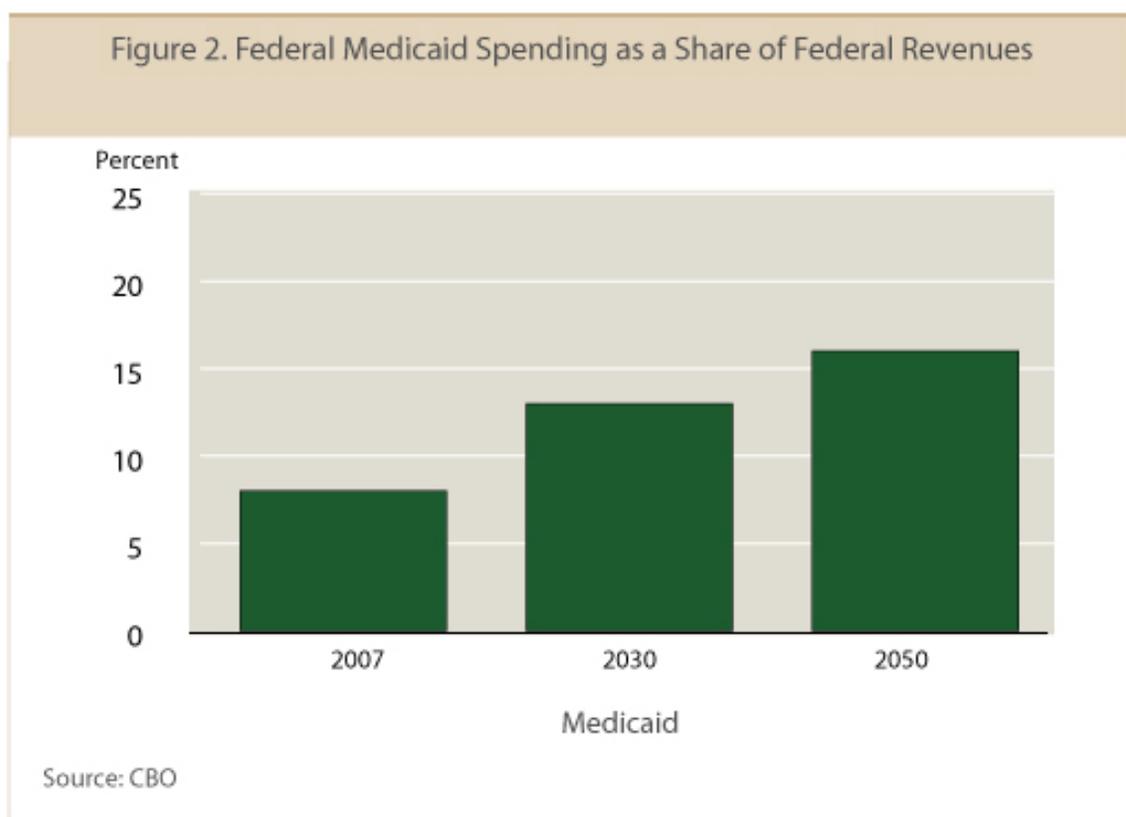
There are several potential reasons, including complexity and the unwillingness of consumers to confront the possibility of a frail old age. However, industry surveys suggest the principal reason is price.¹⁹ For a healthy 60-year old, a mid-range policy can cost \$2,000 or more annually.²⁰ Recently nearly all carriers have increased premiums for in-force policies.

In addition, Medicaid may itself be a significant disincentive to private purchase of long-term care insurance. If individuals believe government will pay for their long-term care, they may be less likely to purchase costly private coverage.²¹

As a result, private long-term care insurance remains a niche product. While much of the recent political debate over health reform has focused on the 40 million-plus who do not have medical insurance, it may be worth noting that more than 250 million Americans do have this coverage. This is in stark contrast to the 7 million who have long-term care insurance.

