

CHAPTER 9

THE PERVERSE PUBLIC AND PRIVATE FINANCES OF LONG-TERM CARE

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One of the first lessons of economics is that people respond to incentives—and the incentives in our long-term care system are all wrong. Medicaid pays for almost half of long-term care (Komisar and Thompson 2007), but only after a disabled person has spent down almost all of her wealth. That amounts to a nearly 100-percent tax on assets for many people. Medicaid provides nearly comprehensive long-term care insurance, but only after private insurance has paid. Since, for many people, private policies largely pay for services that would be covered under Medicaid, there is little reason to pay for insurance.¹

The response to the existing incentives is predictable: Americans save very little and few purchase long-term care insurance. Although the implicit Medicaid tax is only one among many factors at work, its perverse incentives are clearly counterproductive.

These incentives increase reliance on Medicaid, whose costs are a significant component of the ballooning federal deficits and create tremendous pressure on state budgets. While this is a problem even now, the future costs for federal and state governments will only grow as the enormous baby boom generation ages and requires more increasingly expensive long-term care services. In short, government policy discourages individuals from saving for long-term care without itself setting aside resources to meet the responsibilities it has taken on. This is a recipe for economic catastrophe (Burman et al. 2010) and places in doubt the government's ability to actually deliver the services it promises in the future.

Although these issues might discourage those who would like to make access to long-term care universal, a fundamental reform of the system of financing long-term care presents an opportunity to realign incentives and bolster both federal and state finances. A well designed universal long-term care system would eliminate the asset test and the strongest savings disincentives under the current system. Of course, any

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program that guarantees payment for all or a significant fraction of long-term care expenses will reduce incentives for private saving (compared with a system where individuals are fully responsible). The solution is to require full prefunding of the nation's long-term promises, either through a system of mandatory private long-term care insurance or through a fully prefunded federal program. There are, alas, both practical and political problems with both approaches. For that reason, incremental options to realign private incentives might be more feasible.

The plan of the chapter is as follows. The first section outlines the effects of the dysfunctional long-term care financing system on federal and state budgets and private households' decisions. Next, the implications for public policy and several reform options are examined. A concluding section discusses limitations and challenges and suggests some broad benchmarks for evaluating public policy options.

Public and Private Finances

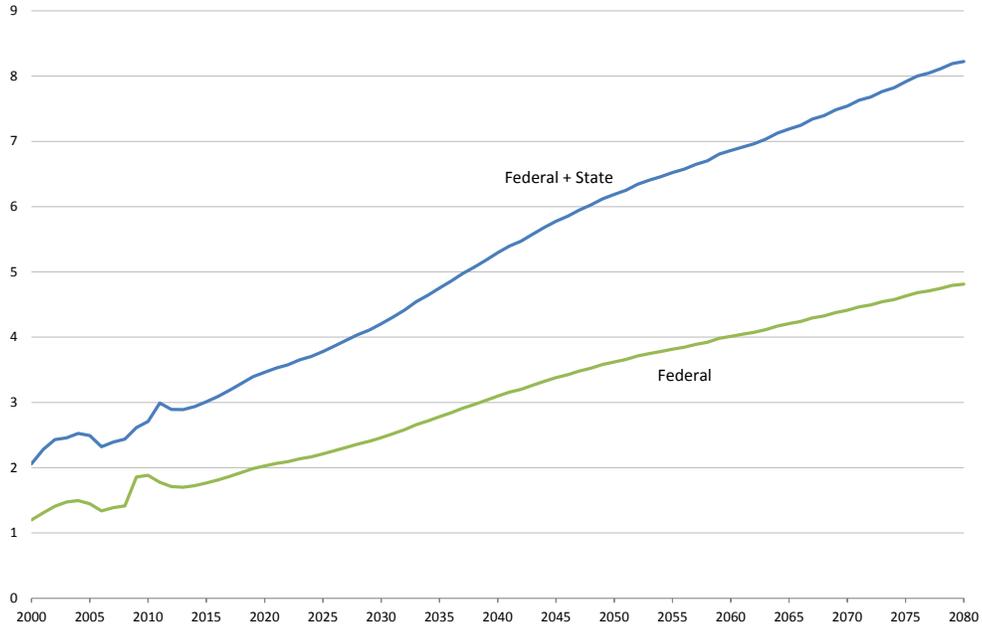
This section focuses on the effect of current long-term care financing on national and state budgets, savings, and households' ability to finance long-term care needs when they arise.

Effects on Public Finances

The current system of financing long-term care is a significant factor in the deteriorating long-term budget situation of both federal and state governments. In 2009, federal and state spending on Medicaid was about 2.7 percent of GDP² (see Figure 1.) That is more than half of spending on defense, which is less than 5 percent of GDP. In 2008, 30 percent of Medicaid spending paid for long-term care (Center on Budget and Policy Priorities 2008), but that percentage will increase dramatically over time as baby boomers age and their long-term care needs rise. Assuming a continuation of current policy, demographic and health cost trends, federal and state spending on Medicaid will exceed spending on defense by 2040.³ This presents serious challenges, especially as we consider expanding access to long-term care.

