Can the elderly afford long-term care? As to many questions, the answer is, “It depends.”

The high-income elderly can afford to pay for long-term care themselves, and the poorest can rely on Medicaid coverage. But a significant group of lower-middle-income elderly find it difficult to afford such care and painful to spend down to eligibility for Medicaid. Long-term care becomes affordable to more elderly people, however, when the risks are spread across the population through private insurance. Moreover, if coverage is purchased early enough—for example, when people are in their fifties—even those with modest incomes can afford it. Private long-term-care coverage cannot yet be considered a viable option, however. Such insurance is neither readily available nor in great demand. Because current plans limit the services covered, they do not truly protect the elderly from financial catastrophe.

This chapter assesses the ability of today’s elderly and of future cohorts to pay for long-term care. The ability to pay for such care—directly or through insurance—is measured in relation to current and expected future income and wealth. Private long-term-care insurance and alternative sources of support are discussed as optional ways to pay indirectly for such care.

We briefly discuss possible policy options for financing long-term care and the trade-offs among them at the end of the chapter. We suggest that both increased private insurance and expansion of the public-sector safety net might lead to adverse side effects. Stimulating the growth of private insurance—for example, through public tax subsidies—would benefit the rich more than the middle class. Ex-

The authors would like to thank Enrique Lamas and Christine Ross for providing unpublished data. Jack Meyer offered helpful comments on an earlier draft of this paper. We hold our institutions and sponsors harmless with respect to the contents of this paper and its conclusions.
tending Medicaid benefits (or combined Medicare-Medicaid benefits) to the lower-middle-income elderly would discourage many with modest incomes from buying private insurance. These side effects should be weighed against the advantages of public and private strategies for expanding coverage of long-term care. Options for helping the lower-middle-income elderly, particularly the oldest among them, pose the toughest challenges and require careful consideration by future policy makers.

The Income and Wealth of the Elderly

Today’s Elderly. The income and wealth of the elderly have improved greatly over the past two decades. In the mid-1960s nearly 30 percent of older Americans had incomes below the federal poverty line; today only about one of eight is poor. Moreover, the per capita income of the average elderly household has caught up with the average for the nonelderly, and the wealth of the elderly has increased markedly over the past decade, as the chapter by John Weicher documents.

A few words of caution about these generalizations are appropriate, however. First, an examination of the income distribution of the elderly reveals a large group of near poor; indeed, about one of five older Americans has an income below 125 percent of the poverty line. Second, middle-income elderly are highly vulnerable to the potentially huge expenses of long-term care and can be impoverished quickly by expenses that fall outside the coverage of Medicare or private health insurance. Third, in recent years some tax preferences for the elderly have been scaled back. These changes have reduced the resources available for long-term care. Finally, the increases in average incomes mask the slower rise experienced by groups of the elderly—since the average rises with new entrants into the population over sixty-five, who are better off than their elders. With these caveats in mind, however, we can conclude that rising social security benefits and Medicare have substantially improved the economic well-being of older Americans over the past two decades.

Tomorrow’s Elderly: The Good Times Generation. Recent evidence from the 1950 to 1980 censuses and from wealth surveys taken between 1962 and 1984 suggests that the next generation of the elderly—those born between 1925 and 1935, who will reach sixty-five between 1990 and 2000—will be better off than today’s elderly.¹ These people (aged thirty to forty in 1965) have had the good fortune to be in their prime working years during the period of maximum earnings
growth of the halcyon 1960s. The value of their homes soared during the inflationary 1970s, and their financial assets were liquid enough to enable them to take advantage of the high real interest rates and stock market boom of the early to middle 1980s. Indeed, people born in the 1930s have been dubbed the "good times" generation by demographer Carl Harter.

A Federal Reserve Board survey of consumer finances found that the mean net worth of those fifty-five to sixty-four in 1983 was 84 percent above the national mean net worth. Similar surveys for 1962 and 1969 found that the fifty-five- to sixty-four-year-olds in those years (whose survivors are among today's elderly) had net worth holdings ranging from 39 to 56 percent above the average. In 1983 the mean net worth of those forty-five to fifty-four was 41 percent above the national mean. But a similar age group two decades earlier (1960s) had a net worth only 3 to 7 percent above the national average.

This generation is also more likely to have a greater share of persons receiving higher private pensions and, because of their high earnings, larger social security benefits than any preceding generation. These average indicators suggest—even assuming that the stock market boom of the mid-1980s will not continue into the next decade—that tomorrow's elderly will be better off than today's.

Looking beneath the Averages

Despite the rosy overall picture painted by the evidence cited, the heterogeneity among the elderly is still troublesome. About one of five older Americans lives on an income below 125 percent of the poverty line, and the concentration of the near-poor group with incomes between 100 and 125 percent of the poverty line is greater for the elderly than for the nonelderly.

Moreover, these poorer elderly persons have not gained in recent years at the same pace as their higher-income counterparts. Incomes have grown more slowly for the elderly at the bottom of the income distribution than for those at the top. Thus the average growth in incomes of the elderly overstates the gains being made by those who start out with lower incomes.

The elderly with the lowest incomes are also likely to be most at risk for long-term care. The oldest of the old are more likely to be poor, and their incomes are substantially below those of the elderly in their late sixties or early seventies. To some extent this reflects cohort differences that will improve over time. But these more limited resources also result from the large number of the oldest old who live
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alone. In particular, women living alone dominate the group age eighty and older—and it is precisely these elderly persons who are most likely to be institutionalized.