In the future, today’s financing challenges will become even more severe, largely as a result of extraordinary demographic change. By 2030, more than 71 million Americans will be 65 and older, and by 2050 nearly 90 million people, or 20 percent of the population, will be 65-plus. The very old—those most likely to need long-term care-- will be the nation’s fastest growing age group. Today, fewer than 6 million Americans are 85-plus, but by 2050, 21 million will reach that age.²² More than 20 million seniors will need some long-term care, twice as many as in 2000. Six million will have severe disabilities.²³

In addition, as the number of those needing care rises, the pool of potential caregivers is expected to shrink. Today, for each person over 85, there are more than 30 adults between the prime caregiving ages of 20 and 64. However, by mid-century, there will be just 11.²⁴



In part because of these demographic changes, the long-term budgetary consequences of Medicaid cost growth will be profound. The combined federal and state shares of this program are projected to grow from about 2.9 percent of Gross Domestic Product today to 6.5 percent by 2045. The federal share alone would increase from about 1.6 percent of GDP to 3.7 percent.²⁵

For a somewhat different perspective, consider Medicaid spending as a share of expected taxes. In 2007, federal Medicaid spending absorbed about 8 percent of revenues. This is expected to increase to 13 percent by 2030 and 16 percent by 2050. Combined with Medicare, total spending for these two programs will absorb two-thirds of projected federal revenues by mid-century.²⁶

In an effort to reduce pressure on Medicaid, state and federal officials have taken numerous steps to encourage purchase of private insurance. These have included new state and federal tax incentives, a federally-funded marketing campaign to encourage consumers to purchase coverage, offer of group coverage to federal employees, and an expansion of the Partnership Program. This program makes Medicaid benefits more readily available to consumers who purchase designated long-term care insurance policies.

Both the federal government and at least 34 states provide tax credits or deductions for the purchase of long-term care insurance. The amount of the federal tax subsidy is based upon age, but in 2009 a taxpayer between age 60 and 70 could deduct up to \$3,180 in premiums for approved long-term care policies.²⁷ However, the benefit of this deduction is limited, since it can be used only if total medical costs exceed 7.5 percent of Adjusted Gross Income. In addition, benefits received through private policies are generally tax free.

While seven states offer tax credits, most design their incentives as deductions. This structure tends to provide the largest subsidy to the highest income buyers, who would be most likely to purchase insurance even without the incentives. For many other potential consumers, the cost of a policy is still too high, even with the tax break.²⁸

Overall, premium subsidies appear to have only modest effects. One new study finds that sales are one percentage point higher in states with tax incentives than in states with none.²⁹ The most significant response appears to be in those states with credits, rather than deductions. Other research concludes that a 25 percent reduction in premium costs increase demand by only about 11 percent.³⁰ In 2006, fewer than 300,000 individual policies were sold. This implies an increase in sales of only about 30,000 even with an extremely generous 25 percent credit.

A third study associates a state tax subsidies with a greater response--a 30 percent increase in the probability of coverage. However, this analysis also finds that the subsidy cost to states may still exceed any Medicaid cost savings that results from higher take-up of private insurance.³¹

In a more explicit attempt to reduce Medicaid costs, Congress enacted the Partnership Act. This program, introduced in four states in the late 1980s and expanded in 2005, offers long-term care insurance buyers a trade-off. Normally, one becomes eligible for Medicaid long-term care benefits only after spending down financial assets to \$2,000 (excluding a principal residence, a car, and certain other personal property). However, a buyer of a Partnership long-term care policy may retain financial assets equal to the total value of her insurance policy--substantially more than a Medicaid beneficiary who has not purchased a Partnership policy. For example, once insurance benefits are exhausted, a buyer of a \$200,000 Partnership policy could retain \$202,000 in assets and still qualify for Medicaid (assuming the purchaser also meets Medicaid's medical need and income tests).

As of 2007, 23 states were participating in the enhanced program.³² However, early evidence suggests that Partnership policies are not likely to reduce state Medicaid by a significant amount. In the four states that initiated the program in the 1980s,³³ only

218,000 policies were purchased over nearly 20 years. More recent versions of the program may be more attractive, although no data are yet available on participation.

An equally-important question is whether the Partnership program can reduce state Medicaid costs. Again, there is no evidence that such savings have occurred to date.

The federal government has also embarked on a series of marketing initiatives in an effort to encourage the purchase of private policies.

In 2001, the federal Office of Personnel Management began making coverage available to federal employees and retirees. As with most group long-term care insurance (and in contrast to health insurance), enrollees pay full premiums. There is no employer subsidy, although benefits are more generous than many private policies. On May 1, 2009, OPM announced a rate increase of between 5 percent and 25 percent on current enrollees whose policies include inflation protection.³⁴ As of May 1, 2009, approximately 224,000 federal employees had purchased coverage, a take-up rate of less than 10 percent,³⁵ quite similar to the private market.

