Financing Long-Term Care

HEALTH AND PUBLIC POLICY COMMITTEE*, AMERICAN COLLEGE OF PHYSICIANS; Philadelphia, Pennsylvania

The availability and delivery of long-term care services in the United States have been hindered by major organizational and financial problems. The American College of Physicians has previously identified and addressed some of the organizational problems that impede access to long-term care. In this issues paper, we provide background information on and analysis of the costs and the methods currently used to finance such care in the United States. The Canadian National Health Care System is also described for comparison. We then analyze such alternative financing mechanisms as private individual insurance (beyond Medigap), employment-based long-term care insurance, self-insurance, vouchers, financing through Medicare, home equity conversions, and prepaid capitated case management plans. The advantages and disadvantages of each of these methods are presented.

[MeSH terms: activities of daily living; aged; capital financing; health insurance for aged and disabled, title 18; health maintenance organizations; home care services; insurance, health; insurance, long-term care; long-term care; medical assistance, title 19; nursing homes; United States Veterans Administration. Other indexing terms: Canadian National Health Care System; home equity; life-care communities; Medicaid; Medicare; Medigap; self-insurance]

THE AVAILABILITY and delivery of long-term care services in the United States have been hindered by major organizational and financial problems. The American College of Physicians (ACP) has previously identified and addressed some of the organizational problems that impede access to long-term care. This issues paper provides background information on and analysis of alternative means of financing, as the College proceeds to examine the public policy options involved and to develop its own policy positions.

Actions Taken by the American College of Physicians

Many barriers impeding access to long-term care services were identified at the College's 1980 Annual Session, in which attention was focused on aging and long-term health care. That meeting was followed by the ACP-sponsored national conference, "The Changing Needs of Nursing Home Care" (1). The College has subsequently continued to give much attention to analyzing these problems and developing recommendations for improvement. Several ACP position papers have specifically addressed ways to restructure the system.

In the ACP position paper, "Long-Term Care of the Elderly" (2), we defined long-term care as

> . . . the medical and support services needed to attain an optimum level of physical, social, and psychological functioning by persons who are frail and dependent due to chronic physical or mental impairments. It includes services to prevent avoidable deterioration of health, to treat acute exacerbations of chronic illness, to maintain the maximum possible independence, and to restore the individual to the optimal level of functioning that can be sustained.

In that paper, we argued that basic systemic changes were needed to achieve a comprehensive, coordinated, and continuous system of long-term care. We also called for changes in reimbursement policies to enhance the development of a more effective and efficient long-term care delivery system by encouraging the integration of acute and chronic care services. We further advised that attempts to reduce the cost of health care should not create new financial barriers that impede access to needed long-term care, and we urged internists to become more involved in the coordination of long-term care services.

Further structural changes for long-term care were recommended in the ACP position paper, "The Role of the VA in an Evolving Health Care System" (3). In that paper, we stated that even the substantial commitments of the Veterans Administration's resources for long-term care were likely to be inadequate to meet the increasing demand for services expected from growing numbers of dependent elderly veterans. Consequently, we called for greater planning and integration—without loss of the Veterans Administration's identity—of the Veterans Administration's and the community's resources to help meet both the acute and chronic care needs of the entire population.

In the position paper, "Home Health Care" (4), we recommended that home health care was one option in long-term care that should be available to serve patient care needs, that home health care personnel should be appropriately trained and certified, and that medical equipment and technologies should be reviewed for safety and effectiveness in the home care setting. Adequate funding was recommended for home health care services under Medicare, Medicaid, and other health care programs. The need to reduce confusion about coverage of home health services under various payment programs

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was also recognized, and physicians were urged to become better able to advise patients on the availability and use of services, as well as to become more involved in home health care.

The issue of long-term care was also addressed in the position paper, "Medicare Payment for Physician Services" (5). In that paper, the College emphasized that the costs of major illness (including long-term care) should not prevent Medicare beneficiaries from receiving needed health care services. Maintenance of standards of quality and cost-control were also seen as fundamental principles that should govern the Medicare payment system.

In this paper, the College seeks to focus attention on alternative means of financing long-term care. In this endeavor, we have been encouraged by recent developments sparked by the issuance of a report to the President on catastrophic illness by the Secretary of the Department of Health and Human Services, Otis R. Bowen, M.D. (6). The "Bowen Report" has heightened public awareness of the costs of catastrophic illness and has stimulated efforts to assure that people are protected from impoverishment from high health care expenses. The report and ensuing legislative proposals are important steps in protecting individuals and families from the catastrophic costs of health care. Unfortunately, most proposals, including those of Secretary Bowen, address the costs of acute care but offer little protection from the costs of long-term care. The College wishes to expand the level of the national policy debate to also include the financing of long-term care, the costs of which can be as great, or even greater, than those of acute care. Consequently, an ACP position paper is currently being written that will identify principles for addressing alternative financing proposals and that will contain ACP policy recommendations. In the interim, it is hoped that the information presented in this issues paper will provide a basis for discussion and an analysis of the possible alternative financing mechanisms.

