

CHAPTER 11

LONG-TERM CARE COVERAGE FOR ALL: GETTING THERE FROM HERE

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The United States would benefit from having an equitable, efficient and universal system of publicly-funded long-term care insurance that recognizes and rewards the provision of family care. Dramatic increases in public and private spending on health care have delivered important gains, including greater life expectancy. But they have also been accompanied by rapid escalation of the costs of meeting the less acute, chronic problems of aging and disability, many of which are borne by spouses, adult children, other family members and friends. Indeed, the unique challenge of designing long-term care coverage for all lies in the intersection of paid and unpaid care. The demands for various publicly-funded services are clearly contingent on the configuration of family and other informal-care resources available to those in need of care, while the supply of informal care responds to the incentives created by publicly-funded long-term care programs.

Our current system of long-term care is fragmented, inadequate, and inequitable, often leaving the elderly, individuals with disabilities, and family members who care for them economically vulnerable. The CLASS Act initially passed by Congress as part of the Affordable Care Act, represented a tentative (and hotly-contested) step in the right direction. Paradoxically, the CLASS Act in effect created a Federally-operated long-term care insurance system, despite the intense controversy about, and ultimate failure of, any attempt to include a “public option” in the accompanying Affordable Care Act legislation. But the CLASS Act was conceived as a voluntary rather than mandatory program, and therefore merely hinted at the possibility of universal coverage. It also raised problems of adverse selection, which seem to have been the principal factor in the Administration’s October 14, 2012 announcement that there is no “... viable path forward for CLASS implementation at this time.”¹

In this chapter, we build on the earlier contributions to this volume to discuss both problems and possibilities that could inform efforts to move toward more comprehensive reform. We begin with a review of the current institutional and political context, summarizing criticisms of existing policies and discussing some possible explanations of the particular difficulties facing long-term care reform. Next, we make a case for a universal system of long-term care insurance, arguing that seemingly utopian principles can help shape political realities. Finally, we discuss a number of theoretical and practical precedents for a universal long-term care

insurance system in the U.S. that could go well beyond the scope of the original CLASS Act. Our conclusion reiterates the need for a long-run strategy to implement comprehensive change but also acknowledges the obstacles such a strategy will face.

The Institutional and Political Context

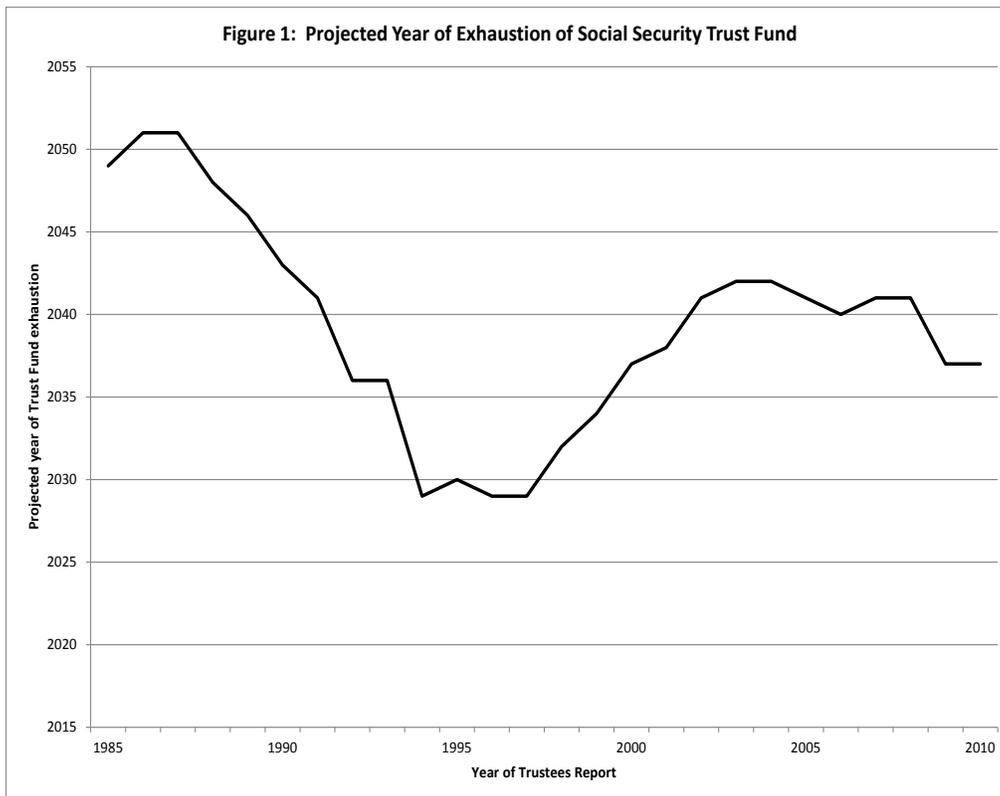
Discussions of the impact of population aging span the political and cultural spectrum and often deploy the word “crisis.” Stephen Crystal published *America’s Old Age Crisis* in 1984. Carroll Estes and James Swan published *The Long Term Care Crisis* in 1992. The World Bank published *Averting the Old Age Crisis* in 1994. Celebrity Martha Stewart has referred to “The Other Health Care Crisis—America’s Elderly” (Stewart 2010).