In 2005, the U.S. Department of Health and Human Services initiated the “Own Your Own Future” campaign, a major joint marketing effort with participating states to encourage consumers to purchase private long-term care insurance. The effort included mailings to those aged 45 to 70, and development of state websites. As of April 2008, 18 states were participating.³⁶ To date, there is little evidence that this initiative has resulted in significantly more sales.

SOLUTIONS

There appears to be a broad consensus that the current system of both delivery and finance is not working well. As a result, policymakers are considering several proposals for substantial reform. These fall under three categories: Shifting the focus of Medicaid long-term benefits to home care, expanding the long-term care and geriatric workforce, and restructuring the means of finance.

The least controversial of these are proposals to create new incentives to encourage workforce growth. The Workforce for an Aging America Act,³⁷ sponsored by Senate Aging Committee Chair Herb Kohl (D-WI), would provide tuition assistance for education of direct care workers as well as improved training for both paid and family caregivers.

The second set of initiatives would accelerate Medicaid’s shift from institutional to community care. While these proposals would help serve an unmet need, they would also require creation of a greatly expanded home care infrastructure, including more aides, more adult day programs, better transportation, and more accessible housing.

The Empowered At Home Act, sponsored by senators John Kerry (D-MA) and Charles Grassley (R-IA) would allow states to offer home and community services to people with higher incomes, and allow participants to keep more assets, which would give them greater ability to pay ordinary costs of staying at home, such as taxes and utilities.³⁸

The Community Choice Act sponsored by Senator Tom Harkin (D-IA) and Representative Danny Davis (D-IL) would be even more far-reaching. It would require states to offer equal access to home and community care under Medicaid.

Such steps appear to be quite responsive to the public's desire for more home care and greater flexibility in care settings. However, some state Medicaid officials are very concerned about what is known as the woodwork effect. Their fear is that low-income families who now provide informal care at no cost to the state would seek assistance from a more widely available Medicaid home care benefit.

Expanding community care could be quite costly. The Congressional Budget Office estimates that expanding mandatory home and community services under Medicaid could cost as much as \$5 billion annually.³⁹ However, Congress will likely adopt some measures to encourage states to expand these programs under Medicaid, even as new curbs are imposed on Medicare funding of post-acute care.

Further integrating Medicare and Medicaid may also enhance the quality of long-term care services. Modest programs to achieve this goal have been created in Wisconsin, Minnesota, and Massachusetts. However, there is little evidence to date that, as designed, these programs save money.

One possible solution to both the care coordination and Medicaid cost problems is to dramatically scale back, or even eliminate, Medicaid's role in providing long-term care. This could be done through universal or near-universal long-term care insurance.

Table 1. Models for Long-Term Care Financing Reform

	Mandatory	Gov't Insurance	Private Insurance	Funding Source
Medi-LTC	No	Replaces Medicare LTC	Yes, at 50	Premiums
Burman/Johnson	Yes, universal for 65+	Yes, Medicare Pt. E	Supplement only	Income tax surcharge
CLASS Act	Available at 18, opt-out	Yes	Supplement	Premiums/payroll deduction
Galston	Yes, at 40	Catastrophic only	Yes	Premiums

Current initiatives to reform long-term care financing in the United States are built on three models. The first would further enhance private long-term care insurance in an effort to make this product more attractive. The second would build a core government insurance model. The third incorporates various public/private hybrids.

In an effort to further expand private insurance in a more comprehensive way, three researchers have designed a plan called Medi-LTC.⁴⁰ Under this proposal, private carriers could sell three simplified benefit packages through Medicare, similar to the way Medicare Supplement (Medigap) health insurance is marketed today. Unlike Medigap, however, benefits could be customized, although each package would have to provide at least basic coverage. Carriers would be permitted to underwrite policies and, thus, could reject applicants based on health status.

In one important feature, private insurers would pay for the nursing home and home health benefit now provided by Medicare. In return for transferring this risk to private insurers, Medicare would use its cost savings to subsidize premiums.

The Medi-LTC proposal has several advantages. It would cost the government relatively little. Direct marketing through Medicare would likely increase demand for private policies. And competition among plans could lower prices.

However, proposals to enhance private insurance are unlikely to greatly expand long-term care coverage. An analysis by Georgetown University concludes that these proposals would increase the total number of policyholders by no more than 4.4 million (equivalent to 13 percent of those over age 50).⁴¹ It will be difficult to achieve substantial premium reductions without a far greater increase in the size of the risk pool.