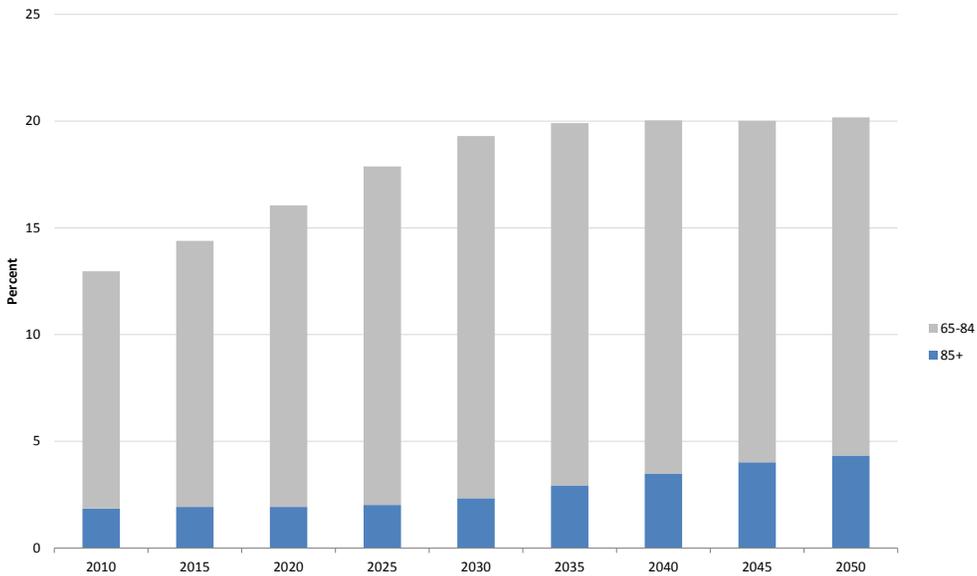
There are two primary cost drivers. First, the proportion of the population aged 85 and over will almost double between now and 2040 (see Figure 2). More than one-fifth of this group was in nursing homes in 1995.⁴ Second, health care costs continue to grow faster than the economy—by more than two percent per year on average. (Congressional Budget Office 2009) Assuming nursing home costs track health care spending, this translates into steadily increasing Medicaid spending relative to GDP.⁵

Figure 1. Public Medicaid Spending as a Percentage of GDP, 1965-2085



Source: Government Accountability Office (2010), supplemental data (personal correspondence).

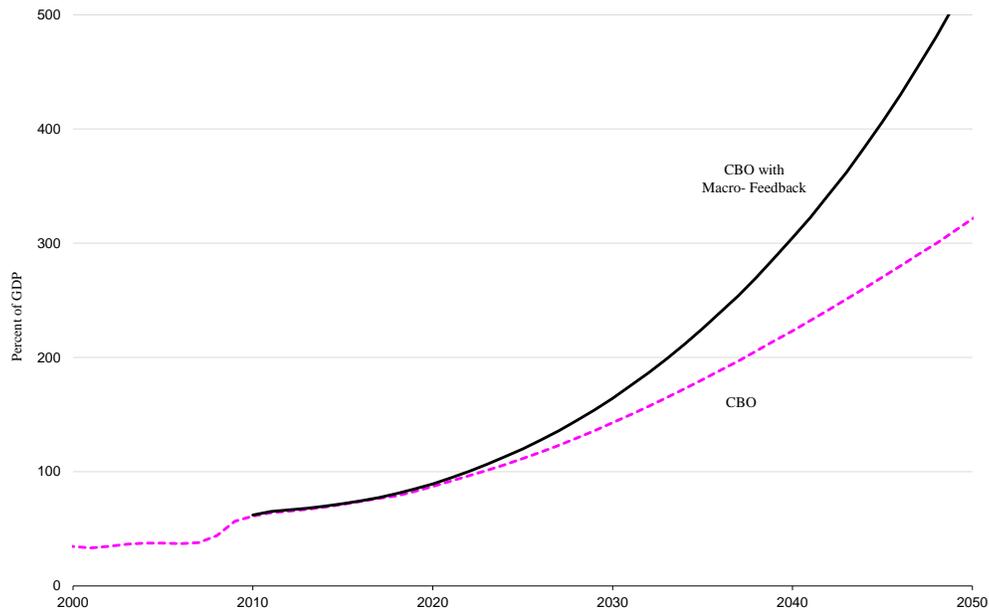
Figure 2. Percentage of Population 65-84, and 85 and over, 2000-2050



Source: U.S. Census Bureau, <http://www.census.gov/population/www/projections/files/nation/summary/np2008-t2.xls>

Medicaid is an important element in the unsustainable growth in public spending over coming decades. Burman, et al. (2010) estimate that if current policies continue, the debt will reach at least 100 percent of GDP by 2022 and 200 percent by 2034 (See Figure 3) with potentially disastrous consequences for the economy. Higher taxes would slow the rate of growth of debt, but cuts in entitlement spending will also be necessary over the long run.

Figure 3. Projections of Debt Held by the Public, 2000-2050



Source: Burman, Rohaly, Rosenberg, and Lim (2010)

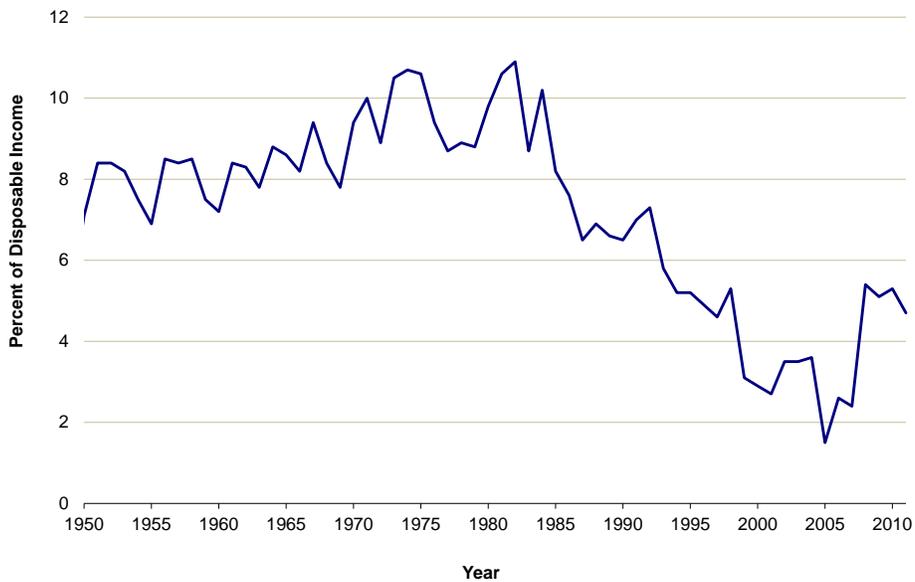
Almost all states have balanced budget requirements, so rising Medicaid liabilities will not translate directly into increased debt,⁶ but long-term care financing pressures threaten to exacerbate states' already precarious finances. State spending on Medicaid was less than 1 percent of GDP in 2010, in large part because of temporary federal aid under the American Recovery and Reinvestment Act. (Kaiser Family Foundation 2010) The Government Accountability Office (2010) estimated that the state share of Medicaid spending increased to 1.2 percent of GDP in 2011 and will grow to 1.7 percent of GDP in 2020, and 2.2 percent in 2030 if current trends continue. Combined with rapidly growing underfunded liabilities for public employees' pension and health benefits, this will create pressures on state budgets every bit as daunting as those facing the federal government.