Yet neither the American public nor its political leaders seem to have adopted a “crisis” mentality. Several possible factors could explain this disconnect. One could argue that the most serious problems of elder care remain a bit farther down the road, and we are now dealing with more urgent concerns. Further, the annual changes appear small compared to the cumulative effect: if we contrast the programmatic or budgetary implications of demographic profiles at the beginning and end of a sufficiently long time period—2000 and 2030, for example—the contrast is indeed alarming (Knickman and Snell 2002). Yet the path from the crisis-free present to the crisis-laden future entails small, incremental steps each year, and it is impossible to isolate the point at which we pass from not-yet-crisis to crisis.

Moreover, while population aging—among other factors—may clearly suggest the likelihood of a policy crisis at some point in the future, the timing of such a crisis seems to be a moving target. This point is nicely illustrated in Figure 1, which plots the projected years of exhaustion of the Social Security Trust Fund—i.e., the year in which Fund balances will drop to zero—taken from annual reports and covering the period 1985 through 2010. The Trust Fund’s Board of Trustees is required to assess, and to report annually on, the fiscal health of Social Security over a 75-year time horizon. In 1984, the year after the most recent major legislative “fix,” the Trust Fund was projected to maintain a positive balance for at least 75 years, but beginning in 1985—only one year later—that was no longer true. The number of years to fund exhaustion has fluctuated, reaching a high of 65 years (in 1986) and a low of 32 years (in 1997), averaging 42 years over this 25-year period. It is easy to rationalize avoidance of painful programmatic changes when doomsday is both so far in the future and so uncertain.

Another possible explanation for our collective avoidance of the long term care issue lies in the uneven demographic impact of long-term care shortfalls. Individuals and

families at the very top of the wealth distribution can effectively self-insure, drawing from financial assets to finance both medical care and long-term care.



Low-income families, often confronting more immediate problems, may be unable to cope with unanticipated long-term care costs, become even more indigent, and be forced to rely on whatever form of state provision remains available. Middle-class families may face considerable variation in both anticipated and actual demands for long-term care. Better-educated individuals seem to cope better with disability than others, using both more assistive technology and more paid help (Cutler et al. 2006).

Family income and education are not the only sources of diversity in ability to meet long-term care needs. Differences in family structure may also play a role, since the availability and willingness of family members to provide care represents a form of informal insurance. In the developing world, for instance, parents' desire to provide security for old age often influences fertility decisions (Nugent 1985). Availability of family members clearly influences forms of care in old age in the U.S., and some evidence suggests that elderly women without surviving children are more likely than others to become dependent on Medicaid-financed nursing home care (Wolf 1999).

Cultural differences may also come into play, since recent Hispanic immigrants to the U.S. tend to be younger on average, have more children on average, and expect to rely more heavily on family care in old age (Angel and Angel 2010).

Men face less serious problems with long-term care provision than women do, because many expect to be cared for by their wives, who are, on average, over 2 years younger than them,¹ and also have a longer life expectancy. Because women face a greater likelihood of living alone in old age, they are particularly vulnerable. Further, many rely on their daughters for care. According to a recent survey by the National Caregivers Alliance and the American Association for Retired Persons, women represent about 67 percent of all informal caregivers for the elderly and about 68 percent of all elderly recipients of informal care (NCA/AARP 2009).

Economists tend to assume that women simply choose to provide care because it gives them satisfaction. But more than 43 percent of all caregivers in the NCA/AARP survey reported that they felt that they had no choice. They stepped forward for a variety of reasons: because no other family member or friend was willing or able to provide adequate care or because paid services were economically out of reach. Those who felt they had no choice were more likely to report emotional stress, poor physical health and financial hardship. About 45 percent of women, compared with 38 percent of male caregivers, put themselves into the “no choice” category (NCA/AARP 2009). Many women would prefer to share care responsibilities more equally with others, but if they can’t, will take on them regardless, as a moral duty central to cultural ideals of womanhood.

A more immediate determinant of the political context derives from partisan conflict over the role of entitlement spending, intensified by concerns over mounting public debt resulting from the Great Recession. Proposals to repeal the Affordable Care Act have been accompanied by budget proposals that include significant cuts to Medicare and Medicaid spending, along with an organizational shift toward more market-based voucher approaches. Concerns about long-term care are currently overshadowed by a political debate of epic proportions.

Yet the problems of long-term care provision are obviously relevant to this debate. Medicaid is biased toward institutional rather than home and community-based care and fails to meet the needs of many families (Harrington Meyer and Hausauer forthcoming). It discourages private savings and may also contribute to low private long-term care insurance rates (Burman this volume; Stevenson et al. this volume). Moreover, the asset-recovery features of Medicaid amount to ex post imposition of user fees, undermining any notion that the program provides collectively-shared risks against the costs of adverse outcomes (Harrington Meyer and Hausauer forthcoming).

The Rationale for Universal Coverage

The rationale for universal long-term care insurance, like that for universal health care insurance, is based on both moral and economic principles. Like the families of which it is constituted, society has an obligation to help care for those who cannot care for themselves. The need for care as a result of disability or advanced age is somewhat unpredictable and unevenly distributed. At the oldest ages, when the probability that someone will need this type of care grows quite rapidly, the costs of providing the needed care can become extremely high. The earlier in their lives that prudent individuals set aside funds in anticipation of these late-life needs, the smaller the amount that must be set aside. However, individuals typically lack the foresight to engage in this type of self-insuring savings, and many simply can't afford to. Social insurance can overcome these problems, providing a means of pooling the risks of long-term disability for both caregivers and care recipients. It can potentially improve the level and quality of overall care provision while reducing its average cost. Private insurance also provides a potential, but only partial solution to the risk-pooling problem.