Since our concern is not just with the income of the elderly but also with their ability to afford to insure themselves for health care expenditures (for both acute and long-term care), the group at risk extends beyond the poor and the near poor. In fact, many of the poor can rely on Medicaid in case of major illness, particularly one requiring institutionalization. If they have few or no assets, they should be covered when the need arises. It is the next group up the income ladder, the lower-middle-income elderly, who face the greatest challenge in protecting themselves against the costs of long-term care.

Several researchers have indicated that a large proportion of lower-middle-income elderly persons are and will continue to be a source of concern, especially with regard to medical care and long-term and chronic care needs. In particular, the elderly whose annual incomes are between the poverty line and two and a half times that level (roughly $6,000 to $15,000) are most likely to have little or no health insurance coverage to supplement Medicare. More than 25 percent of elderly Medicare enrollees with incomes below $15,000 in 1984 neither had private supplemental coverage nor were eligible for Medicaid, compared with only 10 percent of those whose incomes exceeded $25,000. Moreover, the proportion of persons without supplemental coverage rises with age and with poor health. Within this group the third with the lowest incomes will probably qualify for Medicaid if a major illness strikes. Once they have reached this point (assuming they live in a state that covers the medically needy), they are unlikely to incur additional out-of-pocket costs for either acute or chronic long-term care. The rest, however, face a substantial risk of high and crippling expenses for acute-care needs alone.

The large number of this group who do not buy supplemental acute-care insurance are also unlikely to be able to purchase long-term-care insurance. For those in the lower-middle-income range who now purchase supplemental coverage, the additional expense of private long-term-care insurance might be prohibitive. If so, the unfortunate choice may come between long-term-care insurance and medigap. Perhaps as many as half the elderly in this income range would lack adequate combined insurance.

Before explicitly considering the affordability of private insurance for long-term care, however, we concentrate on the question of who can afford to pay out of pocket for such care. Private insurance is not yet an option for most older Americans. Even if it becomes more
widely available, those already over sixty-five are unlikely to benefit immediately.

The variation in wealth among the elderly determines their ability to afford long-term care. Table 9–1 presents the joint distribution of income and wealth among the population sixty-five and older in 1984. Of most concern are the two bottom quartiles of the income distribution. The lowest 50 percent of households of all ages, which had incomes below $24,000 in 1984, included a disproportionate share of elderly households. The bottom quartile contained 43.7 percent of all units with a reference person sixty-five or older and 54.4 percent of those with a reference person seventy-five or older. The mean total net worth of the lowest quartile of elderly households was roughly $40,000. If the average nursing home stay for this group is 456 days at a cost of about $50 per day, roughly $23,000 in assets would cover the cost. There are other considerations, such as differences in length of stay and in the number of persons in the household versus the number needing nursing home care. Nevertheless, it appears that on average even elderly people in this low-income group could cover their long-term-care needs directly by expending all their resources.

Once home equity is excluded from net worth, however, mean wealth drops to about $16,000—not enough to cover an average stay for one person. Moreover, such calculations assume that wealth is earmarked only to meet long-term-care needs. For many of the elderly, income from assets is an important source of the funds necessary to maintain a reasonable standard of living before, and sometimes after, a nursing home stay. But even these figures hide the variation within each quartile. Among all elderly households, for instance, median net worth was only about 60 percent of mean net worth in 1984. Those with unusually high resources pull up the average and distort the picture of what a typical elderly household has at its command.

To consider the joint distribution of income and net worth in a way that enables us to focus on the middle-income elderly, we have employed data for 1979 provided by Radner and Vaughn in a 1986 study. Table 9–2 shows the percentage distribution of elderly households in the first two census money-income quintiles (defined for all households) during 1979. These included 72.1 percent of all households with a reference person sixty-five or older and 77.7 percent of those with a reference person seventy-five or older. Higher-income elderly households—those with annual incomes of $12,849 or more, who were in the three top income quintiles—are assumed to be able to “afford” nursing home care. Among those with incomes below
TABLE 9-1
HOUSEHOLD NET WORTH, BY AGE GROUP AND INCOME QUARTILE, 1984

<table>
<thead>
<tr>
<th></th>
<th>Total Population</th>
<th>65+</th>
<th>65–69</th>
<th>70–74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of households</td>
<td>86,783</td>
<td>18,151</td>
<td>5,668</td>
<td>5,014</td>
<td>7,468</td>
</tr>
<tr>
<td>(thousands)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean household income</td>
<td>26,868</td>
<td>17,534</td>
<td>22,426</td>
<td>17,264</td>
<td>14,002</td>
</tr>
<tr>
<td>(dollars)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household income quartile</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Less than $10,800</td>
<td>25.0</td>
<td>43.7</td>
<td>30.0</td>
<td>43.2</td>
<td>54.4</td>
</tr>
<tr>
<td>$10,800–23,999</td>
<td>25.0</td>
<td>36.7</td>
<td>42.8</td>
<td>38.5</td>
<td>30.9</td>
</tr>
<tr>
<td>$24,000–47,999</td>
<td>25.0</td>
<td>15.4</td>
<td>20.9</td>
<td>13.9</td>
<td>12.3</td>
</tr>
<tr>
<td>$48,000 or more</td>
<td>25.0</td>
<td>4.2</td>
<td>6.3</td>
<td>4.4</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Distribution by Income Quartile (percent)
### Mean Net Worth (dollars)