The underwriting issue would have to be resolved as well. Any market-based system must be carefully designed to avoid cherry-picking, where carriers set rates to encourage the healthiest buyers and discourage those most likely to claim. Similarly, where underwriting is permitted, government assistance would have to be made available to those who are uninsurable. Finally, the viability of a voluntary private insurance model may be at risk should accurate, widespread genetic tests be developed for diseases such as Alzheimer's.

In addition, under a private insurance model, some provision may have to be made to protect policyholders against a carrier's failure, perhaps decades in the future. This might require, for instance, some form of government reinsurance.

While the United States has embarked on efforts to relieve pressure on its means-tested Medicaid program by enhancing private insurance, many other industrialized countries have taken a different route. Within the past 15 years, Germany, Japan, Korea, and France, among others have created or expanded their government long-term care insurance programs.

This effort is now being followed by some in the United States who would replace the current welfare-like Medicaid system with universal tax-funded insurance. Such a program could be managed as a new Medicare benefit or through a new independent quasi-government entity. There are several variations that differ mostly by the type of tax used to fund the program.

One prototype plan, proposed by Urban Institute researchers Leonard Burman and Richard Johnson, would provide both home care and nursing facility care to the frail elderly and younger disabled through a new Medicare Part E. Beneficiaries would pay a \$500 annual deductible and a 20-percent copayment up to \$5,000 per year. These costs would be reduced for low-income beneficiaries. The home care benefit would be limited to 100 hours per month. Providers would be paid according to a fixed fee schedule.⁴²

The Medicare-type model has several benefits. It would largely replace the existing welfare-based Medicaid system by covering those middle-class families who cannot afford private insurance. In addition, Medicare is operated at a lower cost per beneficiary than comparable private health insurance, and it is likely that a similar long-term care program would be as well.

The Burman-Johnson prototype would rely on a one-percentage-point income tax surcharge that would have raised an estimated \$55 billion in 2007. This structure is highly progressive, with taxpayers in the middle quintile paying an average of \$147 annually and those in the top 1 percent of the income distribution paying an average of more than \$10,000.

Alternatively, an insurance program could be financed through a payroll tax surcharge, similar to the financing design adopted by Germany a decade ago. Depending

on its structure, such a tax can also be quite progressive, although less so than an income tax surcharge. A payroll tax increase has some disadvantages, however, principally that it would raise labor costs in the United States at a time of intense international labor market competition.

A third option would be to introduce a new value added tax (VAT), most likely as part of a broader levy to finance health care reform. A VAT operates much like a national sales tax, although it is imposed at each stage of production rather than only at the retail level. Many other nations, such as France, use VAT revenues to help fund social insurance. However, none specifically designate the levy as an explicit funding source for long-term care insurance.

While tax increases to finance a long-term care insurance program have been broadly accepted in most major industrialized countries, such as Germany, Japan, and France, it is unclear whether voters in the United States would support additional taxes.

As a result, other options focus on the use of alternatives to tax increases. In these models, monthly contributions are fixed regardless of income (except for a low-income subsidy). Thus, these contributions, may feel more like a premium than a tax. While there is little economic difference between a mandatory premium and a tax,⁴³ this reframing may be politically advantageous.

Senator Edward M. Kennedy (D-MA) and others have introduced the Community Living Assistance Services and Supports (CLASS) Act that creates a government insurance benefit and explicitly anticipates the purchase of private supplemental coverage.⁴⁴ Enrollment would be automatic starting at age 18, but with an opt-out option. Those who chose not to purchase initially would pay higher age-related premiums if they decided to enroll at a later time.

After a five- year vesting period, the program would provide a lifetime benefit averaging at least \$50-a-day. Benefits would be based on level of functional need, would be paid in cash,⁴⁵ and could be used for a wide range of services. Premiums would be fixed and not income-adjusted, though contributions would be made through payroll deduction. Sponsors estimate the initial premium would be \$65-per-month, although the Secretary of Health & Human Services would have broad flexibility in setting actual rates. Premiums would increase annually with the Consumer Price Index.

