APPENDIX B. HEALTH STATUS AND EXPENDITURES OF THE ELDERLY, AND BACKGROUND DATA ON LONG-TERM CARE

CONTENTS

Although the health status of the elderly has improved in recent decades, many elderly persons have conditions that require medical and long-term health care. In 1995, total spending on long-term care for the elderly was around $91 billion (Price, 1997). Most persons 65 years or older have some form of health insurance. About 97 percent are covered by Medicare or Medicaid, and most have supplementary coverage. This appendix reports on the health status health care expenditures and long-term care insurance of the elderly (see section 3 for a discussion of health insurance supplementing Medicare coverage).

HEALTH STATUS

By various measures, the health status of the elderly population has been gradually improving over the years. For example, life expectancy at age 65 has increased from 13.9 years in 1950 to 17.5 years in 1996 (see table B–1). Although life expectancy for the general population declined by 0.3 years in 1993, the first decrease since 1980, the overall trend this century has been an upward one. Improvements in life expectancy, as measured by declines in mortality rates, have been greater for females than for males. Some morbidity indicators, such as the incidence of high blood pressure, improved among those aged 65–74 years in the 1970s, 1980s and early 1990s (see table B–2). However, the proportion of overweight seniors seems to be increasing.

TABLE B–1.—LIFE EXPECTANCY AT BIRTH AND AT 65 YEARS OF AGE BY SEX AND RACE, SELECTED YEARS 1950–96

[Remaining life expectancy in years]

Year	At birth			At 65 years			At birth	
	Both sexes	Male	Female	Both sexes	Male	Female	White	Black
1950 [1]	68.2	65.6	71.1	13.9	12.8	15.0	69.1	60.7
1960 [1]	69.7	66.6	73.1	14.3	12.8	15.8	70.6	63.2
1970	70.8	67.1	74.8	15.2	13.1	17.0	71.7	64.1
1980	73.7	70.0	77.4	16.4	14.1	18.3	74.4	68.1
1988	74.9	71.4	78.3	16.9	14.7	18.6	75.6	69.2
1989	75.1	71.7	78.5	17.1	15.0	18.8	75.9	69.2
1990	75.4	71.8	78.8	17.2	15.1	18.9	76.1	69.1
1991	75.5	72.0	78.9	17.4	15.3	19.1	76.3	69.3
1992	75.8	72.3	79.1	17.5	15.4	19.2	76.5	69.6
1993	75.5	72.2	78.8	17.3	15.3	18.9	76.3	69.2
1994	75.7	72.4	79.0	17.4	15.5	19.0	76.5	69.5
1995	75.8	72.5	78.9	17.4	15.6	18.9	76.5	69.6
1996	75.9	72.7	79.0	17.5	15.7	19.0	76.6	69.9

[1] Includes deaths of nonresidents of the United States in the 1950 and 1960 data.

Source: For the years 1950–95, National Center for Health Statistics (1997a, p. 108); for 1996, National Center for Health Statistics (1997b).

TABLE B–2.—SELECTED HEALTH STATUS INDICATORS FOR PERSONS 65–74 YEARS OF AGE BY SEX, SELECTED PERIODS 1971–94

[Percent of population]

Health status indicator	Male			Female		
	1971–74	1976–80	1988–94	1971–74	1976–80	1988–94
Hypertension [1 2]	67.2	67.1	57.3	78.3	71.8	60.8
High-risk serum cholesterol levels (Mean serum cholesterol level, [3] in mg/dL)	34.7 (226)	31.7 (221)	21.9 (212)	57.7 (250)	51.6 (246)	41.3 (233)
Overweight [4]	23.0	25.2	42.9	38.0	38.4	42.3

[1] Excludes pregnant women.

[2] Hypertension or elevated blood pressure is defined as either systolic pressure of at least 140 mmHg or diastolic pressure of at least 90 mmHg or both. If the respondent is taking antihypertensive medication, he or she is considered hypertensive.

[3] High-risk serum cholesterol levels are defined as greater or equal to 240 mg/dL (6.20 mmol/L), risk level as defined by the National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Treatment of High Cholesterol in Adults, November 1987.

