

# ECONOMIC COMMENTARY

Federal Reserve Bank of Cleveland

## Long-Term Health Care: Is Social Insurance Desirable?

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**T**he aging of the U.S. population portends steep increases in the demand for health care services well into the next century. Although many Americans rely on public health programs and private health insurance to provide financial protection for a diverse group of medical risks, the availability of such support for long-term disabilities is woefully inadequate. As of 1992, fewer than 10 percent of those age 65 or older were covered by private long-term care insurance.<sup>1</sup>

Expenditures on long-term care can be economically devastating for the families of disabled persons and may potentially sap public budgets. Total spending on nursing home services stood at \$60 billion in 1991, of which more than half was financed by federal, state, and local governments (see figure 1). Policymakers engaged in reforming the country's health care system must bear in mind that as the baby boom generation ages, the problems associated with ensuring adequate long-term care will be exacerbated.

This *Economic Commentary* explores the underlying reasons for the private insurance market's failure to cover long-term care risks adequately. It also evaluates several proposals for funding long-term care through social insurance. We contend that none of these proposals considers the potential negative economic impact of the intergenerational wealth redistribution implicit in social insurance schemes.

### ■ Problems Facing Private Insurers

At the individual level, long-term care is best financed by purchasing insurance because future needs are uncertain and the potential costs are enormous. In 1990, the average annual cost of a nursing home stay was between \$25,000 and \$35,000.<sup>2</sup> The private market for insuring long-term care expenses is extremely thin, however. Only 2.4 million long-term policies were sold in 1991, of which just 8.7 percent were employer sponsored. In the same year, direct payments by individuals accounted for 43 percent of nursing home receipts.

Much of the failure of the long-term care insurance market can be traced to the twin problems of adverse selection and moral hazard. Both concern the pricing of insurance for a group of potential purchasers whose chronic disability risk is unknown, and both significantly increase the costs of private insurance.

In general, the probability of requiring extended care rises markedly with age.<sup>3</sup> Thus, most young persons opt out of purchasing such coverage even at extremely low prices. This means that individuals who do buy long-term care insurance — older Americans — are precisely those with the highest risk of requiring extended care in the near future.<sup>4</sup>

The inability to sell long-term care insurance to young people compels an increase in the price at which private

**As the baby boom generation ages, ensuring adequate long-term health care will become an increasingly important issue on the national agenda. A one-year nursing home stay averaged between \$25,000 and \$35,000 in 1990, yet as of 1992, only 10 percent of Americans age 65 or older had private long-term care insurance. This *Economic Commentary* takes a look at why the private insurance market has failed to cover extended-care risks adequately and examines the wealth distribution problems that socially funded insurance entails.**

providers can profitably offer coverage to the elderly. Even among the elderly, relatively healthy individuals may choose to forgo coverage, driving up the average risk of disability among the remaining pool of potential purchasers. The increase in the price of insurance caused by such an "adverse selection" of the riskiest individuals into the pool of potential buyers means that many elderly Americans cannot afford long-term care insurance (see table 1).

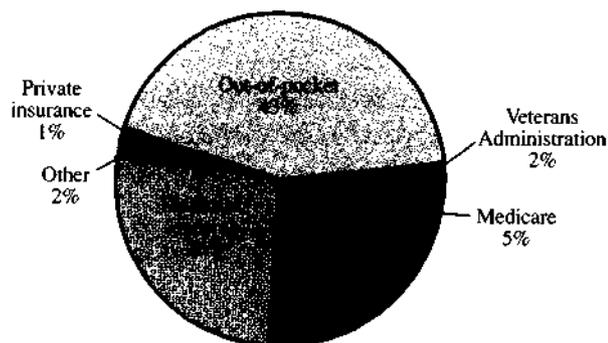
The moral hazard problem refers to the change in individuals' behavior after purchasing insurance. For example, a person who buys long-term care insurance may not protect his health to the same extent as someone who does not. Because a significant amount of extended care is currently provided by

relatives, pricing long-term insurance at lower rates may mean less care by family members and higher-than-anticipated claims on insurers.

A third important reason for the limited availability of private insurance is the difficulty of predicting increases in the cost of extended medical care. This applies particularly to nursing home services, which account for the largest share of long-term care outlays (82 percent in 1988). Among all health care services, the rise in the cost of nursing home care has been the steepest—12.6 percent per year between 1970 and 1990.<sup>5</sup> For any large group of insurance purchasers, the fraction that will suffer chronic disabilities within a specified period can be predicted with a fair amount of precision. With appropriate pricing, individual risk can then be diversified across the group. However, the risk of loss stemming from large and uncertain increases in the cost of providing long-term care is one that applies equally to each insured individual and that cannot be diversified.