Benefits of Pooling Risks

Insurance, and especially mandatory—that is, universal—social insurance, produces economic benefits in two ways. First, in any group of individuals, each of which faces an uncertain risk of experiencing an unfavorable outcome, the pooling of risks through insurance makes everyone better off, on average. Individually, in the absence of insurance, some people will experience a loss while others will not. It is unlikely that many people could set aside assets sufficient to cover those losses. By pooling risks through insurance, the amount that must be set aside to cover expected losses—i.e., the insurance premium—is reduced. A “law of large numbers” operates, such that as the insurance pool grows larger, the average claim on the common pool of assets approaches the average loss among those covered (Weimer and Vining 1989). In the limit, the “margin of error” between average claims and expected losses vanishes.

Second, and more importantly, as we approach the ideal of universal coverage, the problem of adverse selection is fully overcome. Adverse selection refers to the fact that insurance coverage is likely to be more attractive to those with higher-than-average expected losses, and less attractive to those with relatively low expected losses. If insurance premiums are set so as to cover expected payouts—i.e., they are actuarially fair—then those who believe that they face below-average expected losses will opt out of coverage. This, in turn, will necessitate raising premiums to cover the above-average expected losses among those who remain insured. But as premiums are raised, more people will find it attractive to opt out, producing a “death spiral” of

ever-increasing premiums to cover the expected losses within an ever-decreasing pool of higher-risk covered individuals.

The benefit of overcoming the adverse-selection problem through universal coverage is illustrated in recent work by Munnell and Hurwitz (2011). Munnell and Hurwitz developed a simple analytic model for estimating the costs of the CLASS Act. In their baseline scenario, which assumed an overall voluntary participation rate of 6 percent among eligibles, a \$75-per-day benefit (as in the Congressional Budget Office's official cost estimates), and risks of qualifying for benefits determined by disability rates found in recent population surveys, the average premium needed to cover anticipated costs over the 75-year planning horizon stipulated in the CLASS Act legislation was \$194 a month. In an alternative mandated-coverage scenario—i.e., under universal coverage—the required monthly premium fell by nearly half, to \$94 per month.

The Limits of Private Insurance

Private insurance companies want to avoid the costs associated with adverse selection, while at the same time charging premiums low enough to attract customers. Consequently, they adopt practices such as underwriting and noncoverage of preexisting conditions, as a way of limiting their exposure to uncertain costs. Nevertheless, expansion of private insurance might have helped compensate for the voluntary nature of the CLASS proposal, supplementing its modest benefits, particularly for nursing home stays (Stevenson et al., this volume). However, several factors limit the potential scope for wide private coverage.

Important among these is the difficulty that individuals face in assessing the level and quality of assistance that they will need (a factor which would also limit take up of a voluntary public program like that found in the CLASS Act). Behavioral economics suggests that individuals tend to discount the future in somewhat inconsistent and inefficient ways, and to underestimate levels of future need (Thaler and Sunstein 2008). In addition to uncertainties about their own ability to age in a healthy and independent way, individuals generally lack information about the potential and actual supply of assistance from other family members. Even raising this subject for discussion can be stressful, contributing to tendencies to avoid and procrastinate. Qualitative research suggests that individuals are aware of a high level of denial and fear in their responses to long term care issues (Curry et al. 2009).

Indeed, some individuals may fear that purchase of long-term care insurance will discourage or crowd-out more desirable family care. Spouses, daughters or sons may be less willing to supply care services if a substitute can be easily purchased, creating

a kind of intra-family moral hazard problem (Pauly 1990). While this principal-agent problem, modeled in more detail by Zweifel and Strüwe (1998) also applies to support for public choices, it bears more heavily on decisions of families for whom incentive effects are likely to be large. High wealth families can use strategic bequests to counter the problem (Bernheim et al. 1985). Among low-income families, the need to earn wages for self-support (and lack of available space to bring elderly or disabled family members into the home) may constrain the ability of family members to provide direct care, reducing the impact of their incentives to do so.

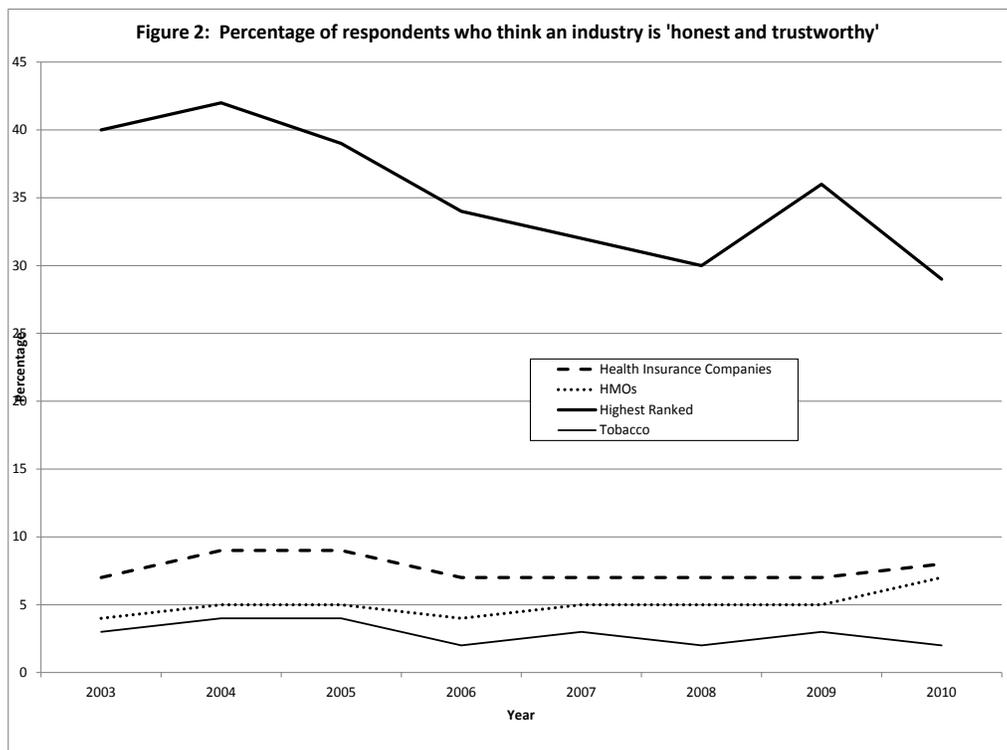
Several studies have found that individuals with living children—in other words, potential future caregivers—are less likely to buy private long-term care insurance (Kumar et al. 1995; Cramer and Jensen 2006; Johnson et al. 2007). In all cases, these studies include extensive controls for income, assets, and the cost of insurance.