Medicaid is an important part of the nation's long-run fiscal problem and reforming Medicaid could contribute significantly to a solution.

Effects on Saving

The federal borrowing binge would be less problematic if individuals were saving more, but personal saving has been declining dramatically over time. (See Figure 4.) One factor in that trend is the strong disincentives for saving built into the Medicaid program. For many older individuals with long-term care needs, Medicaid amounts to a 100-percent tax on assets above the threshold for eligibility for assistance (typically, \$2,000 for a single person). Medicaid also strongly discourages purchasing long-term care insurance because much of what is covered under private insurance simply replaces services provided for free under Medicaid.

Figure 4. Personal Saving Rate, 1950 - 2011



Source: Department of Commerce, Bureau of Economic Analysis, NIPA Table 2.1. Personal Income and Its Disposition, line 35.

Absent federal aid, the potential need for long-term care would encourage precautionary saving both during working years and retirement. The risk of high medical expenses and disability would provide a powerful incentive for workers to save (Hubbard et al. 1995; Palumbo 1999; Scholz et al. 2006; Vidangos 2009). And the high cost of nursing home care (and other medical expenses unreimbursed by

Medicare) would contribute a strong reason to maintain substantial asset reserves during retirement (De Nardi et al. 2010).

However, the availability of essentially free nursing home care for people with depleted assets and low incomes completely reverses the incentives. Like all social insurance programs that have asset tests, Medicaid depresses saving for two reasons:

First, the provision of support in the bad states of the world reduces the uncertainty facing households and therefore decreases precautionary saving (this effect would be present even in the absence of the asset test). Second, the restriction on asset holdings implies an implicit tax of 100 percent on wealth in the event of an earnings downturn or large medical expense. The possibility of facing this implicit tax further reduces optimal saving (Hubbard et al. 1995: 363).

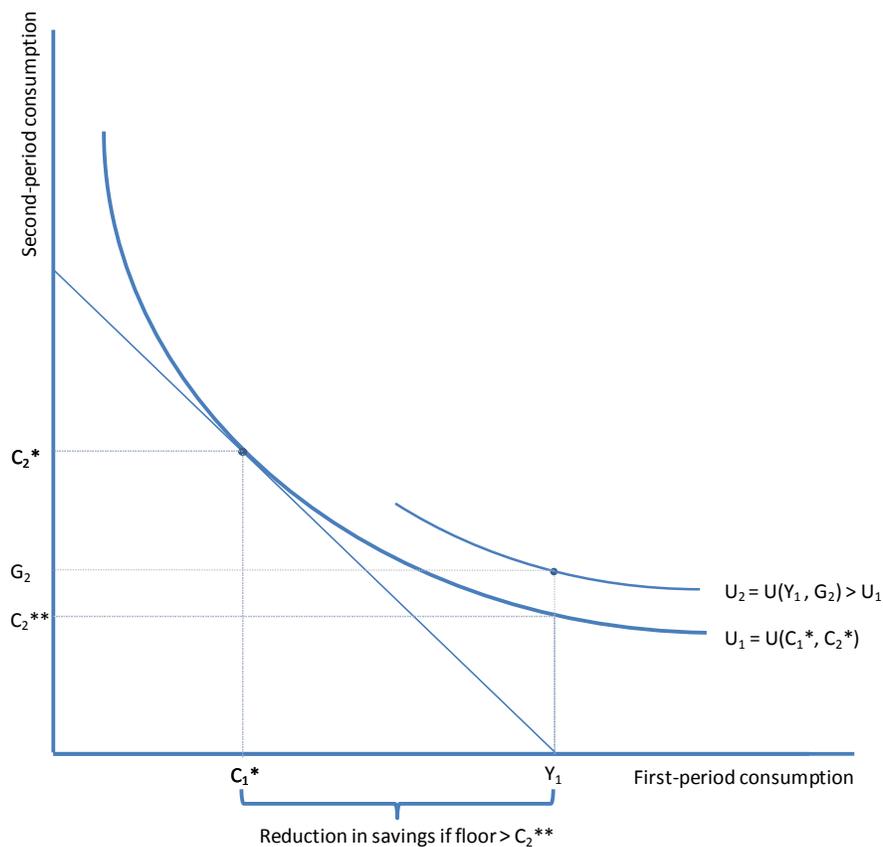
The main factor appears to be that Medicaid offers a guaranteed benefit—covering room and board and necessary medical expenses for seniors who become disabled. This is an intentional policy choice—a safety net for seniors who suffer what would otherwise be devastating long-term care expenses—but it means that older people at almost all income levels have less incentive to maintain a reserve to pay for such expenses, and workers have less incentive to accumulate a substantial retirement nest egg.