Facts about the Costs of Long-Term Care

Long-term care involves personal care and supervision on a continuing basis for an extended period. It includes a range of services from informal unpaid care provided by family and friends to skilled nursing home care. Long-term care typically is required for assistance with the basic activities of daily living, and, because the need for such assistance dramatically increases with age, most persons in need of long-term care are elderly.

Roughly 84% of the care-givers for the noninstitutionalized and dependent elderly are relatives who provide care without charge (6). Most long-term care expenditures are for nursing home care. In 1984, total national personal health care expenditures for people 65 years of age and older was about $120 billion. Hospital and physician services constituted $79 billion of this total. Of the remaining $41 billion, nursing home care accounted for over $25 billion, or more than 60% of nonhospital and nonphysician costs (7).

On average, elderly consumers pay slightly more than 25% of their total health care costs themselves. However, although they pay directly for only a little more than 3% of hospital costs and about 26% of physician costs, they pay 50% of nursing home costs and almost 60% of other health care costs. Medicare pays only about 2% of nursing home costs, and private insurance, only about 1%. Medicaid pays almost 42% of elderly patients' nursing home costs, and other government programs pay about 4% (8).

Only about 5% of the elderly population (1.5 million people in 1985) are estimated to be in nursing homes at any one time, but the lifetime risk for entering a nursing home is about 20% (9). The average length of stay in a nursing home is 456 days and costs approximately $22 000, which is roughly $50 per day. However, more than 50% of nursing home stays are for less than 3 months, and nearly 40% are for less than 1 month. Only 18% of nursing home residents stay for 2 years or more, and the average stay for these residents is 831 days (6). Nursing home costs for these elderly persons average in excess of $40 000.

Although most home health care is provided by relatives without payment, paid home care in 1982 averaged about $164 per month (10). At the same time, the cost of home care for elderly persons having five or six limitations in the activities of daily living was about $439 per month. Current Medicare national average home care costs are about $43 per day (11). Recent estimates of total annual home health care expenditures range from $4 billion to $8 billion. Forecasters have predicted that by 1990, total home health care costs will be $13.8 billion and could rise to almost $25 billion by 1995 (12).

The elderly have shown a preference for receiving chronic care in the home or in community settings, but public and private insurance programs have traditionally offered coverage primarily only for institutional care. Coverage for home health care, however, has been increasing. Since 1970, Medicare expenditures for home health care have grown at an annual rate of 20%, increasing from $63 million in 1970 to $1.2 billion in 1982. Medicaid home health costs correspondingly increased from $15 million to over $400 million. Private insurance for home care has also increased. Although nearly nonexistent 15 years ago, by 1984, home health care benefits were included in almost all Blue Cross insurance plans and in over 40% of all commercial insurance policies (13). Still, much of the expense (25% to more than 50%) of paid home health care is borne out-of-pocket by elderly persons or their families.

The rate of utilization of long-term care services increases with age. In 1985, 6.7 million elderly persons required some long-term care assistance. Of these persons, 1.4 million (21%) were nursing home residents. The remaining 5.3 million (79%) were not institutionalized but required some assistance because of functional impairments. Of these persons, 1.66 million required assistance for instrumental activities of daily living, such as shopping and cooking, and 3.7 million had more severe disabilities limiting the activities of daily living, such as eating and going to the bathroom (6). People with such functional limitations include 2% of those aged 65 to 74, 7% of those aged 75 to 84, and about 16% of those aged

85 and older (10).

Inflation and a growing elderly population have accounted in large part for a tenfold increase in nursing home expenditures between 1965 and 1980, but increasing utilization rates have also been a major factor. Since the inception of the Medicare and Medicaid programs in 1966, the rate of nursing home use among persons over age 65 has doubled. As the elderly population continues to grow, particularly the numbers of the very old (those persons over age 84), the demand for all long-term care services can also be expected to continue to rise.

Current Methods of Financing

PERSONAL FINANCIAL RESOURCES

Most people, including the noninstitutionalized elderly, consider themselves to be relatively healthy and assume that they have adequate financial protection from the costs of long-term care. However, many of those in need of long-term care services find that their personal resources and insurance protection are inadequate. A national survey conducted in 1985 for the American Association of Retired Persons revealed that 79% of the population at large and 70% of the people over age 65 believed that Medicare would cover a long nursing home stay regardless of the type of care required, and half of those with Medicare and supplemental insurance thought that they were covered for long-term care expenditures (14).

Instead, most elderly persons find that they must rely primarily on their own financial resources to pay for long-term care services. When extended skilled nursing care is required, many find that their resources are inadequate.