Because the benefit would cover significantly less than all long-term care costs for many beneficiaries, the sponsors expect consumers to purchase supplemental private insurance.⁴⁶

The CLASS Act would provide cash benefits, much as Social Security disability insurance does today, and as Germany permits. Such a benefit design provides the elderly, disabled, and their families the flexibility to spend the funds for such purposes as supporting family caregivers, renovating a home to accommodate a wheelchair, or obtaining assistive devices without having to navigate complex government regulations or limitations of insurance contracts.

A crucial question will be the behavioral response to an opt-out, especially among those in their 20s and 30s. It seems likely, however, that if the program permits an opt-out, adverse selection would result in higher premiums than in a mandatory program.

In addition, the CLASS Act would retain a substantial Medicaid program. Similar models, including one proposed by the American Association of Homes and Services for the Aging, would shift many low-income individuals out of Medicaid by providing premium subsidies that would allow them to purchase insurance. The AASA plan is also designed so that it is entirely self-funded. Thus, the basic premium has built in the cost of a low-income subsidy.

While the CLASS Act and the AAHSA plan set the government as the initial payer, another approach would require individuals to finance a large share of long-term care costs before receiving the benefits of social insurance. There are many variations of this design but, in all, individuals would pay what amounts to a very large deductible in return for catastrophic government coverage.

In one design proposed by the Brookings Institution's William Galston, individuals would be required to purchase a private long-term care policy beginning at age 40. Insurers would sell to all applicants without underwriting. A prototype policy would cover \$150-day for the first five years of care. Purchasers would pay market premiums, although subsidies would be available to low-income buyers. As with Medigap, insurers would offer a range of standardized benefits, though they could continue to compete on price. Such a structure would simplify purchasing decisions for buyers. By taking advantage of an expanded risk pool, premiums should fall significantly from today's market prices.

In other variations, consumers would be required to pay for the first \$100,000 of care, or the first two years of care before receiving federal benefits.⁴⁷

A version proposed by the American Health Care Association and others would establish a sliding-scale deductible, called a Personal Responsibility Amount, that would be tied to a person's earning history or assets. Once that amount, which would range from \$50,000 to \$180,000, was spent on long-term care, government would pay for additional costs. Those who do not contribute to these accounts would be required to contribute most of their assets (including their home equity) and income to the cost of their care.⁴⁸

These public/private partnerships assume that many consumers will purchase private insurance to supplement government coverage. In the Galston proposal, this coverage is explicit. In proposals such as the CLASS Act, widespread participation in private plans is assumed. However, little is known about the willingness of private carriers to sell coverage that would wrap around a federal benefit.

Many designs for universal or near-universal insurance raise other issues as well. A guaranteed revenue stream might make it more likely that providers, such as nursing homes and home health agencies, will raise prices.⁴⁹ Today, these prices are negotiated by Medicaid, the dominant payer. In a social insurance model, Medicare could serve the same function. In private insurance models, it is possible that carriers would respond by creating networks of providers to offer services at negotiated prices, but it is not known how insurers, providers, or consumers would respond to such a shift.

CONCLUSION

While no new structure is ideal, each of the models discussed has advantages over the current system. Combining reforms in delivery, workforce, and financing can result in

improved care and more flexibility for recipients and their families. If well-designed, these reforms can be achieved without adding to the nation's budgetary pressures, and may perhaps even reduce government spending.

The broader health reform debate now taking place in Washington creates a rare opportunity for policymakers to rethink the relationship between medical treatment and the long-term care needs of the chronically ill and those with disabilities. It is, for instance, an ideal environment to better coordinate long-term care with medical treatment. Broad health reform also presents an opportunity to review the bifurcated structure of Medicare and Medicaid that often works to the detriment of those eligible for both programs. It allows policymakers the chance to alter the balance between institutional and home- and community-based care. And, as policymakers attempt to redesign health coverage, so should they be considering improved payment mechanisms for long-term care. It is difficult to imagine a well-designed health reform that fails to address these issues.