It is common in the economic literature to model Medicaid as providing a guaranteed minimum consumption level—basically subsistence for people with disabilities. In this context, De Nardi et al. (2010) simulate the effect on saving among the elderly of different Medicaid program rules and conclude that the highest three income quintiles would all save much more if the consumption floor (minimum benefit) were cut in half. In one version of their model, the top income quintile would maintain a roughly constant average asset balance until age 90 with the lower guaranteed benefit, compared with steadily declining asset levels under current rules. De Nardi et al. (2010) conclude that Medicaid encourages asset depletion at all income levels, although by a negligible amount for the bottom two quintiles since they enter retirement with few assets.

Presumably, if their sample had allowed for finer divisions, they would have concluded that those with very high incomes would be unaffected by the Medicaid consumption floor because it is so much lower than the desired level of consumption in retirement. Figure 5 illustrates the effect of a consumption floor in a very simple standard two-period life cycle model.⁷ Absent the social insurance program, an individual who has income Y_1 in period 1 and no income in period 2 (retirement)

chooses first period consumption, C_1^* and saving ($Y_1 - C_1^*$) to maximize lifetime utility.⁸ Second-period consumption is C_2^* , equal to savings plus interest. Now suppose the government guarantees second-period consumption of G_2 . If $G_2 > C_2^{**}$, the individual can achieve greater utility ($U_2 > U_1$) by spending his or her entire lifetime income (Y_1) in period 1 and consuming the minimum guarantee (G_2) in period 2. Saving decreases from $Y_1 - C_1^*$ to zero.

Figure 5. Effect of Retirement Consumption Floor on Saving



The intuition is straightforward. The government guarantees a certain benefit level that can be attained with no saving. This makes the individual better off than without the guaranteed benefit, so the optimal strategy is to not save at all and enjoy a much higher level of consumption during working years in exchange for only a modest reduction in living standard in retirement.

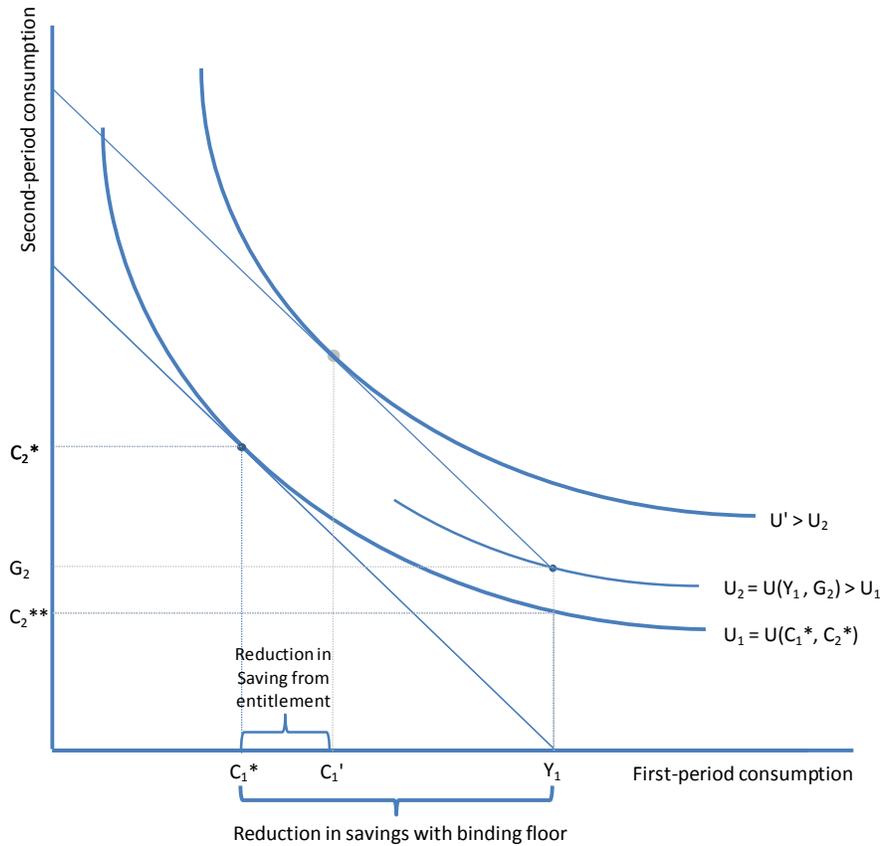
Obviously, this example is vastly over-simplified. Medicaid provides a floor on only one component of retirement consumption, covered long-term care services, which only have value for the minority of seniors who end up needing them. Most people cannot predict whether they will become disabled so there is uncertainty. And Social Security augments retirement income for seniors. Because of that program, many people would save little or nothing even before considering Medicaid and the possibility of needing long-term care. But the simple example sheds some light on how Medicaid nursing home care affects saving decisions.

People with very low and very high income are unlikely to be affected by the Medicaid guarantee—the former because Social Security provides more retirement consumption than they would choose if they could borrow against future benefits, and the latter because their desired retirement consumption is high relative to the guarantee amount (so $C_2^{**} > G_2$). For the rest of the population, the likelihood of being affected by the Medicaid floor depends on the probability of needing long-term care and the cost of that care. Increased longevity and a propensity toward certain illnesses such as diabetes or Alzheimer's disease increase the risk of needing long-term care services at some point. The higher the probability, the more powerful is the saving disincentive. Finally, as costs for long-term care services increase, the Medicaid guarantee becomes more valuable relative to planned retirement consumption, which further discourages saving.