In 1984, the median family income of households headed by a person aged 65 or over was $18 236. This median income was significantly below the $29 292 median income for persons in families headed by someone aged 25 to 64 (8). The median income of single or widowed elderly persons was $7 349, which is about half that of nonelderly persons ($15 561). However, it has been argued that the average amount of disposable income of elderly persons is more equal to that of the general population, because they generally no longer bear costs incidental to daily work and generally no longer are financially responsible for the cost of child rearing, college education, or home mortgage payments.

However, these comparisons mask the wide and unequal distribution of income and assets among the elderly. Income varies greatly based on age, sex, race, and marital status. In 1983, the median cash income of couples aged 85 and older ($11 988) was less than three fourths of the median cash income of couples aged 65 to 74 ($17 798). The median cash income of single persons aged 85 and older ($5 912) was also three fourths that of single persons aged 65 to 74 ($7 651). In every age group, elderly women had lower incomes than elderly men, and black and Hispanic people had lower incomes than white people (8).

In 1980, only 2% of the elderly, compared with 4.8% of the nonelderly, had cash incomes that were less than 50% of the poverty line—a threshold still above Medicaid eligibility levels in many states. Nearly half (49.1%) of the elderly, however, compared with 32.2% of the nonelderly, had cash incomes that were 200% or less of the poverty line. In 1984, the poverty rate for persons 85 and older was twice that of those aged 65 to 74. Nearly one in three women aged 85 and older was poor or had an income within 125% of the poverty level. The poverty rate among elderly blacks (31.7%) was triple, and among elderly Hispanics (21.5%), it was double that of elderly whites (10.7%). The highest poverty rates were among minority women living alone; nearly three out of five elderly black women living alone had an income below the poverty line (8).

Although elderly persons have substantially more assets than nonelderly persons, these assets primarily consist of home equity. If all cash income, benefits (including reduced tax rates), and wealth were converted to annuitized assets, 32.5% of the elderly and 27.7% of the nonelderly would still be at or below 200% of the poverty line (8).

Thus, although older Americans as a group appear relatively well off, many elderly persons have incomes and other economic resources that are at or near the poverty level. These resources are generally insufficient to cover nursing home costs of $1500 to $2000 per month or even home health care services at $20 to $200 per day (depending on intensity). Such continuous costs can quickly exhaust life-time savings. Projections based on a 1984 survey in Massachusetts indicated that 63% of persons aged 66 and older who were living alone (75% of nursing home residents) would impoverish themselves after only 13 weeks in a nursing home (15). A more recent analysis also concluded that seven in ten elderly persons living alone would spend down their income below the federal poverty line within 13 weeks after being admitted to a nursing home and that those with incomes between $6000 and $10 000 would become impoverished within only 6 weeks (11).

MEDICARE

Medicare covers care in a skilled nursing facility but for only up to 100 days. Care in an intermediate care facility is not covered, nor is skilled nursing care beyond 100 days. Skilled nursing facility coverage is restricted to only admissions that follow hospitalization. The first 20 days are covered without cost to the beneficiary, but copayments are required for each additional day.

Medicare coverage for home health care is also linked to treatment for recovery from an acute illness. Medicare payment is allowed only for care that would be considered a covered service if provided on an inpatient hospital basis. To qualify, beneficiaries must be under the care of a physician, confined to the home, receiving services under a plan approved by a physician, and in need of skilled nursing care on an intermittent basis, or require physical therapy, or speech therapy. There is a 20% copayment requirement for items that are considered to be durable medical equipment; otherwise there are no cost-sharing requirements. Medicare will not cover care that is considered maintenance or custodial. Thus, once a patient no

longer meets the requirements for skilled nursing care on an intermittent basis, coverage also ceases for non-skilled services such as those of a home health aide. Medicare home health care also does not include full-time nursing care, drugs or medicines, personal comfort items, general housekeeping services, "meals on wheels," blood transfusions, or transportation services.

SUPPLEMENTAL INSURANCE

To compensate for the gaps in coverage under Medicare, many elderly persons buy private supplemental insurance. Most so called "Medigap" policies, however, are patterned after Medicare; they pay the co-payment and deductible amounts but provide little protection for the costs of noncovered services, such as those required on a continuing basis for chronic illnesses and disabilities. The National Health Expenditures Study of 1977 and the National Medical Care Utilization and Expenditure Survey of 1980 showed that nearly two thirds of elderly Medicare beneficiaries had purchased additional private insurance for which they paid $3.8 billion in annual premiums (16).

Approximately 40% of the elderly had private insurance that included coverage for skilled nursing care. Although 85% of these policies covered Medicare copayments for days 21 to 100 of skilled nursing care, less than 16% provided protection for at least 365 days or offered benefits of $100 000 or more (17). Only a few policies offer benefits covering limited home and community-based services (18).