[4] Overweight is defined for men as body mass index greater than or equal to 27.8 kilograms/meter^2, and for women as body mass index greater than or equal to 27.3 milograms/meter^2. These cut points were used because they represent the sex-specific 85th percentiles for persons 20–29 years of age in the 1976–80 National Health and Nutrition Examination Survey.

Note.—Data are based on physical examinations of a sample of the civilian, noninstitutionalized population.

Source: National Center for Health Statistics (1997a, pp. 190–92).

Despite the trend toward improved health status among the elderly, their needs for medical and long-term care services are substantial and growing. Many of the elderly have one or more chronic conditions, many of which give rise to the need for continuing health care. Table B–3 shows the incidence of several common chronic conditions among the elderly. Half report having arthritis, about 36 percent report high blood pressure, and over 30 percent report heart disease. The incidence of many chronic conditions is directly related to age and inversely related to family income.

TABLE B–3.—SELECTED CHRONIC CONDITIONS PER 1,000 ELDERLY PERSONS BY AGE AND FAMILY INCOME, 1994

Chronic condition	All elderly	Age		Family income			
		65–74	75 and over	Less than $10,000	$10,000–$19,999	$20,000–$34,999	$35,000 and over
Arthritis	502	477	537	651	549	509	416
Cataracts	166	113	242	243	200	166	135
Hearing impairment	286	235	360	287	337	319	274
Deformity or orthopedic impairment	166	154	182	208	202	165	147
Hernia of abdominal cavity	64	63	66	52	64	90	58
Diabetes	101	102	101	134	112	88	80
Heart disease	325	281	387	477	307	349	309
High blood pressure [1]	364	347	388	525	352	372	326
Emphysema	46	47	43	49	51	44	41

[1] As self-reported in the 1994 National Health Interview Survey; the higher 1988–91 hypertension data in table B–2 are from physical examination of a sample population. Overall self-reported hypertension fell between 1991 and 1994.

Source: National Center for Health Statistics (1995a, pp. 81–2; 87–90).

Self-assessed health is a common method used to measure health status, with responses ranging from excellent to poor. Nearly 72 percent of elderly people living in the community describe their health as excellent, very good, or good, compared with others their age; only 28 percent report that their health is fair or poor (see table B–4).

Family income is directly related to the elderly people's perception of their health. Income level is also strongly correlated with morbidity and mortality, lending credibility to the use of this measure as an assessment tool (Angell, 1993). In 1994, about 49 percent of older people with incomes over $35,000 described their health as excellent or very good, compared to others their age, while only 29 percent of those with low incomes (less than $10,000) reported excellent or very good health.

Surveys on long-term care indicate that rates of chronic disability among the elderly have declined significantly (Manton, 1997). Some demographers, in looking at the reductions in the projected percentage of those 65 and above who are disabled, are predicting that older people will not only have increasing longevity, but a later life with less dependency (Kolata, 1996). It should be noted that living

longer seems to be the demographic trend, and it is not known what the tradeoffs may be in cost of care and quality of life.

TABLE B–4.—SELF-ASSESSED HEALTH STATUS OF THE ELDERLY BY FAMILY INCOME, 1994

[In percent]

Characteristic	All persons [1] (thousands)	Self-assessed health status [2]				
		Excellent	Very good	Good	Fair	Poor
Gender:						
Men	12,932	16.7	22.6	32.2	18.3	10.2
Women	18,094	14.9	23.3	34.2	18.4	9.1
Family income:						
Under $10,000	4,067	10.7	17.8	30.8	23.9	16.8
$10,000–$19,999	7,226	13.6	21.6	34.4	19.6	10.8
$20,000–$34,999	6,741	16.4	25.5	34.7	16.8	6.6
$35,000 and over	5,148	22.5	26.9	32.7	12.8	5.1
All persons 65+ years [3]	31,026	15.7	23.0	33.4	18.4	9.6

[1] Includes unknown health status.

[2] The categories related to this concept result from asking the respondent, "Would you say your health is excellent, very good, good, fair, or poor?" As such, it is based on the respondent's opinion and not directly on any clinical evidence.

[3] Includes unknown family income.

Note.—Percentages may not add to 100 percent due to rounding. Data are based on household interviews of the civilian, noninstitutionalized population.

Source: National Center for Health Statistics (1995a, Table 70).