More immediate explanations for low take-up rates for long-term care insurance are high cost and reliance on Medicaid as a fall-back (Stevenson et al. this volume). Low trust also deters take up. Most consumers express a low opinion of health insurers—a group that overlaps with long-term care insurers—and are, consequently, disinterested in spending more on their products. The Harris Poll has, in recent years, asked respondents which among a list of 17 industries are “... generally honest and trustworthy – so that you normally believe a statement by a company in that industry.” Health insurance companies have consistently been ranked near the bottom, ahead of only HMOs, oil companies and—in last place—tobacco companies (see Figure 2). During 2003-2010, only 7 to 9 percent of respondents felt that health insurance companies were “honest and trustworthy.”² The respondents’ reasons for holding these views were not sought, although one imagines that denials of coverage or claims might be among those reasons. Although private long-term care insurance policies are offered mainly by life insurance companies rather than health insurance companies, consumers’ views about the experiences they can expect with long-term care insurance may be shaped by their experiences with health insurers, given the role of health problems in producing long-term care needs. These results must be placed in a context of general mistrust: the most trustworthy industry in most years (supermarkets) were viewed as honest and trustworthy by 29 to 42 percent of respondents (in 2008, the highest ranked industry was “hospitals,” and in 2010 hospitals and supermarkets both were viewed as honest and trustworthy by 29 percent of respondents).

The Benefits of Universality

Beyond the economic benefits of risk pooling discussed before, which are maximized as the risk pool grows to include the entire population, there are social and political

benefits to universality of social policy. Waldfogel (2009) points out that while targeting program benefits on those with the greatest needs—as, for example, in the case of Medicaid’s long-term care benefits—may seem to promote efficiency in the use of public resources, that efficiency imposes costs in the form of high administrative costs, stigmatization of beneficiaries, and adverse behavioral incentives. Universal benefits, however, “... have the advantage of promoting social solidarity and social inclusion” (p. 40). The latter point echoes Kuttner’s (1984) earlier comment, that when “... the middle class shares basic public services with the poor, the middle class demands high quality and dignified treatment; the middle class is also reminded that poor people are human. Thus, does universalism in public services cement the political constituency for egalitarian social policy” (p. 231).



Source: see note 2.

The social solidarity promoted by universal programs seems to be reflected in the widespread negative reactions to policy proposals that would cut back on Social Security and Medicare, which are the two programs that most closely achieve universality in the U.S. at present. Skocpol (1995), for example, points out that “[m]ost Americans feel that they have built up a stake in the retirement insurance

system, and will profoundly resent politicians who go back on what is considered a sacred social contract” (p. 308).

Waldfogel (2009) points out that universal programs may be less effective than targeted programs in achieving redistribution, because universal programs provide benefits to those at all income levels. However, Social Security benefits manage to achieve some redistribution through the “tilt” in the benefit formula, such that those who have made minimal contributions obtain a higher rate of return on their contributions—that is, a “replacement ratio”—than those with high incomes (Clark et al. 2004). In a universal long term care insurance program, progressivity in the determination of benefits does not seem possible, because benefits are likely to be tied solely to the need for care and not to cumulative contributions to the program. However, it is easy to envision a progressive formula for determining contributions in a mandatory payroll-tax based program.

The Problem of Moral Hazard

“Moral hazard” is a generic problem when people can insure themselves against adverse contingencies. This issue is typically framed in two ways. First, the insured will overuse the covered service because it seems to be “free”—the usual example here being medical care (a problem often counteracted by copayments which require users to pay a portion of the cost). Second, the insured will engage in risky behavior which raises the probability of adverse outcome, because insurance coverage reduces the cost of the adverse outcome—the usual example in this case being automobile insurance, which induces people to be poorer drivers. A third form of moral hazard, alluded to above, applies particularly to long-term care: family members may be less willing to provide care services for free if they learn that it will be provided and paid for by a third party.

Some argue that moral hazard militates against universal coverage of long-term care (e.g., Garber 1996). We disagree, for three reasons. First, the types of services provided through long-term care insurance, such as help dressing, eating, bathing, or using the toilet—that is, Activities of Daily Living (or ADLs)—are not services that people are eager to consume; they prefer, and expect, to do these activities independently if possible. Insurance for housekeeping and meal services may be more susceptible to overuse and therefore a more apt example of possible moral hazard. But this problem can be at least partly remedied by conditioning insurance benefits on the more severe, and personal, even intrusive, needs associated with ADLs.