Public concern about marketing abuses, difficulties in understanding insurance terminology, the cost of premiums in relation to benefits, and duplicative coverage led to the passage of Section 507 of the Social Security Amendments of 1980 (P.L. 96-265). This law, known as the Baucus Amendments, provided a mechanism for voluntary certification of supplemental health insurance policies that meet the standards of the National Association of Insurance Commissioners (19). These standards specify that supplemental policies should at least include coverage for the 20% copayment requirements for Medicare Part B services and days 21 to 100 in a skilled nursing facility. A recent study of supplemental insurance policies in six states (California, Florida, Mississippi, New Jersey, Washington, and Wisconsin) (20) showed that few policies, except those of the state of Wisconsin, provide long-term care coverage in excess of these minimal standards. Approximately 33% of the policies in Wisconsin cover stays in skilled nursing facilities in excess of 100 days; in the other states, between 0% and 11% of the policies provided such coverage.

MEDICAID

The high costs of long-term care and the inadequacies of Medicare and private insurance protection force many sick and frail elderly persons to resort to public assistance from Medicaid. To qualify, income and assets must be below state eligibility levels (in 1986, in most states, an individual could have no more than $1700 in assets and a couple could have no more than $2550, excluding a home and certain furnishings (21). It is estimated that half of all nursing home residents covered by Medicaid were not initially poor but "spent down" their savings before becoming eligible (6). Once covered, all of a nursing home resident's income, except for a small personal needs allowance ($25 per month in most states), must be devoted to the costs of his or her care.

Medicaid, a program designed to provide comprehensive primary and acute care for needy families with children and to supplement the Medicare program for the elderly poor, has become the largest source of funds—other than those paid directly by the elderly themselves—for nursing home care. Of the slightly more than $25 billion spent in 1984 for nursing home care for people aged 65 and over, the elderly paid $12.5 billion (50%) out of their own pockets, and Medicaid paid $10.4 billion (41.5%) (8).

Although aged, blind, and disabled persons comprised only 28% of Medicaid recipients, they accounted for 74% of Medicaid expenditures (22). Most of these expenditures (68%) were for nursing home care (8). Meanwhile, only 12% of Medicaid funds went for care of dependent children, and 13% went for care of adults in families with dependent children. Thus, at a time when budgetary and fiscal pressures are making Medicaid dollars increasingly dear, the growing long-term care needs of an expanding population of destitute elderly and disabled persons are consuming a greater share of the resources available to meet the health care needs of needy families.

THE CANADIAN NATIONAL HEALTH CARE SYSTEM

In 1966, the Canadian Parliament passed the Medical Care Act, establishing a framework for a publicly administered, universal health insurance program. Each of Canada's ten provinces subsequently adopted qualifying insurance programs under which all of Canada's 25.5 million citizens are now covered for hospital, medical, and long-term care expenses (23).

Benefits vary among provinces, but in general, long-term care coverage includes benefits for health care, personal care, and social services. Eligibility is based on functional impairment without regard to age or income. There are no limits on patient demand, nor system-wide controls on volume. Payments to physicians are made according to fee schedules that are established by each province. Until 1984, physicians and hospitals could "extra bill" patients for charges above the government fee schedules. Since passage of the Canada Health Act in 1984, provinces that permit physicians to impose direct charges on patients lose federal grants on a dollar-for-dollar basis in proportion to such charges. Consequently, most provinces now ban extra billing (24). Covered services include both nursing home care as well as community-based services. However, little coverage is provided for home health care or related services. In general, beneficiaries pay no premiums, deductibles, or coinsurance costs. Co-payments, when levied, are considered to be minimal (25).

As originally enacted, the costs of each provincial

health insurance plan were split on a 50/50 basis between the provinces that administer them and the federal government. By 1977, concern about rising costs led the federal government to abandon this arrangement. A new system of block grants was established using a formula that limits increases in federal outlays to increases in the Gross National Product (GNP). The provinces must now absorb the difference when health care costs increase at a rate faster than the GNP. In addition, legislation passed in 1977 provided that the federal government would pay annual grants of $20 per capita (indexed to the GNP) to assist the provinces in providing less expensive support services as alternatives to hospital care. These services include adult home care, ambulatory care, and other long-term care services.

Total costs of the Canadian health care system amounted to $38.5 billion (Canadian dollars) in 1985, or 8.6% of the GNP (24). These costs compare with total health expenditures in the United States in 1985 of $425 billion (U.S. dollars), or 10.6% of the GNP (26). However, like the United States, pressures to reduce the federal budget deficit have resulted in cutbacks in Canadian federal health care expenditures. The Canadian federal budget deficit in fiscal year 1986 to 1987 was 6% of the GNP, compared with an estimated U.S. budget deficit for fiscal year 1987 of 5% of the GNP (23). In 1986, the Canadian provinces received $11.9 billion in federal support for health insurance, but budget reductions in the rate of growth of federal transfers are expected to achieve cumulative savings of $4 billion between 1986 and 1991.

The Canadian National Health Care program is believed to be immensely popular with the general public, and all attempts to reduce benefits have encountered strong political opposition (23). It is doubtful that the Canadian approach to financing long-term care would be transferable to the United States, a country with ten times the population and different social, political, and economic traditions. However, the Canadian approach does indicate that a publicly financed universal health insurance program covering long-term care is feasible.