CAUSES OF DEATH FOR THE ELDERLY

Table B–5 shows the 10 leading causes of death for three subgroups of the older population. In the United States, two-thirds of elderly persons die from heart disease, cancer, or stroke (National Center for Health Statistics, 1997c). Heart disease was the major cause of death among the elderly in 1960, and remains so today despite rapid declines in age-adjusted death rates from heart disease that are due to improvements in treatments as well as lifestyle changes. Cancer death rates among the elderly, however, have risen during the same period, due especially to increases in lung cancer deaths (National Center for Health Statistics, 1997a). In 1995, heart disease still accounted for 36 percent of all deaths among persons 65 and older, while cancer accounted for 22 percent of all deaths in this age group. The third leading cause of death among the elderly—stroke (cerebrovascular disease)—has been decreasing over the past 30 years. In 1995, cerebrovascular disease accounted for only 8 percent of all deaths in the 65 and older age group (NCHS, 1997c).

TABLE B–5.—DEATH RATES FOR 10 LEADING CAUSES OF DEATH AMONG OLDER PEOPLE BY AGE, 1995

[Death rates per 100,000 population in age group]

Rank	Cause of death	Age			
		65+	65–74	75–84	85+
1	Diseases of the heart	1,835	800	2,065	6,484
2	Malignant neoplasms	1,137	868	1,365	1,824
3	Cerebrovascular diseases	414	137	481	1,637
4	Chronic obstructive pulmonary diseases	264	161	352	528
5	Pneumonia and influenza	222	57	233	1,036
6	Diabetes	133	87	163	278
7	Accidents	87	45	98	268
8	Alzheimer's disease	60	11	73	275
9	Nephritis, nephrotic syndrome, nephrosis	60	25	73	207
10	Septicemia	50	21	60	173
	All other causes	791	352	889	2,760
	All causes	5,053	2,564	5,852	15,470

Source: National Center for Health Statistics (1997c, tables 7 and 9).

Alzheimer's disease (AD) is now the eighth leading cause of death for older people. Alzheimer's has only been classified as a unique cause of death since 1979, so reported death rates have been increasing rapidly since that year, and probably do not yet reflect the actual numbers of deaths attributable to the disease. Alzheimer's affects approximately 4 million Americans at present, including about 12 percent of the population over 65 and nearly half of those age 85 and older (Hodes, 1997). Death rates from AD are also highly age related (NCHS, 1997c). Presence of Alzheimer's may be masked by inability to confirm the diagnosis except by autopsy of brain tissue, although new diagnostic tools are being developed. In the future, reporting of Alzheimer's disease as the cause of death is likely to increase, and more accurately reflect its true prevalence and impact.

MEDICARE REIMBURSEMENT AND OUT-OF-POCKET LIABILITIES OF THE ELDERLY

Tables B–6 through B–8 illustrate for 5 selected years how Medicare reimbursement, acute health care costs, and out-of-pocket liabilities of Medicare enrollees have changed. The years chosen are 1975, 1980, 1985, 1990 and 1995. Constant 1995 dollar values were obtained using the CPI–U.

The fastest growing component of Medicare reimbursement is for benefits under the Supplementary Medical Insurance (SMI) Program. For SMI, reimbursements have increased at an average annual rate of 12.1 percent, while the growth in total costs (including enrollees' share of costs) is 10.5 percent (see table B–6). As a result, the share of SMI costs reimbursed by Medicare increases significantly over the period—from about 64 percent in 1975 to about 76

percent by 1995. The growth in Medicare's share is caused by the declining significance of the SMI deductible, so that more enrollees' costs are eligible for reimbursement.