<table>
<thead>
<tr>
<th>Household income quartile</th>
<th>Total</th>
<th>96,406</th>
<th>102,770</th>
<th>123,851</th>
<th>96,823</th>
<th>88,371</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $10,800</td>
<td></td>
<td>27,858</td>
<td>40,731</td>
<td>39,896</td>
<td>30,047</td>
<td>41,978</td>
</tr>
<tr>
<td>$10,800–23,999</td>
<td></td>
<td>50,623</td>
<td>91,996</td>
<td>87,254</td>
<td>91,043</td>
<td>97,777</td>
</tr>
<tr>
<td>$24,000–47,999</td>
<td></td>
<td>77,125</td>
<td>184,562</td>
<td>172,594</td>
<td>187,131</td>
<td>198,010</td>
</tr>
<tr>
<td>$48,000 or more</td>
<td></td>
<td>230,018</td>
<td>553,301</td>
<td>615,486</td>
<td>517,742</td>
<td>470,364</td>
</tr>
</tbody>
</table>

### Mean Net Worth Excluding Home Equity (dollars)

<table>
<thead>
<tr>
<th>Household income quartile</th>
<th>Total</th>
<th>58,498</th>
<th>62,875</th>
<th>79,220</th>
<th>59,412</th>
<th>52,795</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $10,800</td>
<td></td>
<td>11,770</td>
<td>16,489</td>
<td>15,902</td>
<td>15,086</td>
<td>17,483</td>
</tr>
<tr>
<td>$10,800–23,999</td>
<td></td>
<td>25,160</td>
<td>50,198</td>
<td>45,707</td>
<td>48,018</td>
<td>56,743</td>
</tr>
<tr>
<td>$24,000–47,999</td>
<td></td>
<td>40,237</td>
<td>124,012</td>
<td>114,245</td>
<td>120,293</td>
<td>139,381</td>
</tr>
<tr>
<td>$48,000 or more</td>
<td></td>
<td>156,824</td>
<td>441,290</td>
<td>496,374</td>
<td>408,190</td>
<td>369,841</td>
</tr>
</tbody>
</table>

TABLE 9-2
NET WORTH AND FINANCIAL ASSETS AMONG THE ELDERLY, 1979

<table>
<thead>
<tr>
<th>Wealth Range (dollars)</th>
<th>Households with Reference Person 65 or Older (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>65+</td>
</tr>
<tr>
<td>Elderly in bottom two income quintiles</td>
<td>72.1</td>
</tr>
<tr>
<td>Net worth</td>
<td></td>
</tr>
<tr>
<td>Bottom quintile</td>
<td>0–3,143</td>
</tr>
<tr>
<td>Next 2 quintiles</td>
<td>3,144–37,263</td>
</tr>
<tr>
<td>Top 2 quintiles</td>
<td>37,264+</td>
</tr>
<tr>
<td>Financial assets</td>
<td></td>
</tr>
<tr>
<td>Bottom 3 quintiles</td>
<td>0–3,310</td>
</tr>
<tr>
<td>4th quintile</td>
<td>3,311–15,248</td>
</tr>
<tr>
<td>Top quintile</td>
<td>15,249+</td>
</tr>
</tbody>
</table>

NOTE: Percentage of all households with a reference person sixty-five or over with money incomes below $12,849 in 1979.

a. Total net worth minus home equity, vehicles, and household durables.


$12,849, we look at ability to meet nursing home needs from two perspectives on wealth: net worth and financial assets (that is, net worth excluding vehicles, household durables, and home equity).

First, we assume that those with net worth of $3,143 or less—the lowest fifth of all households—would spend down and qualify for Medicaid to meet the average nursing home bill of about $17,000 in 1979.11 Even if annual incomes are $10,000 or more, total resources and incomes are likely to be insufficient to meet nursing home bills. Presumably, this 10.9 percent of all elderly households and 12.9 percent of those with a reference person seventy-five or older would qualify for Medicaid if an average nursing home stay for one or more members arose.

Some of those with incomes below $12,849 can still afford long-term care because they have enough assets. For example, 28.8 percent of all elderly households in this lower-income group (and 25.7 percent with a reference person seventy-five or over) are in the top two asset quintiles. Their net worth totals $37,264 or more, and they are assumed to be able to afford nursing home care while still leaving
some assets at death. Of greater concern is the 32.4 percent of households with a reference person sixty-five or over who have incomes below $12,849 and assets between $3,144 and $37,263. These households are at substantial risk of financial destitution if they have to pay for an average (or longer) nursing home stay for one or more members of the household.

Table 9-2 also shows financial assets only. The largest difference is the net equity in one’s own home. All states will allow a spouse to exempt the home from countable assets under Medicaid if the other spouse needs nursing care. In most states the sale of a home is at the discretion of caseworkers where the money income and liquid assets of a single homeowner are insufficient to meet nursing home bills. The home may need to be sold to meet those bills. In an unknown number of cases, elderly persons with chronic health problems have transferred their homes to relatives to escape “capture” by Medicaid. In any case, excluding home equity provides a somewhat different look at the probability of financial devastation if a long nursing home stay arises.

We assume that the elderly with financial assets of $3,310 or less would qualify for Medicaid coverage of nursing home care if they both needed a long stay in a nursing home and could exclude home equity from their countable assets. In such cases 39.2 percent of the elderly with incomes below $12,849 would qualify for Medicaid. At the other end of the spectrum, 16.7 percent have sufficient liquid assets—$15,249 or more—to pay for the average nursing home stay with these funds alone. But about 16 percent of households with a reference person sixty-five or older and 20 percent of those with a reference person seventy-five or older would lose nearly all their financial assets if one person needed an average nursing home stay.12

Our data do not cover the number of elderly per household, the number needing long-term care, or the complicated state rules that govern treatment of home equity if nursing home care is needed. Nevertheless, we can roughly differentiate among those elderly who are likely to qualify for Medicaid, those who are likely to be able to afford an average long-term-care bill, and those of greatest concern—the lower- to middle-income and “middle-asset” elderly who risk financial devastation if faced with the average long-term-care bill. In this group we find 16 to 32 percent of all elderly households and about 20 to 39 percent of those most at risk of needing such care (the group with a reference person seventy-five or older). The number might also depend on whether the state in which the person lives has a program for the medically needy. In addition, a small proportion of people with higher incomes than considered here may have
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no net worth. Without insurance they too would find it difficult to pay for long-term care.