Alternative Financing Mechanisms

PRIVATE INDIVIDUAL INSURANCE (BEYOND MEDIGAP)

Until recently, private long-term care insurance covering anything more than co-payments and deductibles for Medicare-covered services has been relatively unavailable. Arguments for compulsory national long-term care insurance in 1980 attributed the lack of development of such a market primarily to the high cost of premiums relative to the historically low incomes of the elderly (27). The existence of a "safety net" of public assistance from Medicaid, the Veterans Administration, and other public programs could also deter people from feeling the need to purchase insurance. The market has been limited by people's perceptions that Medicare (or Medicare as supplemented by Medigap policies) would provide sufficient protection. An equally important factor has been the tendency of individual persons to minimize the extent of their personal risk for long-term care expenses (18, 28-30).

Insurers have been reluctant to offer long-term care insurance for several reasons, including the difficulty in defining uniform benefit packages, problems of "adverse selection," the possibility of insurance-induced demand, the fear of open-ended liabilities, and barriers caused by government regulation. Other reasons include difficulties in obtaining administrative economies and premium pricing problems due to inflation (28).

"Adverse selection" refers to the problem of being able to anticipate a claims experience, thus causing disproportionate numbers of policies to be bought by those most likely to file claims. This problem is contrary to insurance principles of spreading risks and costs as widely as possible among a broad and diversified population and exposes the insurer to either substantial losses or unacceptably high premiums. Insurance-induced demand, or risk for "moral hazard," refers to the possibility that people with insurance coverage might more readily avail themselves of covered services. Long-term care insurance has been seen as prone to such abuse, because services typically involve nonmedical personal and social services, such as homemaker and custodial care, for which the individual or his or her family might not otherwise seek paid assistance. The concerns about open-ended liability stem from recognition that people can require care for the rest of their lives.

Despite these obstacles, as the number of elderly persons has increased, as their awareness of insurance needs has grown, and as their purchasing power has improved, the market for private long-term care insurance has expanded. A review of 16 sample policies in 1984 showed that some insurers are finding ways to provide reasonable insurance protection through greater use of risk management techniques (31). Coverage for unskilled care is often contingent on previous receipt of skilled care. Some insurers restrict coverage to institutional care in state-licensed skilled or intermediate care facilities. Most insurers use an indemnity approach, paying a fixed amount for each day of covered service. Other techniques for limiting the insurer's liability include screening sales for health status and not covering pre-existing conditions. Coverage for home care still remains relatively scarce. Home health coverage initially was primarily only for private duty nursing; however, some insurers are now offering policies paying a fixed amount per day for other home health care services.

Most policies are marketed on an administratively costly individual basis, much like supplemental insurance. Few insurers are willing to guarantee renewability without an escape clause, and most insurers of individually marketed policies reserve the right to raise premiums (29, 30).

By 1986, almost 70 companies were offering long-term care insurance on a national basis, nearly twice the number estimated for 1984. In the *New York Times*, long-term care insurance was described recently as the fastest growing type of insurance; almost 200 000 people had private policies in 1986, and as many as 400 000 could have coverage within the next year (32).

Many people see the growth of the private individual insurance market as the solution to assure that the elderly have financial access to long-term care services. Some people advocate that the government should encourage the purchase of private long-term care insurance and should not compete with the private sector. Others point to the relatively high costs and limitations of private insurance and argue for increased governmental involvement. The following section lists some of the advantages and disadvantages of a private sector approach.

Advantages

1. Financial barriers to long-term care might be reduced or removed.
2. The financial assets of the elderly might be better protected.
3. The elderly might be better able to remain financially independent.
4. A competitive insurance market could provide various policies from which people could select insurance that best suits their individual needs and preferences.
5. Insured persons with high long-term care costs might be able to avoid the indignity of seeking public assistance.
6. Substitution of private insurance for Medicaid would help restore Medicaid to a program primarily for the poor and indigent with dependent children.
7. Reliance on the private sector is seen by many people as preferable to increased requirements for tax dollars.

Disadvantages

1. Screening by insurers could limit insurance availability primarily to persons in good health, leaving unprotected those most at risk.
2. "Skimming" by insurers could also result in low premiums for persons least at risk and high premiums for those most likely to need long-term care.
3. Increased availability of insurance coverage can be expected to result in increased demand for long-term care services. Because insurance lowers the cost of obtaining services for policy-holders, both patients and providers will have less incentive to refrain from using services, even those that may be marginally beneficial (33).
4. Lack of guarantees of premium rates or renewability could result in elderly persons being denied insurance as they become older or disabled when they are most in need of protection.
5. A voluntary system in which individuals are encouraged to purchase private insurance could result in increased protection for the relatively affluent, but might not be of benefit to those of moderate or low incomes who feel they cannot afford the insurance.
6. Any national program relying primarily on private insurance might be of greater benefit to the well-educated than to persons who are unaware of the advantages of obtaining insurance protection.
7. Marketing and other administrative costs of private insurance are generally much higher than administrative costs under Medicare. In 1984, private nongroup Medigap policies on average paid only $0.60 in benefits for every $1 collected in premiums. Blue Cross-Blue Shield had a 90% payout ratio, and Prudential, the largest commercial insurer, had a rate of 78%. In comparison, total administrative costs for Medicare were only about 3% (34). Thus, a private insurance approach might be more expensive in terms of overall national costs than a program relying on expanded Medicare coverage.