TABLE B–6.—REIMBURSEMENTS AND OUT-OF-POCKET COSTS UNDER MEDICARE, SELECTED YEARS 1975–95

[Incurred costs per HI or SMI enrollee]

Source	Year					Average annual rate of growth 1975–95 (percent)
	1975	1980	1985	1990	1995	
	In current dollars					
Hospital insurance:						
Reimbursement	$466	$920	$1,570	$1,981	$3,201	10.1
Copayments	34	67	119	187	244	10.4
Total	500	986	1,690	2,168	3,445	10.1
Supplementary medical insurance:						
Reimbursement	186	399	766	1,307	1,819	12.1
Copayments	84	137	248	400	547	9.8
Balance billing	22	56	87	68	13	−2.6
Total	291	592	1,101	1,775	2,379	11.1
Total Medicare reimbursement	651	1,318	2,336	3,288	5,020	10.8
Total costs under Medicare	792	1,579	2,791	3,944	5,824	10.5
	In constant 1995 dollars					
Hospital insurance:						
Reimbursement	1,263	1,703	2,225	2,310	3,201	4.8
Copayments	93	124	169	218	244	4.9
Total	1,356	1,827	2,394	2,529	3,445	4.8
Supplementary medical insurance:						
Reimbursement	503	738	1,085	1,524	1,819	6.6
Copayments	227	254	352	467	547	4.5
Balance billing	60	104	124	80	13	−7.4
Total	790	1,097	1,560	2,071	2,379	5.7

TABLE B–6.—REIMBURSEMENTS AND OUT-OF-POCKET COSTS UNDER MEDICARE, SELECTED YEARS 1975–95—Continued

[Incurred costs per HI or SMI enrollee]

Source	Year					Average annual rate of growth 1975–95 (percent)
	1975	1980	1985	1990	1995	
Total Medicare reimbursement ..	1,766	2,441	3,310	3,834	5,020	5.4
Total costs under Medicare	2,147	2,924	3,955	4,599	5,824	5.1
Percent of costs paid by Medicare	82.3	83.5	83.7	83.4	86.2	0.2

Note.—The CPI–U was used to get constant dollars.

Source: Congressional Budget Office.

TABLE B–7.—ENROLLEE COSTS UNDER MEDICARE, SELECTED YEARS 1975–95

[Incurred costs per HI or SMI enrollee]

Source	Year					Average annual rate of growth 1975–95 (percent)
	1975	1980	1985	1990	1995	
	In current dollars					
Hospital insurance copayments	$34	$67	$119	$187	$244	10.4
Supplementary medical insurance copayments	84	137	248	400	547	9.8
Balance billing	22	56	87	68	13	−2.6
Total direct costs	140	260	455	656	804	9.1
Premium costs	80	110	186	343	553	10.1
Total enrollee costs	221	371	641	999	1,357	9.5
Enrollee per capita income [1]	5,158	8,431	12,767	15,454	16,460	6.0

TABLE B–7.—ENROLLEE COSTS UNDER MEDICARE, SELECTED YEARS 1975–95—Continued

[Incurred costs per HI or SMI enrollee]

Source	Year					Average annual rate of growth 1975–95 (percent)
	1975	1980	1985	1990	1995	
	In constant 1995 dollars					
Hospital insurance copayments	93	124	169	218	244	4.9
Supplementary medical insurance copayments	227	254	352	467	547	4.5
Balance billing	60	104	124	80	13	−7.4
Total direct costs	381	482	644	765	804	3.8
Premium costs	218	204	264	400	553	4.8
Total enrollee costs	599	687	908	1,165	1,357	4.2
Enrollee per capita income [1]	13,983	15,613	18,094	18,024	16,460	0.8
	Percent of costs under Medicare paid by enrollees, by source of payment					
Hospital insurance copayments	4.4	4.2	4.3	4.7	4.2	−0.2
Supplementary medical insurance copayments	10.6	8.7	8.9	10.1	9.4	−0.6
Balance billing	2.8	3.6	3.1	1.7	0.2	−12.4
Total direct costs	17.7	16.5	16.3	16.6	13.8	−1.2
Premium costs	10.2	7.0	6.7	8.7	9.5	−0.4
Total enrollee costs	27.9	23.5	23.0	25.3	23.3	−0.9
Enrollee-paid costs as a percent of enrollee per capita income [1]	4.3	4.4	5.0	6.5	8.2	3.3

[1] From the Current Population Survey, with income adjusted for underreporting.

Note.—The CPI–U was used to calculate constant dollars. HI = hospital insurance, SMI = supplementary medical insurance.

Source: Congressional Budget Office.