The absence of adequate insurance coverage forces the disabled into one of three situations. They can 1) stay at home and either purchase home health care services or rely on family and friends, 2) enter a nursing home as a private-pay patient, or 3) enter a nursing home with the expectation of later qualifying for the state's Medicaid program.<sup>6</sup> While nursing home care absorbs the predominant share of long-term care spending, almost 80 percent of the elderly and about 40 percent of the severely disabled live at home.<sup>7</sup> Many of those who initially enter nursing homes as private-pay patients ultimately deplete their assets and end up on Medicaid. In general, however, there is an excess demand for nursing home facilities because most states limit the supply of beds in an effort to control costs. This forces some disabled individuals to remain at home. Regardless of which of these three situations actually occurs, spouses and children of the disabled bear a large share of the burden either directly, by providing care themselves, or indirectly,

FIGURE 1 NURSING HOME PAYERS, 1991



SOURCE: Suzanne W. Letsch et al., "National Health Expenditures, 1991," *Health Care Financing Review*, Winter 1992, pp. 1-30.

TABLE 1 AVERAGE ANNUAL LONG-TERM CARE PREMIUMS, 1991

Age of Buyer	Individual and Group Association Base Plan	Employer Sponsored
30	n.a.	\$108.99
40	n.a.	\$183.21
50	\$477.00	\$340.66
65	\$1,103.00	\$884.17
79	\$3,989.00	\$3,808.82

SOURCE: Health Insurance Association of America (footnote 4).

through receiving lower inheritances as assets are depleted to purchase nursing home services. Taxpayers also bear a portion of the burden through Medicaid support.

#### ■ A Rationale for Public Provision of Long-Term Care

In the mid-1980s, the Reagan administration supported legislation aimed at encouraging the private insurance market to cover long-term medical contingencies. Unfortunately, progress on this front has been painfully slow. For the reasons mentioned above, private insurers are unwilling to take on risks that seem to ensure only losses.

By the end of 1991, 131 private insurers were offering extended-care policies of various types, but none covered all of the expenses associated with such services. Insurers limit their risk exposure by imposing high deductibles and long waiting periods, as well as relatively short maximum covered lengths

of stay. They also set maximum benefit levels years in advance and limit inflation adjustments. Although some of these restrictions have been eased recently by several larger insurers, the private market for long-term care coverage still accounts for only 1 percent of the total spending on such services.

Because the development of a mature private insurance market for extended health care is uncertain, some have proposed instituting a social insurance scheme with broad public participation.<sup>8</sup> They argue that Social Security and Medicare, which are intended to provide only a floor of financial security for the elderly, have been successful. These programs leave to individual discretion the option to purchase supplementary health insurance or to increase personal saving. Proponents of a social insurance scheme for long-term care services recommend mandatory participation to provide a basic level of long-term coverage, leaving open the option to purchase

supplementary insurance via additional trade-offs with private pension plans and personal saving.

Some of the proposals currently on the table envision a system similar to Medicare. But this would mean imposing standardized eligibility criteria and uniform benefit packages that may narrow the choices available to the disabled and their families. Furthermore, restrictions on the quality and type of care provided may require a restructuring of the existing nursing home stock and services. For that reason, some have proposed an "indemnity" approach wherein cash benefits would be triggered based on prespecified levels of disability. Under this system, the individual would retain control over the type and quality of care. Various alternatives for financing such schemes have been floated, including higher individual taxes and the creation of a separate long-term trust fund, employer funding of insurance premiums, or a tax on Social Security benefits.

The Clinton administration's Health Security Plan is a social insurance plan that mandates long-term care for all "without regard to income or age."<sup>9</sup> It would expand home- and community-based services through federal funding of expenditures that exceed states' current Medicaid outlays and state-only spending on the severely disabled. It also envisages setting, enforcing, and monitoring minimum standards for private long-term care coverage. Premium payments made by individuals and employers for qualified long-term care policies would be tax deductible.

#### ■ Social Insurance: A Solution?

The public health insurance and security schemes in force today, the largest of which are Medicare, Medicaid, and Social Security, have engendered sizable wealth redistributions from younger to older generations.<sup>10</sup> Recent research suggests that this trend may constitute part of the explanation for the decline in U.S. saving over the last two decades.<sup>11</sup> Because the probability of developing a disability requiring long-term care increases significantly with age, the introduction of

a social insurance plan would involve a wealth transfer from those less likely to require extended care in the future to those more likely to need it — that is, from younger to older generations. Even if participation were restricted to persons over a certain age, say 65, there would still be a redistribution of wealth from all younger to older generations because once such a program is initiated, today's younger generations would expect, upon turning 65, to begin subsidizing their elders. The net benefits accruing to the first set of elderly, who will surely receive more than they contribute, would represent a windfall gain, the burden of which would descend on the pocketbooks of all future Americans. This redistribution, coupled with the fact that the elderly would now have more health insurance via yet another annuity, is likely to decrease saving and, therefore, bequests by the elderly.<sup>12</sup>

While the failure of the private insurance market for long-term care may provide some rationale for instituting a public program, adopting a plan that ignores the implications for intergenerational wealth redistribution is likely to hamper future U.S. economic growth by reducing saving and investment. The rationale for mandatory participation in any social insurance program is to protect the prudent members of society from the (future) liabilities of those who are improvident. But including in the group individuals who failed to insure themselves adequately in the past transforms the program from an insurance to a transfer mechanism. Thus, long-term care financing poses a dilemma because the insurance and transfer aspects of the problem are intertwined: Informational problems cause the private long-term care insurance market to be thin, but social provision through universal participation promotes a wealth redistribution toward the elderly that reduces the private incentive to save.