Second, it is hard to envision people adopting behaviors that increase the probability of needing help with ADL tasks, or even to identify what those behaviors might be,

especially for the most severe of conditions underlying LTC needs, namely Alzheimer's disease. Third, paid care services are unlikely to significantly "crowd-out" unpaid family care services, because family members typically provide these out of a sense of moral obligation and personal connection and virtually all have the capacity to opt out if they so choose (whether through abandonment or divorce). An important recent survey shows that utilization of privately paid home care workers does not reduce hours of care provided by family members, but typically supplements these, because families typically do not hire paid home care workers unless the care recipient's needs exceed the level of baseline support they are able to provide. In other words, paid care services largely result in an increase in the total hours of care rather than a reduction in the hours of family care (Christianson 1988; Wiener and Hanley 1992; Pezzin et al. 1996; Home Instead Senior Care 2010). Further, as pointed out above, families constrained by low earnings may be unable to provide family care services unless they are able to gain some remuneration for them.

Previous Universal-Coverage Proposals

A number of universal long-term care insurance proposals have been offered, none of which have fared well in the legislative process (Gleckman, this volume). Here we review some key features of several past proposals that we consider particularly important. Our review is organized along substantive dimensions—population served, services provided, and financing, for example—and concludes by contrasting the provisions of the CLASS Act with those of past proposals. We are also interested in the extent—if any—to which the various proposals recognize the role of family caregiving. We do not include proposals aimed principally at increasing private long-term care insurance coverage (e.g., Cutler et al. 2007; Stone-Axelrod 2005). However desirable that policy goal might be, programmatic incentives to purchase private insurance are unlikely to achieve anything close to universal insurance coverage. For a more extensive review of these and other long-term care financing proposals see Feder et al. (2007).

Threshold Need for Care

An important feature of any long-term care plan is the severity of the need-for-care threshold upon which program benefits are conditioned, because that threshold, or "trigger," will influence the size of the population potentially served by the program. For example, according to data from the 2004 National Long Term Care Survey, 16.6 percent of people 65 and above had at least one ADL limitation, while only 11 percent had 3 or more (out of a possible 6) ADL limitations (Manton, Gu, and Lamb 2006). However, an additional 2.4 percent of the older population had problems with one or more of the generally less-serious IADL activities; a long-term care plan that targeted

those with IADL as well as those with ADL needs would therefore serve a larger population.

The proposals we reviewed are remarkably consistent with respect to the severity of needs addressed. The 1983 American Health Security Act (the “Clinton Health Reform Plan”), for example, included long-term care provisions targeted at people (a) needing help from others with 3 or more from a prescribed list of 5 ADLs: dressing, bathing, eating, toileting, or transferring into and out of bed; (b) with a severe cognitive or mental impairment; or (c) with severe or profound mental retardation (White House Domestic Policy Council 1993: 171-172). Edward Norton and Joseph Newhouse (1994), writing at the time that the Clinton Health Reform Plan was still under active consideration, proposed a public long-term care insurance program in which benefits would depend on “... minimum dependency in ADLs or need for constant supervision” (Norton and Newhouse 1994: 1524), but did not spell out a more specific list of ADLs recognized, nor did they specify what the minimum threshold of dependency might be. In Burman and Johnston’s (2007) proposal for “Medicare Part E,” access to services would be contingent on medical certification of either a severe cognitive impairment or of limitations in at least two ADLs. It is important to recognize that while all of the criteria used to define the target population entail rather severe needs, for which providing assistance can be demanding, these are all tasks in which family and other “informal” caregivers are heavily involved at present.

Covered Services

The Clinton Plan would have provided “expanded” home and community-based services, and extended institutional coverage beyond that already provided by Medicaid. Thus it represented incremental expansions of coverage, overlaid on the existing system of Medicaid- and private-insurance-covered services. In contrast, Burman and Johnson’s “Medicare Part E” proposal is for “comprehensive” services; i.e., Burman and Johnson would replace the entire Federal-State Medicaid system with a new universal entitlement.

These proposals consider only the direct provision of services, generally with reimbursements to service providers from public funds, much like acute-care services in Medicare. Beneficiaries do not see or handle the funds used to pay for their services. Programs that cover only “formal” services, provided by paid service providers, can potentially raise questions concerning the substitution of formal for family and informal care: if those with long-term care needs perceive these services to be “free” they might overuse those services, and family members who would otherwise be ready to provide them informally will have less reason to do so. On the

other hand, as emphasized above, formal and informal care may be complements rather than substitutes.

Financing

The proposals we reviewed exhibit the greatest diversity in the area of financing. In Norton and Newhouse's approach, beneficiaries would have to pay a deductible the equivalent of "several months" of nursing home costs, and financing would be through general revenues, extended through the full taxation of Social Security benefits. Norton and Newhouse envisioned the development of a supplemental private insurance market, analogous to "Medigap" insurance, to cover the extra costs of higher-than-minimum nursing home quality (i.e., cost) thresholds, for those that can afford it. The Clinton Plan for long term care services included increased Federal matching rates, to accompany the required expansions in coverage of services and of the population served; the financing, therefore, would (like the existing Medicaid program) be funded by current revenues at the Federal and state levels.