TABLE B–8.—COPAYMENT AND PREMIUM VALUES UNDER MEDICARE, SELECTED CALENDAR YEARS, 1975–95

	Year					Average annual rate of growth 1975–95 (percent)
	1975	1980	1985	1990	1995	
	In current dollars					
Hospital insurance:						
Hospital deductible	$92	$180	$400	$592	$716	10.8
Supplementary medical insurance:						
Annual deductible	60	60	75	75	100	2.6
Monthly premium [1]	6.70	9.20	15.50	28.60	46.10	10.1
	In constant 1995 dollars					
Hospital insurance:						
Hospital deductible	249	333	567	690	716	5.4
Supplementary medical insurance:						
Annual deductible	163	111	106	87	100	−2.4
Monthly premium [1]	18.16	17.04	21.97	33.36	46.10	4.8

[1] The 1980 supplementary medical insurance monthly premium amount is the average of values for the first and second halves of the year.

Note.—The CPI–U was used to calculate constant dollars.

Source: Congressional Budget Office.

In the Hospital Insurance (HI) Program, by contrast, the rate of growth in reimbursement is roughly comparable to the growth in enrollee's copayment costs. Consequently, the share of HI costs reimbursed by Medicare was 93 percent in both 1975 and 1995.

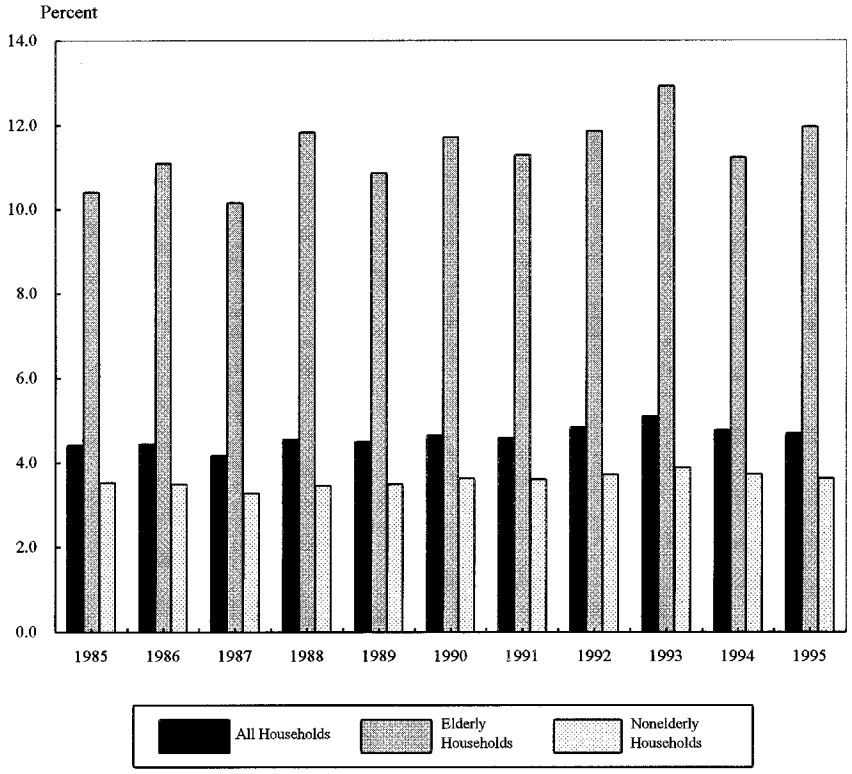
Overall, the share of costs reimbursed by Medicare has increased slightly. The percentage of costs paid by Medicare for services covered under Medicare was 82.3 percent in 1975 and 86.2 percent in 1995 (see table B–6). The share of costs paid directly by enrollees is shown in the third panel of table B–7. Total direct costs plus Medicare reimbursement equals the total or 100 percent.

In constant dollars, HI copayments increased the most rapidly between 1975 and 1990. However, between 1990 and 1995, SMI copayments and premium costs rose the most rapidly. In contrast, the cost to the enrollee from balance billing has decreased significantly since 1985—a direct policy result of the participating physician program and the imposition of lower limits on balance billing (see table B–8 for deductible amounts and monthly premium amounts under Medicare).

Enrollees are spending an increasing share of their income for Medicare's cost sharing and premium charges. In 1975, about 4.3 percent of enrollees' per capita income went to cover their share of acute health care costs under Medicare. By 1995, this figure had risen to 8.2 percent.