EMPLOYMENT-BASED LONG-TERM CARE INSURANCE

Employment-based group insurance is one alternative to costly individual private insurance. Long-term care insurance could be marketed to any large group; however, most group policies are provided through the employment setting. In 1977, 90% of civilian noninstitutionalized persons under age 65 who were covered by private insurance were enrolled in group plans, and nearly all of these plans were employment-based (16). Slightly more than a third of persons on Medicare who had private insurance were covered by group insurance sponsored by their current or former employer (35).

Group insurance can provide similar insurance at reduced premiums, because insurance risks can be spread over a large, relatively healthy population, and savings can be achieved in marketing and administrative costs. Coverage could be extended after the cessation of employment and financed in various ways. These include voluntary individual payment of premiums, mandatory employer payments, establishment of risk pools for high-risk individuals, use of retirement or life insurance benefits to purchase paid-up long-term care insurance, granting of tax credits to either employers or individuals, or other innovative ways.

Advantages

1. People could be insured at relatively low cost, beginning when they are in the work force and are still relatively young and healthy.
2. Costs are lower than those of individually marketed policies.
3. A large segment of the population could be readily covered. In 1977, about 80% of employees in the United States worked in firms where they were eligible for some health insurance (36).

Disadvantages

1. Without provisions for extension of coverage, insurance protection could cease upon termination of employment.
2. Employment-based policies would not benefit the unemployed.
3. Employers could be expected to resist any extensions of benefits that might raise health care costs.
4. Mandatory employer-based insurance could be particularly burdensome for small employers.

SELF-INSURANCE

Self-insurance, as opposed to lack of insurance, implies that some measures are taken to protect oneself from a financial risk. A person with a large endowment or substantial cash reserves might rely on these assets as a means of self-insurance. Individual Retirement Accounts (IRAs), savings accounts, investments, or similar means of asset accumulation can be used for self-insurance.

A variation on this approach has been suggested by the Bowen Commission (6). Under the Bowen plan, tax incentives would be provided for people to save a certain amount each year for the costs of their health care. Savings in Individual Medical Accounts (IMAs) would receive favorable tax treatment, and tax-free withdrawals would be permitted for long-term care expenses. In addition, part of the interest from all such accounts would be used to finance additional nursing home expenses for IMA holders after the balance of their individual account is exhausted. This aspect of the plan would provide additional coverage for up to 25 months, with benefits proportional to the amount and length of individual contributions.

Advantages

1. Individuals would be encouraged to assume personal responsibility for paying the costs of their long-term care.
2. Unused funds would remain in the individual's estate.
3. Increased individual savings would contribute funds for investment in the general economy.
4. Contributions to IRAs or IMAs would be tax deductible.
5. Individuals would retain maximum flexibility in purchasing long-term care services.
6. Under the Bowen Plan, self-insurance would be supplemented by an insurance pool.

Disadvantages

1. The individual personally assumes all financial risks.
2. Self-insurance can be inadequate due to insufficient funding, demands for funds occurring sooner than anticipated, or other unexpected financial demands.
3. Self-insurance is an option that is available generally only to middle- and upper-income families.
4. Favorable tax treatment for IRAs or IMAs would result in reductions in the tax burdens of persons with high incomes but would not benefit those with lower incomes. The effect would be equivalent to a transfer of public dollars from those with lower incomes to those that can afford to take advantage of these benefits. Looked at another way, income that otherwise would yield tax revenues for various public programs would be sheltered in private accounts for the benefit of affluent persons.

VOUCHERS

One method of assuring that people obtain private insurance for long-term care would be to provide all eligible citizens with a government voucher that could be used solely for the purchase of such insurance. Eligibility criteria could be based on age, income, health status, insurability, or other relevant factors.

Advantages

1. All people would have some minimum amount of money to obtain insurance protection from the costs of long-term health care.
2. People could use the voucher to shop for insurance that best satisfies their individual needs and preferences.
3. Competition in the private sector might serve to keep costs down.
4. Competition in the market for long-term care insurance might increase and might foster innovative approaches to respond to the needs and desires of the elderly.
5. Many people might avoid impoverishment and the indignity of seeking public assistance.