Because the data in table 9–2 are for 1979, they do not capture the large increases in wealth realized by the elderly during the early 1980s. Moreover, we have not discussed the potential of home equity conversion plans that might allow the elderly to borrow on their homes to pay long-term-care bills. Still, these figures show that a substantial minority of the elderly will probably be unable to rely on the government or on their own finances to pay for nursing home care.

Long-Term Care: Need and Cost

The prospects of future long-term-care expenses impose a sobering mood on any discussion of the increasing well-being of the elderly. Despite improved longevity the need for long-term care is expected to remain fairly constant within age groups. Given the rapidly growing numbers of very old people, the stage is set for a dramatic rise in the demand for care. Further, the chances of finding new and less costly ways of delivering long-term care are slim. Even with the hoped-for innovations in case management and the delivery of services, which promise limited savings per case, meeting the medical and personal care needs of a “frail elderly” population will be costly.

The Need for Long-Term Care. The use of long-term care is highly concentrated among the oldest of the old. For example, although less than 2 percent of all women sixty-five to seventy-four have been institutionalized, one-fourth of those over eighty-five are in nursing homes. These figures are consistent with the incidence of functional limitations among the elderly. By age eighty-five nearly one-third of the elderly need assistance with personal care.13

Although the most dramatic increases in the proportion of the population over sixty-five are still in the future, the increases in the numbers of the oldest old, which reflect longer life spans, are already occurring. Moreover, these increases will become relatively more pronounced in the 1990s when fewer persons will turn sixty-five, reflecting the relatively low birthrate during the depression. Consequently, the average age of the elderly should rise substantially over the period.

Do these changes in the age distribution of the elderly imply growth in demand for care in the future? The answer rests with the likely changes in health status. In projecting the future needs of the elderly, some researchers have examined whether the factors leading
to increased life expectancy also reduce the degree of functional limitation these older citizens face.\textsuperscript{14} Although controversy persists over whether this group continues to be frail, the researchers conclude that the pattern of health status by age is likely to remain relatively unchanged. Consequently, they project a 53 percent increase in institutionalization for men and a 67 percent increase for women by the year 2000. But these figures probably underestimate the total increase in the demand for personal and medical care.

These projections are based on recent trends toward a slowing of the rate of institutionalization. Although several factors have undoubtedly contributed to this decline, one critical issue is whether more frail elderly persons are choosing to remain at home and receive care there. Home health services are a rapidly growing industry; and with continued high rates of support from families and friends, more people are finding it possible to avoid or at least delay entrance into nursing homes. Medicare expenditures for home health care have been growing at an annual rate of about 25 percent since 1977, largely reflecting greater use of services. The elderly can now be treated at home for conditions that once required hospitalization or institutionalization.

In addition, changes in public policy may substantially affect the use of services in the future. A number of states, for example, restrict the supply of nursing home beds to hold down Medicaid costs.\textsuperscript{15} Relaxation of these limitations may result in rapid growth in capacity. The expansion of private insurance coverage or improved public provision of long-term care would exert pressures to allow increases in the supply of beds by increasing demand for services—although the increase would be concentrated in institutional services if coverage were improved only for them. In view of the preference of elderly persons for remaining at home whenever possible, however, insurers will face strong pressures to include home care options in their coverage. Thus we should expect rapid growth in the use of long-term care in the near future, some of which would be reflected in the costs of private insurance to individuals.

**The Cost of Long-Term Care.** Fortunately, the costs of long-term care are now rising more slowly than a few years ago. After increasing at an annual rate of about 16 percent from 1965 to 1980, nursing home costs grew only 11.2 percent annually in the first half of the 1980s. They are expected to rise less than 10 percent annually for the rest of the decade.\textsuperscript{16}

The cost of an individual nursing home stay is more difficult to pin down because stays can vary enormously. Statistics from the 1977
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National Nursing Home Survey provide some clues, however.\textsuperscript{17} For all nursing home discharges (including the 12 percent of patients under sixty-five), the median stay was seventy-five days; about one-fourth of all discharged patients stayed for a year or more. Such figures substantially understate lengths of stay, however, since two of every five patients discharged went to another facility. Most often the transfer was to an acute-care hospital, after which the patient was likely to return to a nursing home.

The majority of patients discharged to their homes stayed less than three months; these short-term patients constitute about one-fifth of all discharges. In addition, 11.4 percent of discharges were patients who died within three months of admission. Thus nearly one-third of all nursing home discharges are short-stay patients (less than three months). Others have calculated the average length of stay for nursing home patients as 456 days.\textsuperscript{18} The average period of institutionalization for the long-stay patients (more than three months) is 2.5 years. Long-stay patients in nursing homes face charges of $50 or more per day, or $20,000 to $30,000 per year. At least one-fourth of all nursing home patients remain a year or longer—and that number would be much greater if lengths of multiple, interrupted stays were known.

The rates of increase in the costs of home health care reflect both the rising costs of care and, more important, the change in the services provided.\textsuperscript{19} Although increases in Medicare reimbursement rates have been limited in recent years to 6 percent or less for each category of care, the intensity of service use has been increasing. Consequently, growth in the average cost per visit is rising faster. Moreover, users of care have been receiving more of each kind of service.

The cost of a Medicare home health visit averaged $38 in 1983, less than the average reimbursement rate of $51 per day for skilled nursing care (which includes the costs of room and board). These home health costs, however, exclude such expenses as homemaker services, which are necessary to allow a functionally impaired person to remain at home. Cost thus becomes an issue in considering whether home health services will come to replace institutional care for some of the elderly. Any projection of future costs will have to take into account the kinds of services used.