NOTES

1. Judith Feder, Harriet L. Komisar, and Robert Friedland, "Long-Term Care Financing: Policy Options for the Future" (Washington, DC: Georgetown University, 2007).
2. Centers for Disease Control, "National Vital Statistics Reports United States Life Table 2004" (Atlanta, GA: Centers for Disease Control, 2007).
3. From *The Principles and Practice of Medicine* by William Osler, 1897, cited in Joanne Lynn, "Living Long in Fragile Health: The New Demographics Shape End of Life Care" in *Improving End of Life Care* (The Hastings Center, 2005).
4. Peter Kemper, Harriet Komisar and Lisa Alecxih, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect" *Inquiry*, 2005 42: 335-350 (Winter 2005/2006)
5. Metlife, "The Metlife Market Survey of Nursing Homes and Assisted Living Costs 2008" Westport, Conn.: Metlife, 2008).
6. Harriet Komisar and Lee ShireyThompson, "National Spending for Long-Term Care 2007" Georgetown University, 2007
7. Houser, Ari and Mary Jo Gibson, 2008. "Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update" Washington, d.C. AARP Public Policy Institute
8. National Alliance for Caregiving, "Evercare Study of Family Caregivers: What They Spend, What They Sacrifice" Bethesda, MD: National Alliance for Caregiving, 2007).
9. Centers for Medicare and Medicaid Services, "Actuarial Report on the Financial Outlook for Medicaid" Washington, D.C.: Centers for Medicare and Medicaid Services, 2008).
10. Ellen O'Brien, "Long-Term Care: Understanding Medicaid's Role for the Elderly and the Disabled" (Kaiser Commission on Medicaid and the Uninsured, 2005).
11. CMS, 2008, "National Health Expenditures Projections 2007-2017"
12. AARP, "Across the States: Profiles of Long-term Care and Independent Living" ([City?]): AARP, 2009).
13. Ibid.
14. Komisar and Thompson, "National Spending for Long-Term Care 2007" 2007
15. AARP Public Policy Institute, "Chronic Care: A Call to Action for Health Reform" Washington, D.C. : AARP, 2009). Common chronic diseases include arthritis, diabetes, congestive heart failure, pulmonary disease. In addition those with dementias and younger people with diseases such as multiple sclerosis or those who may have suffered traumatic brain or spinal injuries may also require many years of long-term care.
16. These include the Program of All Inclusive Care for the Elderly (PACE) as well as modest state programs in Wisconsin, Minnesota, Massachusetts, and elsewhere.
17. Marc Cohen, "Financing Long-Term Care: The Private Market" LifePlans. PowerPoint presentation, May 7, 2009. Cohen estimates between 6.75 and 7.75 million policies were in force as of May 2009.