Although total direct household spending for all health care by elderly households as a share of household income has increased since the early 1970s, it has remained relatively stable in recent years. Chart B–1 illustrates direct household spending for health care as a percentage of household income before taxes for elderly

CHART B–1. DIRECT HOUSEHOLD SPENDING FOR HEALTH CARE AS A PERCENTAGE OF HOUSEHOLD INCOME, BY TYPE OF HOUSEHOLD, 1985–95



Notes.—Direct household spending for health care includes the amount directly paid for health insurance premiums by a household, as well as other out-of-pocket spending for health care services, including deductibles and copayments.

Elderly households are those in which the primary owner or renter of the household is 65 or older. Such households may include individuals younger than 65. Nonelderly households are those in which the primary owner or renter of the household is younger than 65. Such households may include individuals age 65 or older.

Although expenditures for health care by the institutional population are not collected by the CES, if a member residing in the household contributes to health-related expenses of an institutionalized person, then those expenditures are counted as direct household spending for health care.

Household income refers to income before taxes.

Source: Congressional Budget Office calculations based on data from the Consumer Expenditure surveys (CES) of the Bureau of Labor Statistics, 1985–95.

and nonelderly households for years 1985–95. In 1995, direct household spending for health care as a percentage of household income for elderly households was 12.0 percent, on average, up from 10.4 percent in 1985. Over the same period, nonelderly households spent around 3.6 percent of their household income for health care.

CHANGES IN REAL SPENDING PER MEDICARE ENROLLEE, 1967–95

Real Medicare spending per enrollee removes the effects of changes in Medicare enrollment and general inflation from total Medicare spending (see table B–9). Since both enrollment and prices are almost always increasing, the growth of real per enrollee spending is slower than the growth of total spending. Overall, real spending per enrollee grew at an average annual rate of 7.0 percent over the 1980–85 period; the rate declined to 4.8 percent per enrollee over the 1990–95 period. Similarly, real inpatient hospital spending per enrollee grew at an annual rate of 6.4 percent between 1980 and 1985; the rate declined to 2.5 percent over the 1990–95 period. The difference in these rates is attributable to changes in admissions per enrollee and real expenditures per admission. The reduction in real expenditures per admission reflects the impact of the implementation of the hospital prospective payment system.

Costs in hospital outpatient departments have dropped relative to the previous trend, indicating that hospital inpatient costs have not simply been shifted to the outpatient sector. Introduction of a new payment methodology (a blend of a fixed rate and the hospital's costs) for certain surgical procedures performed in outpatient departments tended to reduce costs somewhat, but this effect was partially offset by the shift of services from the inpatient sector.

At least some portion of growth in the volume of covered home health visits may represent a delayed response to an increasing need for skilled home care resulting from incentives contained within Medicare's hospital prospective payment system to discharge patients more quickly to their homes. During early years of hospital prospective payment, HCFA had in place medical review and claims processing policies that had resulted in high denial rates for provided care. These policies were relaxed by 1989. In addition, the 1989 revised coverage policy guidelines are believed to account for a large portion of the increase in volume because they liberalized coverage policies.

Growth in spending for physicians' services reflects the fact that Medicare began paying for physicians services on the basis of a fee schedule beginning in 1992. Payments for laboratory services have been constrained by the implementation of tighter controls under the laboratory fee schedule.

TABLE B–9.—REAL SPENDING PER MEDICARE ENROLLEE, FISCAL YEARS 1967–95

[In constant 1995 dollars]