Matching Need and Ability to Pay

To understand the degree to which the elderly can assume responsibility for meeting their own long-term-care needs, we need to explore two questions:
What share of the resources of the elderly would have to be devoted to the cost of long-term-care insurance?

What should we expect such persons to pay?

The first of these questions is factual. On the basis of the best projections, what share of income or assets would the elderly be required to spend to insure against potentially catastrophic long-term care needs? The second question raises several more subjective issues. At what age should people begin to purchase such insurance? What are reasonable premiums, given their resources? How likely are they to be willing to pay the share that decision makers judge "reasonable"? Before answering these questions, it is useful to look at current experience with private insurance.20

The Existing Market for Insurance. Much of this discussion must be based on conjecture, since markets for private long-term-care insurance are just developing. Only a few insurers offer such policies, and the policies generally provide conservative coverage. Insurers' experience with loss ratios is limited and offers few lessons for new initiatives.21 Moreover, both the provisions and the premiums vary dramatically among plans, making cost comparisons difficult.

Insurers sometimes limit coverage by requiring a three-day prior hospitalization before coverage begins. This approach limits coverage to institutionalization that has a medical origin and avoids paying for custodial care. But for many of the very old, the need for long-term care is more likely to stem from a gradual deterioration in functional status than from a specific medical need. Private policies thus begin by limiting coverage for one of the major causes of institutionalization.

In addition, many policies explicitly exclude coverage for mental disease and disorders, again severely limiting the value of the policies to the elderly. Alzheimer's disease, which requires continuous care for many years, constitutes the ultimate fear for many. Policies that exclude mental disease, however, would preclude such coverage.

Current private policies often have a waiting period, which can substantially reduce the costs of insurance by eliminating from coverage the numerous patients with short-term needs. Such waiting periods may be desirable as a way of emphasizing catastrophic coverage, but they limit coverage for what may sometimes be expensive nursing care. At the other end of the time spectrum, most private policies also have a maximum length of coverage, usually three years. Thus they also do not provide catastrophic or "stop-loss" coverage.

Finally, most policies restrict acceptance of high-risk patients by asking questions about health, by limiting coverage for preexisting
conditions, and by reserving the right to deny renewal. These factors, together with the high cost of policies for persons first purchasing such insurance after the age of seventy or seventy-five, make it unlikely that private insurance will offer relief to those at risk in the short run. The most promising role for long-term-care insurance is to encourage those who are younger to plan ahead for their long-term-care needs and to consider purchasing private insurance as a supplement to their savings and income.

The Relative Costs of Long-Term-Care Insurance. Mark Meiners estimated that the 1981 costs of a prototype long-term-care insurance policy would have been $435 per year if offered to a sixty-five-year-old as part of a group policy.\(^22\) If offered as an individual policy, the cost would have risen to $543. The expected annual benefits paid under such policies would have been $326—the actuarial value of coverage of $35 per day for a maximum of three years after a ninety-day waiting period.

Although Meiners tried to make generous assumptions about the use of services, he did not make any adjustments for demand induced by the insurance coverage. This latter point becomes particularly troublesome if coverage of home health care is included in private insurance, since such care can readily substitute for informal care. Consequently, in considering the costs of insurance in relation to incomes, we include an "upper-bound" estimate higher than the estimate for an individual insurance policy. Our estimates of the cost of insurance for sixty-five-year-olds thus range from $435 to $660 for 1981.

The cost of long-term-care insurance can be brought down substantially if policies are marketed to younger people. For example, premiums for the insurance recently offered by the American Association of Retired Persons (AARP) are age adjusted. Persons aged fifty to fifty-nine pay just 37 percent as much as those sixty-five to sixty-nine; sixty- to sixty-four-year-olds pay 63 percent as much.

To provide the reader with some idea of the costs of the prototypical Meiners policy for different age groups and family types, we deflated the costs of our prototypical individual policy from $435–610 in 1981 to $385–585 in 1979 using the nursing home price index; we then compared these costs with the 1979 pretax money incomes of three family types—couples, single men, and single women in various age groups (table 9–3). Both sets of estimates presented are based on the typical cost of an individual policy at ages sixty-five to sixty-nine, but the age ratings differ for the typical private policy and the AARP policy.
### Table 9-3

Private Long-Term-Care Insurance Premiums as a Percentage of Average Money Income, by Age Group and Family and Policy Type, 1979

<table>
<thead>
<tr>
<th>Age Range</th>
<th>50–54</th>
<th>55–59</th>
<th>60–64</th>
<th>65–69</th>
<th>70–74</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical private policy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Couple&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.2–1.8</td>
<td>1.9–2.7</td>
<td>2.9–4.6</td>
<td>4.5–6.9</td>
<td>7.8–11.9</td>
</tr>
<tr>
<td>Single man</td>
<td>1.1–1.6</td>
<td>1.7–2.7</td>
<td>2.9–4.4</td>
<td>4.5–6.8</td>
<td>7.3–11.1</td>
</tr>
<tr>
<td>Single woman</td>
<td>1.6–2.4</td>
<td>2.5–3.8</td>
<td>3.9–5.9</td>
<td>5.4–8.3</td>
<td>8.8–13.4</td>
</tr>
<tr>
<td>AARP policy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Couple&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.1–1.6</td>
<td>1.1–1.7</td>
<td>2.2–3.4</td>
<td>4.5–6.9</td>
<td>8.6–14.4</td>
</tr>
<tr>
<td>Single man</td>
<td>1.0–1.5</td>
<td>1.1–1.6</td>
<td>2.1–3.3</td>
<td>4.5–6.8</td>
<td>8.0–12.3</td>
</tr>
<tr>
<td>Single woman</td>
<td>1.5–2.2</td>
<td>1.5–2.3</td>
<td>2.9–4.4</td>
<td>5.4–8.3</td>
<td>9.7–14.7</td>
</tr>
</tbody>
</table>