Burman and Johnston (2007) proposed the financing of comprehensive LTC service provision through a mix of general revenues and an earmarked income tax surcharge. Coverage would be universal, thus there would be no need to establish eligibility by achieving a threshold of covered employment, as is the case for the existing parts of Medicare. Deductibles and copayment provisions would be used to help control costs. This approach would basically solve the problems of Medicaid by eliminating the need for the Medicaid program. However, due to its mixed financing approach, this proposal cannot be viewed as a pure "social insurance" program. And, thanks partly to its explicit welfare component and partly to the fact that its benefits are defined in terms of services—institutional or in-home care services—it (like all the proposals we have reviewed) would presumably be plagued by the same cost-control issues that continually plague the present Medicare program.

Generally, past proposals have attempted to achieve a comprehensive package of long term care service coverage, either through incremental additions to the present system (as in the Clinton plan) or through scrapping the current system and replacing it with a new and more comprehensive system (as in the Burman and Johnson plan). Any such proposal, given its goal of producing a major expansion of covered services, must cope with a need to generate a major expansion in funds to cover those services. In contrast, the "tradeoff" idea developed by Chen in a series of papers (Chen 1994; 2003; 2007) focuses almost exclusively on funding, remaining silent on questions of eligibility and nature of services covered. His proposal relies strongly on private LTC insurance, thereby presumably leaving unchanged many aspects of the current LTC scene. However, Chen proposes an interesting funding concept, namely allowing

individuals to “trade off” some of their Social Security benefit—he suggests five percent—for a LTC insurance policy. Because this coverage is achieved through one’s eligibility for Social Security, itself a compulsory program, his proposed “SS/LTC” plan is a form of “compulsory social insurance.” Chen implicitly recognizes that this level of Social Security benefit won’t buy a generous LTC insurance policy, especially considering that initial purchase would occur no earlier than age 62. In order to expand the amount of coverage, he also suggests applying the same “tradeoff” principle to private pensions: workers could accept a reduced defined-benefit pension payment in return for a defined LTC benefit.

There are interesting fiscal implications to the Social Security part of Chen’s proposal. His proposal puts no additional resources into the overall retirement-security system. If we assume that covered individuals can opt for the LTC benefit only at the point of becoming Social Security beneficiaries, then it actually reduces a beneficiary’s Social Security payment, possibly for many years, given that needs for long-term care are relatively low throughout the 60s and 70s. Once such a system matured, and presuming correct actuarial adjustment, payments would be the same with or without the system. But, unlike many other proposals, Chen’s would actually reduce Federal budgetary pressures during the transition period from program initiation to its reaching maturity.

The CLASS Act: Strengths and Weaknesses

One of the strengths of the CLASS Act lay in its relatively modest, incremental approach. However, this very strength was also a weakness. CLASS was designed to be voluntary rather than universal, and therefore did not create a new entitlement. Moreover, it was legislatively restricted to be self-financing, and therefore adhered strongly to the insurance principle. Rather than paying for services, it would have put money in the hands of qualifying beneficiaries, leaving to them the task of deciding which services will be purchased. The cash benefit to be paid by CLASS was small, far smaller than the average cost of a day in a nursing home or even several hours of professional home care. Therefore, CLASS was far from “comprehensive” with respect to services covered, although there is no reason that its proposed daily benefit could not be increased.

Integration of Family and Informal Caregivers

CLASS was flexible in that it allowed beneficiaries to use their cash benefit to pay family members for the care they provide. Therefore, while CLASS did not build into its design an explicit recognition of the role of family caregivers, it did implicitly integrate informal care into the bundle of covered services. This feature distinguishes

CLASS from all the proposals we reviewed. Indeed, the lack of attention to the role of informal caregivers in these proposals is striking.

Informal family care is often motivated by deep personal affections and based on person-specific knowledge of individual needs. As a result, it often contributes to provision of high quality care, both directly and through monitoring of the quality of paid care services. While family care can be a source of economic and psychological stress, it can also provide personal satisfaction to both caregivers and care recipients. Cultural norms of obligation and duty toward family members are central aspects of social solidarity. For all these reasons, public policy should support, but not coerce, family care provision. Still, even in a world of generous and universal care insurance, family care will continue to play a central role. As Bell and Bowes's chapter point out, Scottish families continue to provide care despite the availability of completely free publicly paid home care services. And, as Gibson's chapter shows, German families continue to choose family-provided care even when state-provided care is an option.

The difficulties of assessing family care resources make it difficult to engage in accurate means-testing of benefits. Private and public judgments about what are properly treated as "means" might differ substantially. For instance, Norton and Newhouse (1994) note that the value of an insured long-term care service, such as the cost of a nursing home, may vary according to one's "family status." Someone with no family members able and willing to help them may, at some level of ADL dependency, have little choice but to enter a nursing home, and for such a person the value of insurance coverage is quite high. At the same level of care need, someone with a spouse or other family members able to provide care may receive the care they need informally, reducing the value of the covered benefit. On the other hand, a married person with severe care needs and no insurance coverage is faced with the prospect of asset depletion prior to establishing Medicaid eligibility, rendering insurance coverage highly valuable as a way to protect the spouse's economic welfare.

While accounting for one's family situation when determining eligibility for benefits might be desirable, it also raises serious practical difficulties. Differentiating eligibility for benefits, or the generosity of benefits, according to the presence or absence of a spouse, or the existence of living children—two of the most obvious potential dimensions of family situation—can easily create problems of equity or fairness, or produce undesirable behavioral incentives, or both. There is, however, a way to allow for the coexistence of family and formal care without conditioning eligibility or benefit levels on one's family situation, and that way was perfectly embodied by the CLASS Act : an unrestricted cash benefit, conditioned solely on the level of care need, leaves in the hands of the beneficiary the possibility of

“compensating” a family caregiver either through direct payment or through asset accumulation, against a possible future of nursing home costs (the latter has the potential to preserve inheritances to some degree).