Fiscal years	Medicare	Hospital insurance	Supplementary medical insurance	Hospital inpatient	Skilled nursing facility	Home care & hospice	Outpatient departments	Physician & lab
	Estimates by the Health Care Financing Administration							
1967	$762	$553	$157	$528	$21	$5	$3	$153
1968	1,146	787	311	705	72	12	10	298
1969	1,339	932	345	849	73	14	16	325
1970	1,359	904	385	837	56	16	19	360
1971	1,405	963	371	917	38	14	25	340
1972	1,494	1,026	389	989	29	14	31	353
1973	1,463	1,013	381	977	27	14	30	346
1974	1,520	1,033	396	994	28	20	43	344
1975	1,740	1,212	450	1,164	32	25	63	378
1976	1,901	1,304	507	1,248	33	35	79	415
1977	2,066	1,421	570	1,360	33	41	94	462
1978	2,208	1,517	608	1,455	31	46	106	486
1979	2,284	1,550	655	1,487	29	49	116	524
1980	2.412	1,631	706	1,568	27	52	126	565
1981	2.607	1,766	765	1,702	24	55	137	613
1982	2,840	1,926	841	1,839	25	66	163	675
1983	3,018	2,012	935	1,906	28	78	179	755
1984	3,123	2,064	982	1,951	27	87	178	802
1985	3,384	2,260	1,042	2,142	26	94	187	853
1986	3,441	2,212	1,151	2,095	26	92	226	923
1987	3,532	2,151	1,305	2,042	27	84	253	1,051
1988	3,570	2,103	1,387	1,989	29	87	266	1,119

1989	3,684	2,171	1,427	1,994	85	93	283	1,141
1990	3,912	2,324	1,506	2,097	99	130	303	1,199
1991	3,882	2,257	1,544	1,999	82	179	313	1,228
1992	4,187	2,526	1,570	2,164	116	248	346	1,221
1993	4,392	2,699	1,610	2,238	156	309	370	1,237
1994	4,684	2,888	1,710	2,303	201	388	402	1,304
1995	4,951	3,077	1,720	2,375	248	459	425	1,361
	Average annual growth rates (in percent)							
1975–1980	6.8	6.1	9.4	6.1	−3.4	16.3	14.7	8.4
1980–1985	7.0	6.7	8.1	6.4	−0.7	12.5	8.3	8.6
1985–1990	2.9	0.6	7.6	−0.4	30.8	6.8	10.2	7.1
1990–1995	4.8	5.8	3.5	2.5	20.0	28.6	7.0	2.6

Note.—Column 1 includes both benefit and administrative costs. All other columns include only benefits. The CPI–U was used to calculate constant dollars.

Source: Congressional Budget Office.

Spending for skilled nursing facilities (SNFs) increased significantly. During the period from 1975 through 1985, real spending per enrollee for SNFs was falling. This trend was reversed during the late 1980s. In 1988, growth in SNF spending accelerated sharply because of a revision in the manual used by administrative agents to determine Medicare coverage that greatly relaxed the definition of covered care to make it conform with legislative language. Growth in SNF spending further accelerated in 1989 under provisions of the Medicare Catastrophic Coverage Act, which briefly eliminated the requirement for a hospital stay prior to a covered SNF stay and which reduced the copayments required of enrollees for SNF stays.

Table B–9 shows Medicare spending per enrollee in constant 1995 dollars. The first column includes both Medicare benefits and administration. All other columns include spending on benefits only.

OUT-OF-POCKET SPENDING BY MEDICARE BENEFICIARIES

In 1992, Medicare covered approximately 53 percent of the health care expenditures of program beneficiaries (55 percent for the aged and 43 percent for the disabled). The majority of beneficiaries had other coverage, either through private insurance or public programs, to supplement their Medicare protection. Medicaid paid an additional 14 percent of the health costs of the Medicare population while private insurance covered 10 percent and other sources (such as the Veterans Administration) covered an additional 5 percent. (For a discussion of supplemental coverage see section 3, Medicare.) However, beneficiaries still financed 20 percent of their medical bills through out-of-pocket payments to health care providers. The proportion of expenditures that beneficiaries paid out of pocket varied by service category, ranging from 2 percent for hospital services to 57 percent for prescription drugs and 83 percent for dental care. Beneficiaries also paid approximately 36 percent of their long-term facility care costs out of pocket (Lashober and Olin, 1996).

In 1992, the estimated average out-of-pocket expenditure for a noninstitutionalized beneficiary not enrolled in a managed care plan was $1,833 (PPRC, 1997). In 1996, the estimated out-of-pocket expenditure (using a different data base) was $2,605 (Moon, Kuntz & Pounder, 1996). Out-of-pocket payments include expenditures for Medicare's cost-sharing charges, payments for services not covered by Medicare or supplemental insurance. Over half of out-of-pocket expenditures are for private insurance premiums and Medicare part B premiums (see table B–10).