**Age-specific Policy as a Percentage of 65–69 Policy**

<table>
<thead>
<tr>
<th>Policy Type</th>
<th>50–54</th>
<th>55–59</th>
<th>60–64</th>
<th>65–69</th>
<th>70–74</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical policy</td>
<td>0.40</td>
<td>0.60</td>
<td>0.84</td>
<td>1.00</td>
<td>1.48</td>
</tr>
<tr>
<td>AARP policy</td>
<td>0.37</td>
<td>0.37</td>
<td>0.63</td>
<td>1.00</td>
<td>1.63</td>
</tr>
</tbody>
</table>

**Note:** Both the typical policy and the AARP policy assume that the 1979 cost of the prototypical policy at ages sixty-five to sixty-nine as an individual policy would be $385 to $585.<br><br><sup>a</sup> Couples’ policies are rated at twice the individual policy price.<br><br>**Sources:** 1980 Census of the Population, unpublished data; “typical policy” age ratings derived from Mark Meiners, “The State of the Art in Long-Term Care Insurance,” National Center for Health Services Research, 1984.

For all family types, private long-term-care insurance would have cost less than 2.5 percent of average money income if purchased at ages fifty to fifty-four. All the estimates in table 9–3 are based on mean incomes. Because of the skewed income distribution, medians may be better measures against which to compare costs. If the table were based on medians, which are about 80 percent of mean incomes for this age group, it would show premium costs still well under 3 percent of money income for this age group.<sup>23</sup>

One critical feature of private long-term-care insurance is the assumed constancy of the premium once a person enrolls. Many current policies offer a constant money premium after enrollment. But, of course, the later in life a person enrolls, the higher the premium. Moreover, as people age, their incomes fall. Thus although the typical policy was reasonably priced—at about 6 percent of income or less—until age sixty-four, it would have become expensive at average incomes beyond that age. For instance, the average sixty-five- to sixty-nine-year-old couple or single man would have paid 4.5
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to 6.9 percent of income, and the average single woman would have paid 5.4 to 8.3 percent; the typical policy would have cost 7.8 to 13.4 percent of income for those seventy and older. If coverage is purchased early enough, then, it can be bought at a reasonable price. Waiting until retirement or later, however, makes the price prohibitive for the average elderly household. But early purchase also carries risks. If not indexed for inflation, benefits may be worth little in twenty or thirty years.

What Should the Elderly Be Expected to Pay? A substantial number of the elderly could afford some kind of long-term-care insurance, particularly if they begin to purchase it before age sixty-five, and the proportion able to do so should increase. These assumptions depend, however, on what we consider a “reasonable” contribution. Moreover, the willingness of people to make such expenditures is not clear.

Some studies looking at the feasibility of long-term-care insurance have assumed that the elderly could be expected to devote as much as 10 percent of their incomes to it. We know that many of the elderly already spend more than that for acute medical care, in out-of-pocket expenses and insurance premiums. The average of such liabilities was more than 11 percent for all the elderly in 1986.24 If the costs of private long-term-care insurance averaged 6 to 8 percent of per capita incomes, the elderly would spend on the average up to 19 percent of their total incomes to meet health care needs. Those with fewer resources might spend 25 or 30 percent of their incomes. More probably, many elderly persons would view with skepticism the purchase of expensive insurance against the small possibility of a future catastrophe. Although the costs are lower for younger people, the risks also seem even more remote.

The findings of a six-state survey in 1982 of elderly purchasers of medigap insurance—a group with higher-than-average incomes and a demonstrated appreciation of the value of insurance—suggest that inducing purchase of long-term-care insurance may prove a formidable task.25 First, more than a third of this group (37.9 percent) believed, erroneously, that Medicare and medigap insurance offered them protection against long-term-care needs.26 Nearly half said they could not afford more than $20 a month; and fewer than 20 percent of the respondents could afford $50 a month. Yet in 1982 insurance costs for someone aged sixty-five would have run at least $40 and perhaps $60 a month. Affordability must, therefore, be a prime issue in marketing private long-term-care insurance.

Another important consideration is whether relatively expensive
private insurance policies are a good buy. People with limited assets to protect might reasonably be expected to forgo buying insurance even if their incomes made it affordable. Assume, for example, that a couple will pay $1,000 a year for twenty years for such protection and will have a one-in-four chance of using it. Their assets would have to exceed $60,000 before they could expect to break even from this expenditure. A couple with $40,000 in assets could probably afford the insurance; it simply might not be an economically sound investment. It is this barrier as well as basic affordability that will deter many households with modest incomes from purchasing long-term-care insurance.

Policy Issues

Although this chapter focuses on the question whether future cohorts of the elderly can afford to protect themselves against long-term-care expenses, we have also implicitly raised issues that may require a public response. It may be necessary to foster private insurance in some way. But even after such insurance becomes more widely available, gaps in coverage and participation are likely. It is too soon to offer definitive answers. Rather, we suggest possible approaches and considerations as policy makers are increasingly called on to face the long-term-care problem.