Indeed, a number of states already have adopted “cash for care” programs, on a limited basis, for Medicaid beneficiaries receiving home care. Studies of the decisions made by participants show that more than half chose to hire relatives to address unmet personal assistance needs, while less than 6 percent hired workers who were not previously known friends or family. Focus group and interview data reveal that participants preferred hiring relatives because they found them more reliable and sensitive (Simon-Rusinowitz et al. 2011).

Ways to increase participation in CLASS-type Programs

The CLASS Act would have created a voluntary program, and was therefore at best a very small step in the direction of universality. It also offered a very small benefit. Among those with long term care needs at a point in time, the proportion whose needs could be paid for in full by the \$50 per day benefit promised by CLASS is probably quite small. And for those with advanced care needs, especially those that require nursing home care, the CLASS Act’s benefit would have fallen far short of daily costs.

However, we feel that three elements of program design are important when imagining a universal-coverage world, as well as the pathway to it: (1) universality; (2) comprehensiveness of service coverage; and (3) integration of family or informal care. We give CLASS high marks for its capacity to integrate family care, while acknowledging that it is neither comprehensive nor universal. But we feel that achieving universality is of more immediate importance than providing comprehensive services, and so we are mainly interested in identifying ways to maximize voluntary participation. In the limit, a voluntary program can become, de facto, one that covers everyone.

One way to increase participation would be to induce employers to offer it among their fringe benefit packages, as one among the several employee-paid benefits generally offered. Another possibility would be to require all Federal contractors to offer CLASS. Additionally, employers who aren’t Federal contractors might be required to offer CLASS as a condition for accepting selected favorable tax treatment provisions.

If CLASS were to be implemented, and if it were to succeed in its intended goal of helping beneficiaries remain at home, then it could delay entry into a nursing home and therefore reduce Medicaid institutional-care costs. The Congressional Budget

Office estimated that CLASS would have reduced Medicaid costs by \$2 billion during its first 10 years of operation (Mulvey and Colello 2011). Projected savings such as these could provide the basis for encouraging participation in a CLASS-type program by letting participants pay at least some of their premiums out of their Federal income tax obligations, in effect diverting some of what would have been the current-revenue sources used to pay current Medicaid costs into a prepaid pool of funds used to pay future long-term care costs. This idea differs from a tax credit, in that it wouldn't reduce the taxpayer's tax bill. Rather, it would reduce current tax revenues but place those lost revenues in CLASS's pool of reserve funds. The obvious problem with this idea is that it would contribute to current fiscal problems. But this is a problem with any "transitional" period.

It should also be possible to get the states to help finance an improved LTC insurance system, if—as should be the case—Medicaid costs go down, at least in relative terms, under the new system. For every dollar of saved Medicaid costs, about half the savings accrue to State governments. Because states should, in principle, be happy to experience savings of any sort, it might be possible to modify the Medicaid cost-sharing formula so that states pay a somewhat larger share of a smaller total expense under a universal LTC program.

A related idea, which might also encourage increased participation in a CLASS-type program among working-age people, is to create a sort of "caregiver's tax credit," in the form of a "virtual" payment of CLASS premiums rather than an explicit adjustment to a caregiver's tax liability. In other words, someone who met an appropriately-defined criterion for providing unpaid long-term care services would be deemed to have enrolled in, and made premium payments to, CLASS for each month of their care provision. This would create a future CLASS benefit liability, without any offsetting payment of actual premiums, which may seem like a very bad deal for the government. However, anyone who established their eligibility in this way would have to switch to making cash premium payments as soon as their caregiving episode ended in order to maintain eligibility; if not, their policy would lapse, negating the future (unfunded) benefit liability. Caregiver tax credits have been proposed many times, but never enacted (for a discussion of such proposals see Wolf 2004, p. 115). The form of "virtual" credit proposed here might appeal to many caregivers, serving to draw them into the program; moreover, it would likely have much less fiscal impact than a true tax credit, even if it were extended to participants without a tax liability (and therefore beyond the reach of a nonrefundable credit).

An even more sweeping modification of CLASS would be to turn its cash benefit into a tiered benefit, possibly in the form of a voucher. Under this scheme, modeled on

Germany's system (as discussed in Gibson's chapter), the voucher could be redeemed for a specified amount of unrestricted cash—keeping open the beneficiary's ability to offer “cash for care” to family members—or for a larger sum if used exclusively for formal care services.

A final suggestion for broadening participation in a CLASS-type program borrows from Chen's (2007) proposal to permit people to divert some of their Social Security benefit into a prepaid (private) LTC insurance plan. We suggest, instead, that at the point of applying for their Social Security benefits, those entitled to a worker's benefit be allowed to designate a portion of their benefit as a CLASS Act premium. While this might seem to invite a good deal of adverse selection, the potential for adverse selection could be controlled by limiting eligibility to those who have reached the age of entitlement for full, rather than reduced, benefits, and requiring them to have been employed for the three years immediately preceding retirement. They would, in effect, be treated as if enrolled in CLASS during those preretirement years. It is not clear how many new beneficiaries might be willing to give up a substantial portion of their Social Security benefit. For example, in 2009 the average retired-worker benefits paid to 66 year olds (most of whom, it seems safe to assume, were newly retired in that year) were \$1,221 per month (Social Security Administration 2011, Table 5.A1.1). The Munnell-Hurwitz estimates, reviewed earlier, found that the actuarially-fair CLASS Act premium for a 66-year old (in the baseline, 6 percent participation scenario) is \$241 a month. This represents nearly 20 percent of the average Social Security benefit payment, a proportion that a substantial proportion of beneficiaries are likely to find prohibitively high. On the other hand, that \$241 monthly premium buys a lifetime \$2,218 per month cash benefit for those that experience a decline in function sufficient to trigger beneficiary status—a tradeoff that many might find attractive.