The two-period model also illustrates how replacing the floor with a universal entitlement would affect behavior. Suppose Medicaid long-term care services were made available to everyone, regardless of asset levels or income. In this framework, that is equivalent to a grant of G_2 in period 2 (for those who need long-term care), which raises lifetime income, shifting the budget constraint out. This makes higher consumption in both periods feasible, and the individual responds by raising first period consumption from C_1^* to C_1' . Moreover, in this case, the person continues to save ($C_1' < Y_1$) so second period consumption also increases—to $G_2 + (Y_1 - C_1')(1+r)$, where r is the interest rate. Second-period consumption is higher than in the case where Medicaid simply provides a floor or than it would be if Medicaid did not exist.⁹

Savings falls (by $C_1' - C_1^*$) because of the income effect (consumption is a normal good and thus increases when lifetime income increases).

Figure 6. Effect of Universal Entitlement on Consumption



The income effect could be offset by raising taxes to pay for the new entitlement. A lump-sum tax with present value of $G_2/(1+r)$ would completely eliminate the income effect, but collecting it from lower-income households would be counter-productive (since the whole point of the policy is that many families cannot afford adequate long-term care while maintaining a minimum consumption level) and, in any event, infeasible. Another possibility would be to finance the new entitlement with a flat rate consumption tax, like a Value Added Tax (VAT). In this model, that would be equivalent to a lump-sum tax, but that is because income (Y_1) is assumed to be fixed. In reality, consumption taxes are tantamount to taxes on labor since they reduce the after-tax value of consumption that can be obtained from an hour of labor. So the VAT would create a labor distortion.

The bottom line is that the current system penalizes saving and alternatives exist that, if properly financed, might reduce the size of saving distortions.

Effects on Demand for Private Long-Term Care Insurance

Medicaid's most obvious distortion is that it crowds out private long-term care insurance (Brown and Finkelstein 2008). For low-income people with no assets, Medicaid is a perfect substitute for long-term care insurance. Since Medicaid rules generally require that private insurance be the primary payer, any long-term care insurance payments would reduce Medicaid payments dollar for dollar. Effectively, Medicaid constitutes a 100-percent tax on private long-term care insurance for people with low incomes in the sense that \$100 spent on private insurance reduces the value of Medicaid reimbursement by the same \$100 (see Figure 7).

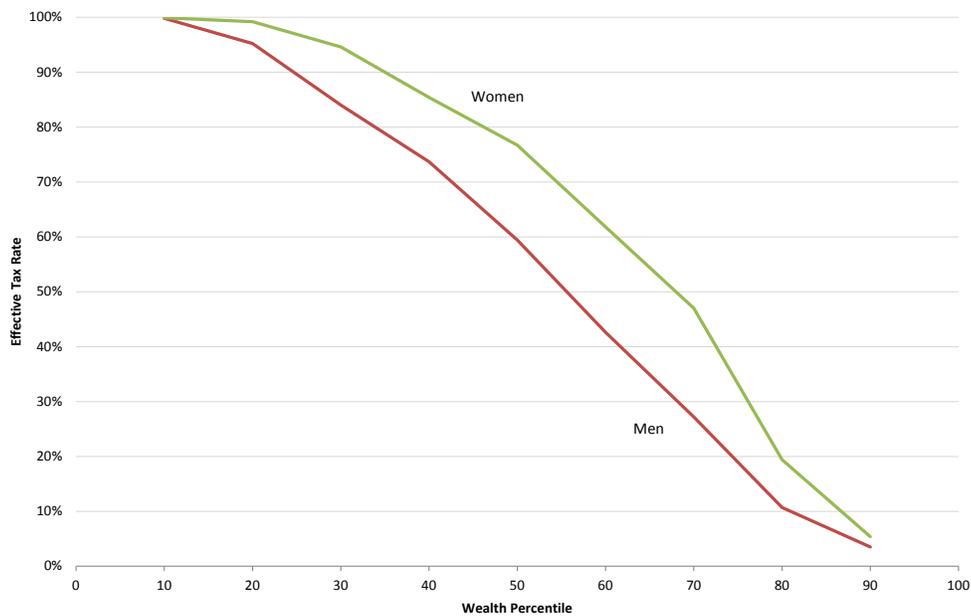
Private insurance is more valuable for families with more assets to protect. Long-term care insurance allows those with higher incomes to preserve their assets for longer. However, even families at the median wealth level face a substantial risk of a long spell of disability that would exhaust their assets despite partial reimbursement of expenses by the insurance. In that situation, long-term care insurance is simply substituting for Medicaid until the insurance policyholder's assets are exhausted. Brown and Finkelstein (2008) estimate that the implicit tax for such families exceeds fifty percent.¹⁰ Put differently, less than half of the long-term care insurance premium goes to coverage (asset protection) that isn't provided by Medicaid. Brown and Finkelstein (2008) calculate that the tax makes private long-term care insurance a bad deal for all but high-income households.

The crowd-out of private long-term care insurance has several undesirable effects. First, it reduces private sector saving since insurers have to maintain substantial reserves to pay future benefits. Second, it reduces public saving (increases deficits) because a larger share of long-term care expenses are paid by the public through Medicaid. Third, it entails a substantial welfare loss to individuals because Medicaid is very incomplete insurance. Individuals with assets can become nearly destitute before reaching Medicaid's asset threshold, and those whose stint in a nursing home is temporary return to the community with substantially diminished resources. Brown and Finkelstein (2008) estimate that most people would be willing to pay a substantial amount to purchase the asset protection insurance that Medicaid lacks, but such "top up" coverage is precluded by Medicaid's rules.

Some reforms have been aimed at encouraging the purchase of private long-term care insurance. A 1996 law made employer-provided long-term care insurance a tax-free fringe benefit, like health insurance. This lowers the after-tax cost of insurance

acquired at work, but it is a poorly targeted subsidy. The subsidy value of an income tax exclusion increases with income (and marginal tax rates), but lower-income workers face the highest implicit taxes on long-term care insurance. As a result, Brown and Finkelstein (2008) estimate that the tax exclusion would not suffice to make private insurance a good deal for most workers. Most states also offer tax deductions or credits. While the credits appear to be more effective at encouraging coverage, the net effect of tax subsidies is very small (Stevenson et al. 2009).