Disadvantages

1. Many sick and frail elderly persons may not be able to shop wisely for long-term care insurance.
2. Sick and disabled persons may be cheated out of their vouchers or may receive inadequate or deceptive insurance policies.
3. Insurers might market policies only to persons at low risk, denying insurance to those with health problems or other indications of high risk.
4. Uniform voucher amounts might be inadequate to buy more than a minimal level of coverage and might be insufficient to pay premiums for those at high risk.
5. Total costs, inclusive of marketing and administrative costs and profit margins, required to purchase a minimum level of insurance from the private sector could be higher than costs under a direct government program.

FINANCING THROUGH MEDICARE

Medicare, the program that covers 98% of the elderly for hospital insurance, would be the most logical public program through which long-term care insurance might be provided. As indicated previously, many Medicare beneficiaries believe that they already have such protection. Extension of Medicare coverage could be accomplished by expanding coverage under Medicare Part A or Part B. Another alternative would be to create a new Part C with benefits funded by separate premiums, by general revenues, by employer-employee contributions, or by any combination of these or other methods. Coverage could also be mandatory or voluntary. Universal coverage would achieve the greatest cost economies and the greatest spreading of insurance risks among the entire elderly population.

Advantages

1. All beneficiaries could be assured of protection from the financial risks of long-term health care.
2. Insurance protection could be provided to all beneficiaries regardless of their insurability. A mandatory national program would eliminate the danger of adverse selection; a voluntary program would still have less risks of adverse selection than would private insurance.
3. Uniform coverage could be assured.
4. Insurance risks would be spread among the entire Medicare population. If premiums were assessed, the costs per person would be as low as possible.
5. The costs of long-term care would not force Medicare beneficiaries to become impoverished and to resort to Medicaid.
6. Total national costs would be less than the costs of similar coverage provided through private insurance companies. Marketing costs of the private sector would not be entailed.

7. Medicare beneficiaries could avoid the need for costly and duplicative insurance policies.

Disadvantages

1. Expansion of Medicare coverage could increase costs to the Federal government at a time when emphasis is on reducing the federal deficit.

2. Medicare coverage could destroy the burgeoning private insurance market for long-term care.

3. Coverage under Medicare could be too restrictive, permitting care in only certain types of institutional settings or otherwise limiting benefits that might be more flexible under private insurance options.

4. Mandatory enrollment of all beneficiaries would mean that many persons who do not need or desire coverage would be forced to pay higher Medicare premiums, employment-based contributions, or taxes.

5. Universal coverage under Medicare could result in greater use of long-term care services and a consequent increase in Medicare costs.

HOME EQUITY CONVERSIONS

Of the 17.7 million households headed by older persons in 1983, 75% were owner-occupied, and 80% of these were owned free and clear (8). These figures represent approximately $650 billion in nonliquid assets that are owned by the elderly but are generally inaccessible unless they sell and move out of their homes (37). Recently, several innovative means of home equity conversion have been developed to enable the elderly to tap these financial assets without forcing them to move.

One arrangement involves the sale of the home to an investor who agrees to permit the original owners to remain in the home for the rest of their lives or for a fixed time period. Title to the home is transferred immediately, but the investor may not obtain possession of the home for several years. The investor and the sellers may devise a financing arrangement that is to their mutual advantages, providing for the on-going financial needs of the elderly couple and allowing the investor gains in capital appreciation and the potential for additional profits if the elderly couple fail to remain in the home for the maximum term of the agreement.

A variation, more recently developed, involves the granting of a mortgage interest in the home. Under this arrangement, originally known as reverse-shared appreciation mortgages, elderly homeowners can obtain cash or a guaranteed monthly income in return for a mortgage interest in their home. Homeowners retain legal title and the right to remain in their homes.

One company using this approach offers the elderly Individual Retirement Mortgage Accounts (IRMAs) (37). Under this program, homeowners receive monthly tax-free loan advances or may elect to receive an immediate lump-sum payment. Borrowers are charged interest on the amount of loans advanced, but repayment of principal and interest is deferred until the loan matures. The loan does not become due until the owners die, sell or move out of the house, or reach age 100, at which time there is an option to extend the contract. Homeowners generally can expect that they will not repay the loans themselves, but that repayment will be made from their estate after they die. Heirs may retain the home by paying off the outstanding repayment obligations that are limited to the fair market value of the home at the time the loan matures. Homeowners may also borrow a self-selected percentage of the value of the home and thus retain a percentage of home equity value.

Advantages

1. Elderly homeowners can take advantage of the asset values of their homes without having to move.

2. Elderly homeowners can retain their independence and have discretion in the purchase of long-term care or other goods and services.

3. Impoverishment and the indignity of seeking public assistance may be avoided.

4. Because the need for Medicaid funding of long-term care of the elderly could be reduced, more funds would be available for poor families.

Disadvantages

1. Unscrupulous investors could obtain possession of the homes of elderly persons without paying fair compensation or might otherwise take advantage of those who are sick or disabled.

2. Persons who live beyond the term of a home equity contract may be forced to leave their homes at a point when they still could function independently if they were able to remain in their own home.