Can We Get There from Here?

Although the CLASS Act seemed to be a small, uncertain, and—in key analysts' minds, at least—unworkable step in towards universal coverage of long term care needs, its suspension seems like a large backwards step. Conditions like those that contributed to its passage (as described in Gleckman's chapter) aren't like to recur any time soon; indeed, the political climate has subsequently evolved in ways that make bold collective initiatives even less likely. Thus any pathway towards universal long term care coverage features significant obstacles. Concerns about the “graying” of the federal budget, first expressed many decades ago (Hudson 1978) seem to be intensifying. Benefits directed primarily at the elderly promise universality in the long-run, since everyone hopes to grow old. However, increased public debt resulting

from severe recessions and tax cuts raises questions about economic ability to deliver on future promised benefits. A general slowdown in economic growth tends to increase distributional conflict.

Further, high levels of income inequality in the U.S., combined with the other sources of heterogeneity outlined in the first section of this chapter, probably reduce the social trust necessary to collaborate on development of universal care programs. Cross-country surveys suggest that countries with higher levels of inequality are associated with lower levels of generalized trust (Rampell 2011). Income inequality has increased significantly in the U.S. as well as many other countries in recent years (Saez 2010). A survey released at a recent World Economic Forum indicates that trust in both business and government has declined more steeply in the U.S. than in other countries as a result of the recent financial crisis (Folbre 2011). All these factors probably contribute toward a recent shift toward a political paradigm emphasizing intergenerational conflict over the public purse (Binstock 2010).

On the other hand, the sheer magnitude of the long-term care problem, combined with the potential efficiency of universal insurance, could increase the pressure to devise policy solutions. Further, as emphasized in the preceding sections, good models of universal long term care have emerged in a number of different political contexts. In our view, a concerted effort should be made to help translate the currently somewhat abstract benefits of public insurance systems into calculations that would allow individuals to develop a better picture of net lifetime benefits. This effort will require improved accounting systems that explicitly take into account the value of non-market household work and family care, activities that contribute to economic growth but typically go unrewarded by the market. Most models of “intergenerational accounting” focus primarily on taxes, ignoring benefits provided directly by the state and indirectly through the creation and nurturance of future tax payers (Folbre 2009). For instance, the time and effort that parents devote to raising the next generation of workers and taxpayers—if fully accounted for—leads to a very different picture of intergenerational transfers than one based on money transfers alone (Wolf et al. 2011).

Effective political leadership combined with careful advocacy should find a receptive audience, even for what may seem like an extremely expansive policy shift. A national poll conducted in 2004 found a majority of respondents expressing concern about the costs of their future long term care needs, with 70 percent agreeing that that government should do more to help people with those costs (Hart Research Associates 2005). A more recent 2010 survey limited to voters in California reached similar conclusions: 95 percent of voters 40 and older indicated the importance to them of affordable long term care options that would help them avoid nursing home care, with

two thirds saying that these objectives should be a high priority for “state elected officials” (Lake Research Partners 2010).

The strongest potential argument for a universal and mandatory long-term care system in the U.S. lies in a better conceptual and empirical analysis of intergenerational reciprocity. We owe the older generation a high quality of care in return for the care they have provided us, not just as parents, but also as taxpayers helping finance our education and health care. As a purely voluntary and self-financing program the CLASS Act had no true intergenerational component, since current participants would have prepaid for their expected future claims against the pool of funds held by the insurance program (the intertemporal transfers—from those paying premiums now, to those collecting benefits in the future—would not have necessarily been intergenerational). By covering working-age disabled people quickly, while delaying entitlement to others during the period of qualifying, CLASS might even have led to downward rather than upward transfers.

But if CLASS provisions were made mandatory, along with redistribution from those with sufficient resources to those with incomes too low to pay the premiums, it could be designed to conform to principles of intergenerational and gender equity, with those who contribute relatively more to the rearing of the younger generation or to the care of disabled or elderly family members eligible for significant deductions from the taxes they pay to help provide for care in their old age. It could also be designed with a view to intergenerational sustainability, balancing the needs of all dependents (children, the disabled, and the elderly) against the ability of the working age population to provide support for them.

Most of us want to be cared for, to provide care, and to see that those who need care get the care they need. Our individual resources are often inadequate, or are poorly timed, to deal with those needs, creating a rationale for insurance. The most economically efficient, and the most socially sustainable, insurance takes the form of mandatory universal social insurance. A number of failures—failures of foresight and imagination, at the individual level, failures of coordination at the family level, failures of markets and of political leadership—stand in the way of achieving the seemingly utopian ideal of universal coverage. But the longer we wait, the harder it will be to see our way to taking even small steps towards that ideal.

Notes

¹ See “[Secretary Sebelius’s letter to Congress about CLASS](#)” (online document).

² See [“Reputation of Pharmaceutical Companies, While Still Poor, Improves Sharply for Second Year in a Row”](#) (Harris Interactive Website).

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