The discussion about the ability of the elderly to finance their own long-term-care needs has roughly identified three groups, each with its own needs:

- elderly people with limited incomes and assets who are likely to rely on Medicaid for their long-term-care needs
- elderly or nearly elderly people who have sufficient resources to purchase private protection for long-term care either out of pocket or through private insurance
- elderly people who are not poor enough to become eligible for Medicaid readily but who cannot afford the costs of long-term-care insurance at retirement without making considerable sacrifices in their standard of living

Although some of tomorrow's elderly who will ultimately find themselves in the third group might be able to pay for long-term-care insurance today, they are not likely to do so under current market conditions. Moreover, this group also includes many people now over seventy, for whom purchase of long-term-care insurance is either not possible or not feasible because of the prohibitive cost.

Although we briefly consider policy options for each of these
groups, one of the most important issues is the extent to which policy trade-offs must be made that benefit one group at the expense of others. That is, if efforts are concentrated on subsidizing private long-term-care insurance for the second group—those already most able to fend for themselves—to what extent will that preclude extending protection to the third group? If Medicaid (or combined Medicaid-Medicare) benefits are extended to some members of the third group, will that discourage them from purchasing private insurance or saving for their potential long-term-care needs?

**Improving Medicaid Coverage.** Although we have not focused on the lowest-income elderly in this chapter, the issue of how far up the income distribution to extend Medicaid’s protection is important. In theory all elderly people faced with enormous medical expenses that would wipe out their resources could receive Medicaid. Medicaid thus offers “last resort” protection. But for those with reasonable amounts of assets, Medicaid is essentially catastrophic protection available only after catastrophe strikes and they have spent down to eligibility levels. In contrast, private insurance would allow the elderly to preserve most of their assets in a financial emergency.

Consequently, one powerful and easily implemented improvement in Medicaid would be to limit how far people must spend down to become eligible for coverage. For example, couples might be allowed to divide their assets before spending down, so that the noninstitutionalized spouse could retain a reasonable amount of wealth. Such a policy would protect people who cannot afford to purchase insurance and might help reduce extralegal efforts to dispose of assets. It would also be a reasonable and limited expansion of government in the long-term-care area, if most of the burden is to be borne by private individuals and insurers. The proposed Medicare “catastrophic care” legislation includes a small-scale version of such a provision. Another area of needed expansion would be to include coverage for home care.

**Encouraging Private Insurance.** The main policy question facing the highest-income and the younger middle-income elderly is how to encourage the development and expansion of private insurance. The degree of public policy support might vary significantly, depending on assumptions about whether the private sector will respond effectively on its own.

First, and least expensive, would be to educate those facing retirement about what Medicare and medigap policies do and do not cover and what the need for and cost of long-term-care services are
likely to be. Presumably the combination of higher resources among the elderly and a greater understanding of the risks of long-term illness should stimulate demand for coverage.

Efforts to encourage the elderly to liquidate their assets— for example, through home equity conversion— might also be stressed, so that they could make more effective use of those assets. Home equity makes up a large proportion of the assets of the middle-income group; it is precisely those elderly persons who may believe they cannot afford premiums for insurance that total 5 percent or more of their incomes. Using a reverse annuity mortgage to prepay some or all of the costs of long-term-care insurance might increase the number of people able and willing to protect themselves. But what form should such efforts take, and to what extent should government become involved in fostering these markets?

Subsidies to employers or directly to workers nearing retirement might be used to encourage the purchase of long-term-care insurance. The traditional means of stimulating such activity is through the tax system. Is it reasonable, however, to subsidize those who can afford such insurance but are reluctant to purchase it? Such subsidies would be valuable to all families and individuals but would offer tax benefits mainly to those who would probably have purchased insurance anyway. Moreover, since those with the highest incomes have the most to protect, this subsidy might, like individual retirement accounts, primarily benefit the well-to-do. Even if tax credits, which offer equal dollar benefits regardless of one’s tax bracket, were used, the benefits might be highly skewed. Only about 40 percent of the elderly have any tax liability; unless the credits were refundable, many people over sixty-five would not benefit from them.

These policy options for fostering reliance on private insurance concentrate on the demand side of the equation. But are insurers willing to offer such coverage? Again, tax inducements to insurers might be used. Alternatively, direct protection might be offered in the form of a government guarantee of benefits beyond a certain level of coverage. For example, if insurers offered a particular package of benefits, the government might pick up the costs for further care after a beneficiary had used more than a certain number of days of care. Capping the insurers’ liability might encourage more inclusive benefits, covering, for example, mental disease and disorders, at a reasonable cost. But these tax advantages would still help mainly those motivated to buy insurance because they have assets they wish to protect.

The critical point in evaluating public expenditures directed mainly at high- and middle-income beneficiaries is whether they are
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likely to hold down other public costs. For example, one researcher has argued that private insurance coverage might reduce reliance on Medicaid by people who now spend down their assets, then rely on Medicaid to cover at least part of their health care costs. But the federal and state savings achieved might or might not be as great as the costs of some of the policy options to stimulate coverage. Moreover, they might do the most good for those least in need—those most able to cover long-term-care expenses on their own.

Helping Those Caught in the Middle. A large number of the lower-middle-income elderly are likely to fall through the cracks in a combined private insurance-Medicaid approach to financing long-term care. Moreover, since private coverage is not a feasible option for most people now over seventy, many of the older elderly will remain relatively unprotected for some time. Some of the policy options discussed could shrink the group adversely affected, by expanding Medicaid or making private coverage more affordable. Nonetheless, gaps will remain.

A more efficient, piecemeal option would be to offer a public program aimed at the group now caught in the middle. The primary advantage of such an approach would rest in minimizing government costs and involvement. But it also raises the problem of coordination with Medicaid and private insurance. A targeted public-sector program—perhaps sponsored by state governments—might allow people to buy insurance that exempted a certain amount of assets from Medicaid spend-down rules and offered improved protection against impoverishment of the husband or wife left in the community. The spend-down requirement might be eased considerably for persons who buy the insurance—perhaps to $25,000 or $30,000 plus the home.