3. Use of home equity conversions to finance long-term care could deplete family assets, denying heirs of what many consider to be their rightful inheritance.

4. Renters would not benefit. Although a large percentage of elderly people own their homes, many do not. The percentage of people who rent increases with age, and people living alone are less likely to own their own housing.

5. The value of many elderly homes would not be sufficient to finance long-term care services for very long. In 1980, 40% of elderly homeowners lived in housing structures built before 1940; the average value of such older homes was $39 000.

6. Many elderly homeowners live in homes that lack complete plumbing facilities, lack complete kitchen facilities, or have other deficiencies (8) that might not qualify them for home equity loans.

PREPAID CAPITATED CASE-MANAGEMENT PLANS

This heading refers to various approaches involving the pooling of the risk and financing of care under case-management systems. In return for prepayment of a per-capita premium, members are covered for a range of services from selected providers on an as needed basis as determined by a case manager. We include in this category Health Maintenance Organizations (HMOs), Social/HMOs, and life-care communities. Other innovative approaches along these lines involve joint ventures between large insurers and comprehensive long-term care delivery systems.

Like most health insurance plans, HMOs have traditionally offered coverage for only acute care services. Home health care and other long-term health care serv-

ices, when available through an HMO, have been provided primarily as an alternative to institutional services. Also, like private insurers, HMOs have been reluctant to offer coverage for long-term health care services due to fear of adverse selection by patients most likely to require these services (38). However, because of their reliance on case management, HMOs could exercise greater control than other private insurers over the utilization of services and might be better able to offer competitive packages of coverage for both acute and long-term health care services.

The Social Health Maintenance Organization (S/HMO) expands the HMO concept beyond one restricted to health care services to one that integrates a full range of acute and chronic care services into a single system (39). In 1985, the Health Care Financing Administration began a $3\frac{1}{2}$ year demonstration project to test this concept in four models across the country (40). Each model involves a sponsoring agency taking responsibility for coordination of comprehensive services to a membership that includes both healthy and disabled persons. Payments are made on a prepaid capitation basis by both individual members and Medicare beneficiaries, and the organization is financially at risk for all costs. This demonstration project is seen as a first step in determining whether community-based long-term care is insurable and can be effectively and efficiently managed.

Life-care communities, also known as continuing care retirement communities, provide housing as well as a range of health and social services. Membership in a life-care community typically requires payment of a substantial entry fee ($50 000 to $100 000) in addition to payment of monthly premiums (41). These communities typically are on a campus-like setting that offer single family units, a range of community-based services, and congregate living arrangements, as well as skilled nursing home care. Members are furnished with housing, acute care, chronic care, and social services as needed, with residents moving within the community from one setting to another as appropriate. Life-care communities are generally designed to appeal to the relatively young, upper-middle income elderly, who are in good health when joining and who can afford the high cost.

Advantages

1. Members obtain security that they will be taken care of for their current and future health care needs, including care for chronic illnesses and disabilities.
2. Acute and long-term care services are integrated into one delivery system with care coordinated by a professional case manager. Such a managed system enhances the potential for the provision of comprehensive, coordinated, and continuous care.
3. Case management involves assessments of individual needs and the matching of services in accord with individual functional abilities. Thus, the provision of duplicative and unnecessary services can be reduced or eliminated, and maximum independence may be preserved.
4. Case management can reduce insurance-induced demand and provide for the efficient delivery of services.
5. Members are able to choose among long-term care delivery systems at a point when they are relatively healthy and alert.
6. People can arrange for their future needs without having to rely entirely on Medicare or other publicly financed programs.
7. Members of life-care communities can enjoy a superior life style and may assure that they receive care when needed that is of high standards of quality.

Disadvantages

1. The organization providing or arranging services is at financial risk. If the organization goes bankrupt, enrollees may find that they are without protection at a time when they no longer can obtain affordable insurance.
2. Case managers control access to care. Some people may find this to be too restrictive.
3. Patient choice of providers is limited to those who are participants in the capitated plan.
4. Prepaid capitated plans have a financial incentive to selectively accept only healthy members.
5. Financial incentives to provide the least costly care could diminish the quality of services and increase the potential for underservice.
6. Inadequate funding could result in reductions in the amount or quality of services, and increases in premiums could make enrollment no longer affordable, especially for elderly persons on fixed incomes.
7. High entry fees and monthly premiums limit life-care communities to the affluent; thus this would not be an option for most people.

Conclusion

In this paper, we have sought to provide only background information on and analysis of alternative means of financing long-term care. College positions and recommendations are now being developed that will build on this analysis. Thus, this paper should be seen as an interim, informational document intended to further national policy consideration to assure that all Americans have financial access to needed long-term care services.

▶ Requests for reprints should be addressed to Jack. A. Ginsburg; American College of Physicians, 655 Fifteenth Street, N.W., Suite 425; Washington, D.C. 20005.

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