Figure 7. Implicit Tax on Long-Term Care Insurance due to Medicaid, by Wealth Percentile and Gender



Source: Brown and Finkelstein (2010).

Some states also raise the asset eligibility threshold for people with private insurance. However, since Medicaid is the secondary payer, the problem remains that a significant share of private insurance pays for benefits that would otherwise have been provided free under Medicaid. Thus, Brown et al. (2007) find only a modest effect on demand for private insurance from higher asset thresholds.

The actual effect of Medicaid on the demand for long-term care insurance is difficult to ascertain both because of inherent flaws in the private insurance market and the fact that individuals' actual behavior deviates significantly from the kind of life cycle optimization commonly used in the literature (including in this chapter). Long-term care insurance carries very high loads—marketing, commissions, and other overhead costs built into insurance premiums. Brown and Finkelstein (2008) estimate the

average load to be 50 percent of premiums for males, although long-term care insurance is roughly actuarially fair for women. (The discrepancy arises because premiums cannot vary by gender and women are much more likely to require long-term care services than men.) Private insurance typically pays for only a fraction of nursing home costs (\$150 per day in 2005) after a waiting period of 90 days.¹¹ About a quarter of policies still have no inflation protection, which makes the insurance especially risky given that benefits might not be claimed for 30 years or more. It is difficult, also, to anticipate how long-term care will be delivered decades in advance so there is a risk that a current plan will not cover tomorrow's delivery mechanism.¹²

Moreover, although premiums do not increase with age after initial purchase, an insurer can raise premiums for an entire class of policyholders based on their claims experience, sometimes at double-digit rates. (Consumer Reports 2008) As a result, policies may lapse because policyholders cannot afford the escalating premiums. And, given the uncertainty about usage of long-term care, the future solvency of any insurer with a substantial portfolio of long-term care insurance is uncertain. For example, if there are great advances in preventing cancer and heart disease, many more Americans might live long enough to develop dementia and require long-term care services, which could bankrupt an insurer that specialized in long-term care. (Conversely, a cure for Alzheimer's disease could provide a windfall to insurers.)

Finally, even if the Medicaid tax did not exist and safe, comprehensive long-term care insurance could be purchased on an actuarially fair basis, many Americans who could afford the insurance might not buy it. Liebman and Zeckhauser (2008) catalogue a number of reasons why people might have too little health insurance and consume too little health care, despite large incentives to over-insure and over-consume. Those factors would apply to long-term care insurance as well. Humans, as opposed to hyper-rational "Econs" (Thaler and Sunstein 2009), are myopic and subject to inertia. Instead of discounting future income and expense at a constant rate, they tend to apply a very high discount rate over the near term (say a year), even though they plan to discount subsequent years at the modest rates that are consistent with economic theories of behavior. This "hyperbolic discounting" (Laibson 1997) leads to procrastination and a need for precommitment mechanisms that will make it possible for humans to follow up on their good (but inconsistent) intentions. Humans have difficulty evaluating small or distant risks and are prone to irrational optimism. (Thaler and Sunstein 2009)

Humans have trouble evaluating risks that are not salient. For example, they overestimate (and tend to over-insure against) the risk of plane crashes, because they make big news when they happen, but humans underestimate more common risks

such as car crashes and resulting disability, or diabetes. (Liebman and Zeckhauser 2008) Long-term care insurance creates a special challenge because people in their 40s or 50s might have little experience with the health problems of people in their 80s. That is, the risk covered by insurance has low salience.¹³

The bottom line is this: Medicaid creates prohibitive implicit taxes on private long-term care insurance for all but those with fairly high assets. However, even if the Medicaid distortions could be eliminated, it is not clear how many more people would purchase the insurance.

Implications for Public Policy

This volume's title asks, "Can we get [to universal coverage of long-term care] from here?" The answer is that it will not be easy. Any voluntary program will fall far short of universal coverage, especially if the inherent flaws in the current system are not adequately addressed. Moreover, since the current system is fiscally unsustainable, adding subsidies or a new entitlement for universal long-term care without a new source of revenues or offsetting spending cuts to pay for it would hasten the arrival of a fiscal disaster. If that happens, coverage for long-term care—and the rest of the social safety net—will all be at risk.

In my view, the ideal system for providing universal long-term care would be entirely self-sustaining. That is, on balance, the present value of expenditures net of revenues would be approximately zero. If the program is run as a public insurance plan, then reserves accumulated in excess of payments must be removed far, far off budget so that they do not simply facilitate large budget deficits in the short term (without providing any real resources to finance benefits as baby boomers age and health care costs increase). And the program should reduce the disincentives to save in the current system.

Medicare Part E

Rich Johnson, and I (Burman and Johnson 2007) outlined a proposal to replace Medicaid coverage with a new Medicare Part E that would pay for universal long-term care services, both at home and in an institutional setting. Unlike traditional Medicare, this new entitlement would be financed by a modest income tax surcharge that would effectively add about one percentage point to income tax rates for people covered by the program. This funding mechanism would exempt the bottom two income quintiles whose incomes are too low to be affected by an income tax surcharge and who would also not gain anything from the new entitlement since it would simply replace the free long-term care insurance that they are currently eligible for under Medicaid. Revenues from the surcharge that exceed outlays would be

deposited in a privately managed interest-bearing account. This off-budget trust fund would grow quite large as the new program phased in, since it would be decades before a large fraction of participants were drawing long-term care benefits.