Such a program might also establish income-related premiums. This kind of program would obviously be aimed at the modest-income family. Those with substantial assets would find it advantageous to seek other means of protecting them, for example, by purchasing private insurance. This strategy implicitly assumes that higher-income families would not need tax advantages or other stimuli to encourage them to purchase private coverage.

A second possibility would be an income-related premium under Medicare—probably administered through the income tax system. The elderly who did not have private long-term-care insurance would be covered by Medicare or a separate long-term-care program, effective above some deductible. Medicaid's main role under such a system might be to pay the deductible for lower-income persons. Medicare beneficiaries would pay a premium of some fixed propor-
tion of their incomes. At the same time the payroll tax might be raised slightly to help keep the program affordable and maintain the insurance principle of spreading costs over a longer period. Nonetheless, the bulk of the financing burden would fall on persons sixty-five and over. Purchasers of private insurance might be allowed to waive this long-term-care eligibility and claim a tax credit up to some percentage of the Medicare surcharge. Such provisions could help maintain a private insurance effort.

Finally, another option might be to deemphasize the emerging private long-term-care insurance market and, instead, to provide some well-controlled amount of long-term-care services in return for a new, income-related insurance premium aimed at everyone. The premium might be phased in gradually on an age-adjusted basis—perhaps beginning at forty, for example. This would keep costs low for all citizens. Furthermore, because the premium would be tied to the income tax structure, it would be less burdensome for people with modest incomes. To control costs and use, the premium might be combined with a relatively large annual deductible, perhaps with a lifetime limit.

Current lack of political support for such expanded government coverage may preclude this option, and other problems would arise even if it were pursued. One of the more difficult issues would be to establish when the new coverage would begin. If today’s elderly were “grandfathered” into the system, the initial costs would be high. Moreover, such a policy might add fuel to the current debate over intergenerational equity and the extent to which the elderly of this generation are beneficiaries of windfall gains that will not be available in the future. Moreover, it might be tempting to use the Old Age, Survivors, Disability, and Health Insurance (OASDHI) trust fund reserves to fund long-term care for the current generation. If so, instead of asking today’s elderly—and tomorrow’s good times generation—to help pay for their own long-term care, we would be benefiting them at the expense of the retirement funds of their children.

One possible approach to mitigating the start-up costs while offering relief to those in need would be to establish a higher initial deductible that could be reduced over time. In this way individuals would implicitly receive credit for the years they contributed to the insurance plan. Medicaid’s role might largely become one of paying the deductible for this broader long-term-care insurance.

Conclusions

We began this chapter by asking whether the elderly can afford long-term care. The implicit answer to that question is that they already
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do. With Medicaid as a last resort, individuals and their families now directly bear the costs of such care. These costs are devastating for a few and raise the fear of such devastation for many more. The more interesting and challenging question is whether there are better ways to provide for the costs of long-term care.

We conclude that, for some of the elderly, Medicaid's role is critical and should be expanded to provide a better floor of protection. For perhaps as many as half of Americans aged fifty to seventy, however, private insurance could play an important role. Yet the potential of private insurance is just starting to be realized, and many who could afford it are not likely to be willing to purchase it. Some public support may be needed to stimulate the market for such insurance and to increase public awareness of both the costs and the benefits.

Most troublesome are the elderly with lower (but above poverty-level) incomes or of advanced age who are unlikely to be well served by private insurance. Currently their major option is to experience catastrophic losses and then rely on Medicaid. But the resultant losses may be devastating to the pride and independence of people who survive the episode of long-term care or to their spouses, who may be left behind with severely limited resources. Moreover, from a government cost perspective, this situation may prove penny-wise and pound-foolish. If a limited extension of government protection could prevent this group's dependence on Medicaid and on other means-tested government programs such as Supplemental Security Income for the surviving spouse, the results might be less costly in the long run for all concerned. Alternatively, the problems of patching together three long-term-care "systems" may necessitate a much expanded role for the federal government—at least in providing the means of coordinating and financing a coherent long-term policy.

Notes


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7. The “reference person” is the same as the householder or the person considered the head of the household. In this chapter an elderly unit, elderly family, or elderly household is considered to be a unit (family, household) with a reference person (household head) age sixty-five or older.


10. Of the 27.9 percent of elderly units with incomes above $12,848, less than 4 percent had net worths below $20,120 in 1979. While these persons may be in some danger of losing their savings if they should need nursing home care, it is unlikely—that given their incomes and assets—that they would lose all their assets (and spend down to Medicaid eligibility levels) unless, for instance, both spouses required nursing home stays for above-average lengths of time.

11. A bill of $17,000 in 1979 would be comparable to the $23,000 figure mentioned earlier.

12. The Medicare Catastrophic Act of 1988 (P.L. 100-360) now offers protection against impoverishment to the at-home spouses of nursing home residents. States must permit these spouses to keep at least $786 a month in income (up to a maximum of $1,500) and $12,000 in assets (up to a maximum of $60,000) without losing Medicaid benefits for their institutionalized spouse.


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19. Medicare has historically been the largest payer for *medical* home health services. Cost estimates for custodial services are much more difficult to obtain.

20. For a more thorough analysis of private long-term-care insurance, see the chapter by Lewin and Wallack in this volume. Our discussion of long-term-care insurance is primarily aimed at reaching a reasonable estimate of costs that can be compared with ability to pay.


26. A survey for the AARP found that nearly 80 percent of the elderly thought they were already covered for long-term care.

27. An education campaign to indicate what *private* long-term-care insurance does and does not cover may also be in order.

28. Meiners, "The Case for Long Term Care Insurance."