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18. LIMRA International. 2009 “Individual Long-term Care Insurance Premium Falls 23 Percent in the Fourth Quarter” Windsor, Conn. Sales of individual policies fell in 5 of 6 years between 2003 and 2008. During this period, group sales increased steadily.
 19. America’s Health Insurance Plans, “Who Buys Long-Term Care Insurance” (2007). Non-buyers had some contact with a sales person. AHIP did not survey the public at large.
 20. Office of Personnel Management estimate of a five-year policy with a \$150 daily benefit, inflation protection, and a 90-day elimination period.
 21. Jeffrey R. Brown and Amy Finkelstein, “The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market” (Cambridge, MA, National Bureau of Economic Research, 2006). Individuals are not eligible for Medicaid until they have exhausted their wealth. In addition, Medicaid is a secondary payer for long-term care services after any private insurance. As a result, many individuals will pay premiums for private insurance that provide benefits that Medicaid would otherwise have paid. Brown and Finkelstein estimate that 60 percent of the private insurance benefits due a male with median wealth (about \$222,000) would be paid by Medicaid if that person had no insurance. For a woman, the amount of such redundant coverage is 75 percent.
 22. Data: U.S. Census Bureau, cited in “Older Americans 2008” Federal Interagency Forum on Aging-Related Statistics.
 23. Richard W. Johnson, Desmond Toohey, and Joshua M. Wiener, “Meeting the Long-Term Care Needs of the Baby Boomers” (Washington, DC: Urban Institute, 2007).
 24. Joshua Weiner, “Projecting the Future of Long-Term Care: The NIC Compendium Project” PowerPoint presentation of Joshua Weiner, Lewin Group Analysis of U.S. Census Bureau Data
 25. Richard Kronick and David Rousseau, “Is Medicaid Sustainable: Spending Projections for The Program’s Second Forty Years” *Health Affairs* 26, no. 2 (2007): w271–w287.
 26. Congressional Budget Office, “The Long-Term Economic Effects of Some Alternative Budget Policies” 2008. This estimate is based on CBO projections of “widely expected” changes in policy.
 27. More than 95 percent of all policies sold in 2006 were tax qualified.
 28. A 60-year-old can expect to pay an annual premium of roughly \$2,000 for a comprehensive policy that pays \$150-a-day for five years. Premium is for policies offered to federal employees through the Office of Personnel Management. Tax deductions reduce taxable income, but the reduction in the after-tax cost of a policy is much lower than the deduction. Also, deductions are more beneficial to those in higher tax brackets than those in lower brackets. Imagine two taxpayers paying \$2,000 annually for a policy. The deduction would reduce tax liability by \$700 for a buyer in the 35 percent bracket. A taxpayer paying a marginal rate of 10 percent would lower their tax liability by just \$200. Credits, by contrast, reduce tax liability dollar-for-dollar and by an equal amount regardless of the buyer’s marginal tax rate. Thus, a 10 percent credit on \$2000 in premiums would reduce the after-tax cost of the policy by \$200. Tax qualified policies must meet certain basic consumer protection standards
 29. David Stevenson, Richard Frank, and Jocelyn Hsu, “Private Long-Term Care Insurance and State Tax Incentives” *Inquiry* forthcoming.
 30. Anne Theisen Cramer and Gail A. Jensen, “Why Don’t People Buy Long-Term Care Insurance?” *Journal of Gerontology: Social Sciences* 2006 61:S185-S193 . While the authors did not specifically look at the impact of tax subsidies, their analysis of Health and Retirement Survey data found that the demand for coverage is relatively price inelastic. They concluded that even a 25 percent price discount—far more than is available through tax incentives—would increase demand by only 11.2 percent.
 31. Gopi Shah Goda, “Do Tax Subsidies for Private Insurance Reduce Medicaid Costs? Evidence from the Market for Long-Term Care Insurance” Cambridge, MA. 2009).
 32. Long-Term Care Partnership State Tracking Map, 2007, Thomson-Reuters, <http://www.dehpg.net/ltpartnership/>
 33. New York, California, Indiana, and Connecticut
 34. News Release, May 1, 2009, “OPM Awards New Long-Term Care Insurance Contract,” <http://www.opm.gov/news/opm-awards-new-long-term-care-insurance-contract,1462.aspx>.
 35. May 1, 2009 estimate: personal communication with John Cutler, Office of Personnel Management. For an earlier analysis of the program, see U.S. Government Accountability Office, “Long-Term Care Insurance: Federal Program Has a Unique Profit Structure and Faced a Significant Marketing Challenge,” GAO-07-202 (Washington, DC: GAO, 2006).

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36. National Clearinghouse for Long-Term Care Information web site, http://www.longtermcare.gov/LTC/Main_Site/Planning_LTC/Campaign/index.aspx
 37. "Workforce for an Aging America Act" <http://aging.senate.gov/record.cfm?id=306650>.
 38. Empowered at Home Act" <http://www.opencongress.org/bill/111-s434/show>.
 39. CBO "Budget Options, Vol. 1: Health Care" Washington, D.C. 2008.
 40. John Cutler, Lisa M. Shulman, and Mark Litow "Medi-LTC A New Medicare Long-Term Care Proposal" (Washington, DC: Georgetown University, 2007).
 41. Feder, Komisar, and Friedland, "Long-Term Care Financing."
 42. Leonard Burman and Richard Johnson, "A Proposal To Finance Long-Term Care Services through Medicare With An Income Tax Surcharge" (Washington, DC: Georgetown University, 2007).
 43. The distributional effects of a tax could vary widely, however, depending on the design.
 44. "Affordable Choices Act" http://help.senate.gov/BAI09A84_xml.pdf.
 45. A cash benefit could be paid directly to beneficiary or made available through a fiscal intermediary that would distribute payments to providers. The CLASS Act contemplates the latter.
 46. "Affordable Choices Act" .
 47. See Christine Bishop, "A Federal Catastrophic Long-Term Care Insurance Program" (Washington, DC Georgetown University, 2007); Anne Tumlinson and Jeanne Lambrew, "Linking Medicare and Private Health Insurance for Long-Term Care" (Washington, DC: Georgetown University, 2007).
 48. Avalere Health LLC, "Post-Acute and Long-term Care Reform: Estimating the Federal Budgetary Effects of the AHCA/NCAL Alliance Proposal" Washington, D.C.: Avalere Health LLC, 2009).
 49. Finkelstein, "Interaction of Public and Private Insurance," found that such a steady revenue stream through Medicare drove up prices of health care providers.