The advantage of the proposal is that it could increase national savings by enough to pay for future long-term care benefits, vastly improving federal and state finances and significantly reducing the federal debt, all else equal. Smaller deficits should translate into lower interest rates over time, which would boost investment and productivity. (Gale and Orszag 2004) The proposal would reduce the strong disincentive for saving inherent in the current program by removing the floor on retirement consumption, as illustrated in Figure 6. Also, since the proposal would be fully financed with a tax surcharge, it would, on average, eliminate the boost to lifetime income that would otherwise be created by the new entitlement. However, the income tax also penalizes saving because both current earnings and the return on deferred consumption are taxed, which would diminish the saving incentive somewhat.

An alternative option to finance Medicare Part E would be via a VAT. As discussed above, this would virtually eliminate the saving distortion (although it would create a small work disincentive), however, it would hurt low-income individuals who would gain nothing from the new entitlement but would have to pay the regressive VAT. This drawback could be mitigated by providing a new refundable income tax credit equal to the tax that would be due at a consumption level equal to the poverty income threshold, with an appropriate adjustment to the VAT rate to offset the cost of the tax rebate. This approach has been suggested by advocates of a national retail sales tax (Jokisch and Kotlikoff 2007) and is also similar to the mechanism proposed to offset the VAT's regressivity by Michael Graetz (2010) and me (Burman 2009) as part of tax reform.

This proposal obviously faces political challenges in creating a "government run healthcare" program in what appears to be a toxic political environment after the highly partisan debate about health reform. But a more serious challenge may be trying to sequester the savings to pay for future long-term care benefits in way that does not enable larger deficits in the short term. For decades, Social Security has been running surpluses that have been dutifully deposited in an interest-earning trust fund. Notwithstanding this arrangement, the federal government's unified budget accounting allowed Social Security surpluses to mask a portion of the deficits attributable to other spending and revenues. The consequence is that when Social Security starts drawing on the trust fund, there will be no real assets set aside to meet Social Security's deficits. The shortfall will have to be offset by current taxes, cuts in

other spending, or additional borrowing. Put differently, casual observation suggests that the trust fund contributions had little or no effect on deficits or national saving.

Burman and Johnson (2007) suggest that the Medicare Part E trust fund be invested in market securities—a diversified portfolio of publicly traded stocks or bonds, for example. This would “work” in principle because purchases of securities are treated as outlays under federal budget rules.¹⁴ The outlays would exactly offset the revenues from the income tax surcharge (or VAT), providing no tempting imaginary surpluses for policymakers to spend.

The risk is that policymakers could change the budget rules to treat the transfers and income earned on the asset portfolio the same as the trust fund to facilitate more spending or tax cuts (and larger deficits). In that regard, experience with budget rules is not encouraging. Congress seemingly cannot resist the temptation to undermine them, unless there is strong external support for fiscal discipline (Penner and Steuerle 2004).

Expanding Private Long-Term Care Insurance

Burman and Johnson (2007) suggest a variant that might avoid these public choice problems. The new long-term care insurance entitlement could be run entirely through private insurers. This has the political advantage of turning a potentially powerful enemy—insurers, who would be put out of the long-term care business by the Medicare Part E proposal—into supporters of the new program. It might also garner some support from conservatives who favor privatizing social insurance programs. (However, the fact that participation would be mandatory would raise objections from some conservatives.) The federal government would make an annual payment to the insurer of choice, ideally with adjustments for difference in health status and expected utilization. The long-term care insurance industry would have to invent a system of totally portable insurance with protection from health care cost inflation, guaranteed issue and renewability, and a uniform set of minimum benefits. An accurate form of risk assessment would be necessary to deter cherry-picking, by which insurers seek to attract the lowest-risk persons to maximize profits.

With a major expansion of private long-term care insurance, there would be greater concerns about the ability of insurers to pay future claims. There would have to be strict requirements about reserves and permissible investments (no subprime mortgages or unhedged derivatives, for example). A more fundamental problem would be with insurers whose sole or primary line of business was long-term care. Currently, most long-term care insurers also sell life insurance and annuities, which allows for diversification of risks. Indeed, Mark Warshawsky (2007) proposed that

long-term care insurance be bundled with annuities because their risks tend to be negatively correlated (people who enter nursing homes are more likely to die than others of the same age, which terminates the stream of annuity payments early). Similarly, unexpected increased longevity can produce losses on annuities, but savings on life insurance. Requiring that participating long-term care insurers have significant lines of other types of insurance could reduce the overall risk of failure for any insurer. Nonetheless, there might be a need for reinsurance against systemic risks that could raise payouts on long-term care insurance.

Less sweeping changes might also mitigate the anti-saving, anti-private insurance risks in the current system, but incremental reforms would not lead to universal coverage. Brown and Finkelstein (2008) point out that providing a refundable tax credit equal to the expected present discounted value of Medicaid benefits that would be covered by private insurance could completely offset the implicit tax on insurance, in theory. In their model, the credit induces most people to purchase private insurance, but the authors acknowledge that factors such as high administrative loads, myopia, and adverse selection—the tendency of people at highest risk to be most likely to purchase insurance, which raises premiums—might cause coverage to fall far short of the model’s predictions. Moreover, while the refundable tax credit would improve incentives, it would not, by itself, improve public finances since the government would be responsible for a larger share of long-term care expenses (including the cost of the new tax credit) and there is no proposed new stream of revenues to pay for it. However, by requiring the government to prepay a growing share of long-term care expenses, it would shift forward much of the cost of government financed long-term, which could create pressure to cut other spending or increase taxes, improving the long-term deficit picture. Unfortunately, as Brown and Finkelstein point out, the required subsidy, which depends on wealth and expected care utilization, could only be estimated with substantial error, which could make the program very expensive.