The solution, then, must separate these two aspects of the problem. Younger generations need to save today to meet their own future extended-care needs. Therefore, a funded but *generation-specific* program wherein the contribu-

tions of each generation are insulated from the claims of other (older) generations is worth considering.<sup>13</sup> If those requiring long-term support in addition to their existing health care benefits are to be accommodated, this could be done via separate and explicit transfers that would, by law, be phased out over time as the need for them tapers off.

#### ■ Conclusion

For most people, especially younger individuals, developing a disability that will require extended care is a low-probability event. Yet the resources that must be expended to provide for such an eventuality are enormous. Thus, protecting against long-term care contingencies is best accomplished through purchasing insurance.

Unfortunately, the private market for extended-care insurance faces significant informational problems that make such coverage prohibitively expensive for many Americans. This provides the motivation for proposing a publicly funded program. However, unless safeguards against the intergenerational redistribution of wealth from younger to older generations are adopted, such a provision could prove detrimental to U.S. economic growth in the long term by reducing saving and investment.

#### ■ Footnotes

1. Long-term care includes nursing home and home health care services for treating chronic health conditions and disabilities related to aging, physical diseases, and mental illnesses that prevent individuals from performing the normal activities of daily life.
2. See *The Consumer's Guide to Long-Term Care Insurance*, Health Insurance Association of America, Washington, D.C., 1991.
3. Two-thirds of the disabled and more than 80 percent of the severely disabled are over 65 years of age. Among persons 85 or older, 55 percent have some disability. By contrast, only 13 percent of those age 65 to 69 and just 2 percent of those under age 65 suffer any degree of disability.
4. In 1991, the average age of purchasers of private long-term care insurance was 69. See *Long-Term Care Insurance in 1991: Policy and Research Findings*, Health Insurance Association of America, Washington, D.C., February 1993.

5. Physicians' fees were in second place (up 11.8 percent), followed by hospital bills (+11.7 percent), dental costs (+10.4 percent), and drugs (+9.5 percent). See Katharine R. Levit et al., "National Health Expenditures, 1990," *Health Care Financing Review*, Fall 1991, pp. 29-54.

6. Medicaid eligibility is met if the disabled individual has less than \$1,500 in liquid assets if single, and less than \$2,250 if married. If the nursing home stay exceeds six months, the individual is required to sell his home and a lien is placed on its value equal to the value of subsequent nursing home expenses (unless the home is occupied by a spouse or child-care provider).

7. See "A Call for Action: Financial Report of the U.S. Bipartisan Commission on Comprehensive Health Care." Washington, D.C.: U.S. Government Printing Office, 1990.

8. See William J. Scanlon, "Possible Reforms for Financing Long-Term Care," *Journal of Economic Perspectives*, vol. 6, no. 3 (Summer 1992), pp. 43-58. See also Yung-Ping Chen, "A Three-Legged Stool: A New Way to Fund

Long-Term Care," in *Care in the Long Term: In Search of Community and Security*. Washington, D.C.: National Academy Press, 1993, pp. 54-70.

9. See *Health Security: The President's Report to the American People*, White House Domestic Policy Council, U.S. Government Printing Office, October 1993.

10. See Laurence J. Kotlikoff, *Generational Accounting: Knowing Who Pays, and When, for What We Spend*. New York: The Free Press, 1992.

11. See Jagadeesh Gokhale, "The Decline in U.S. Saving Rates: A Cause for Concern?" Federal Reserve Bank of Cleveland, *Economic Commentary*, September 15, 1993.

12. Apart from redistributing wealth from younger to older generations, public financing of long-term care would further promote the annuitization of the elderly's resources. This may induce the elderly to deplete their resources at a faster rate and to leave smaller bequests. See Alan J. Auerbach, Laurence J. Kotlikoff, and David Weil, "The Increasing Annuitization of the Elderly: Estimates and

Implications for Intergenerational Transfers, Inequality, and National Saving," National Bureau of Economic Research Working Paper No. 4182, October 1992.

13. Permitting funds to be invested in non-government securities, for example, may be used as a means of enhancing the credibility of such protection. This would reduce or eliminate direct government control over the disposition of the funds.

  
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