A fiscally responsible but politically more difficult variant of Brown and Finkelstein’s tax credit would be a charge for the insurance value of Medicaid long-term care insurance for people who can afford to pay for it. Individuals who purchase qualifying private long-term care insurance would be exempted from the tax. This would be similar to the “pay-or-play” penalty that was a component of the recent health reform legislation. Unlike the credit proposal, this would raise revenues that could reduce federal and state fiscal imbalances. It could eliminate the implicit tax on private long-term care insurance, since those who purchase insurance would be exempted from the penalty. However, those who opt to pay the penalty rather than purchase insurance would still have Medicaid as a fallback option without the asset protection afforded by

private long-term care insurance, and would thus still face a disincentive to save. Unfortunately, this option suffers from the same measurement problems as Brown and Finkelstein's credit. And experience with the insurance mandate in health reform suggests that it could create considerable political opposition and possible constitutional hurdles, depending on how the penalty is structured.¹⁵

Conclusion

This chapter has described the perverse effects on public and private finances of the current system for paying for long-term care through Medicaid. Because of the deteriorating long-term fiscal situation, the current structure of Medicaid might not be sustainable. The aging of the baby boom generation and continually rising health care costs threaten to make current commitments to Medicaid unsustainable.

It is clear that far better policy options exist. Providing universal access to long-term care could be an opportunity to improve individual welfare by eliminating major gaps in current coverage and reducing disincentives to properly save for retirement. Done right, it would also reduce or eliminate one of the major factors in federal and state governments' long-term budget woes—rapidly rising unfunded liabilities to provide long-term care through Medicaid.

In principle, the simplest way to do this would be via a universal public program financed by an income tax surcharge or a VAT. However, the political options facing a large new “government run health program” would seem to be insurmountable. And a new federal VAT would face daunting political hurdles.

A better option might be to repair the fatal flaws in the short-lived CLASS Act: (1) Expand the insurance to cover needed care. (2) Privatize the insurance to win buy-in from the insurance industry. (3) Regulate it to deter cherry-picking and guarantee that the insurance is portable and safe. (4) Provide subsidies big enough so everyone can afford it and dedicate a revenue source to pay for the subsidies. (5) Mandate coverage.

Of course, given the political firestorm that has surrounded health reform and the attacks on CLASS itself, this prescription may be hard to swallow. However, a more rational system of financing long-term care could boost personal saving and mitigate a major source of pressure on federal and state budgets. It could be worth pursuing despite the long odds.

Notes

¹ Medicaid is also heavily biased in favor of nursing home care, which is effectively a tax on home-based healthcare (Gleckman 2009). The issues surrounding the institutional setting for long-term care are beyond the scope of this chapter.

² This is not a normative statement about the right level of spending on long-term care. Indeed, for reasons discussed elsewhere in this volume, the optimal public commitment may be higher than current spending.

³ This is based on the state and local projections by Government Accountability Office (2010) and federal projections of the Congressional Budget Office (2009).

⁴ 21 percent of individuals age 85 and older were in nursing homes compared with 5 percent of those age 75-84 and about 1 percent of 65-74 year olds (Stone 2000).

⁵ Some factors could lower costs over the long run, including declining disability rates and the growth in availability and use of assistive devices and technology. However, reduced availability and willingness of family members to provide care could increase costs.

⁶ Despite state balanced budget requirements, many states have exploited loopholes and accounting tricks to effectively borrow to finance current services, for example by mortgaging tobacco settlement revenues and underfunding employee pensions (McNichol and Lav 2006).

⁷ This model is a variant on Figure 2 in Hubbard et al. (1995).

⁸ The model assumes the individual lives for two periods (working in period 1 and retired in period 2) and has a lifetime income of Y_1 earned from working in period 1. Without the social insurance program, the present value of lifetime consumption equals Y_1 . That is, there are no liquidity constraints and no bequests. Second-period (retirement) consumption equals the amount of first-period income that is not consumed (saving) plus interest.

⁹ This ignores the necessity to eventually raise taxes to pay for the more generous Medicaid benefit. That would tend to reduce after-tax income and both first- and second-period consumption.

¹⁰ The implicit tax is higher for women than for men because women are more likely to need long-term care and need it for longer than men, primarily because of women's longer life expectancy. As a result, a larger percentage of women's than men's long-term care expenses are covered by Medicaid.

¹¹ According to Stevenson, et al. (chapter 9).

¹² Mila Kofman, a health policy analyst at Georgetown University, speculated that "30 years down the road, something better might come along, like some sort of video or robotic monitoring. That's something your policy wouldn't even envision today and may not pay for in the future" (Neighmond 2008).

¹³ Pauly (1990) argues that rational life-cycle utility maximizing individuals might forgo actuarially fair long-term care insurance if people who enter nursing homes rarely recover functional independence and they get no utility from bequests. In that case, preserving wealth upon admission to a nursing home is of little or no value.

¹⁴ President Clinton proposed converting a portion of the Social Security trust fund into a portfolio of assets in 2000, in part to reduce the measured surplus and also to bolster Social Security's finances since securities typically earn higher rates of returns than the

Treasury securities in the trust fund. (Elmendorf et al. 2002) (With the benefit of hindsight, it is clear that this approach would have produced very poor returns if implemented when it was proposed.)

¹⁵ As of this writing, the U.S. Supreme Court is deliberating on the constitutionality of the mandate to purchase coverage in the Patient Protection and Affordable Care Act (PPACA or health reform). The constitutional issues would likely disappear, however, if the penalty were designed as an explicit tax, rather than a fee. (Balkin 2012) Rather than a mandate, other options exist to encourage the purchase of private long-term care insurance. Tumlinson and Lambrew (2007) and Cutler et al. (2007) would each convert the share of Medicare that currently pays for long-term care into a subsidy for private insurance through different mechanisms. Medicare currently pays for about 20 percent of nursing home care. (Komisar and Thompson 2007) These proposals would not address the fundamental shortcomings of Medicaid funding, but would likely induce more people to purchase private insurance.

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