Beneficiaries with greater supplemental coverage also have higher out-of-pocket costs. For example, noninstitutionalized fee-for-service beneficiaries who paid out of pocket toward the costs of individually purchased and employer-provided supplemental insurance spent an average of $2,638 in 1992. Those noninstitutionalized fee-for-service beneficiaries who had no supplemental coverage spent an average of $1,294 out of pocket in 1992 (PPRC, 1997).

An analysis of 1996 data shows that out-of-pocket costs represented 21 percent of household income for the elderly. Out-of-

pocket spending ranged from 11 percent of household income for the high-income group, 18 percent for the middle income, 26 percent for the low income, 30 percent for the poor, and 31 percent of income for the near poor (Moon et al., 1996).

TABLE B–10.—DISTRIBUTION OF AVERAGE OUT-OF-POCKET EXPENDITURES, BY CATEGORY OF SERVICES, 1992

Category	Percentage
Medical provider	16
Prescription drugs	16
Dental	7
Other services	5
Supplemental insurance premiums	38
Medicare part B premiums	18
Total	100

Note.—Excludes out-of-pocket spending by institutionalized beneficiaries and those enrolled in managed care plans.

Source: Physician Payment Review Commission, 1997.

BACKGROUND DATA ON LONG-TERM CARE

The phrase long-term care refers to a broad range of medical, social, personal, supportive, and specialized housing services needed by individuals who have lost some capacity for self-care because of a chronic illness or condition. Chronic illnesses or conditions often result in both functional impairment and physical dependence on others for an extended period of time. Major subgroups of persons needing long-term care include the elderly and nonelderly disabled, persons with developmental disabilities (primarily persons with mental retardation), and persons with mental illness. This section of appendix B focuses on the elderly long-term care population.

The range of chronic illnesses and conditions resulting in the need for supportive long-term care services is extensive. Unlike acute medical illnesses, which occur suddenly and may be resolved in a relatively short period of time, chronic conditions last for an extended period of time and are not typically curable. Although chronic conditions occur in individuals of all ages, their incidence, especially as they result in disability, increases with age. These conditions may include heart disease, strokes, arthritis, osteoporosis, and vision and hearing impairments. Dementia, the chronic, often progressive loss of intellectual function, is also a major cause of disability in the elderly.

The presence of a chronic illness or condition alone does not necessarily result in a need for long-term care. For many individuals, their illness or condition does not result in a functional impairment or dependence and they are able to go about their daily routines without needing assistance. But when the illness or condition results in a functional or activity limitation, long-term care services may be required.

The need for long-term care by the elderly is often measured by assessing limitations in a person's capacity to manage certain func-

tions or activities. For example, a chronic condition may result in dependence in certain functions that are basic and essential for self-care, such as bathing, dressing, eating, toileting, and/or moving from one place to another. These are referred to as limitations in activities of daily living, or ADLs. Another set of limitations, which reflect lower levels of disability, are used to describe difficulties in performing household chores and social tasks. These are referred to as limitations in instrumental activities of daily living, or IADLs, and include such functions as meal preparation, cleaning, grocery shopping, managing money, and taking medicine. Limitations can vary in severity and prevalence, so that persons can have limitations in any number of ADLs or IADLs, or both.

Long-term care services are often differentiated by the settings in which they are provided. In general, services are provided either in nursing homes or in home and community-based care settings. Nursing home care includes a wide variety of services that range from skilled nursing and therapy services to assistance with such personal care functions as bathing, dressing, and eating. Nursing home services also include room and board.

Home and community-based care also includes a broad range of skilled and personal care services, as well as a variety of home management activities, such as chore services, meal preparation, and shopping. Home care services can be provided formally by home care agencies, visiting nurse associations, and day care centers. Home care is also provided informally by family and friends who are not paid for the services they provide. In contrast to nursing home care, which by necessity is formally provided care, most home and community-based care is provided informally by family and friends. Research has shown that about 65 percent of those elderly persons living in the community and needing long-term care assistance rely exclusively on unpaid sources of assistance for their care.

THE LONG-TERM CARE POPULATION

Limitations in ADLs and IADLs can vary in severity and prevalence. Persons can have limitations in any number of ADLs or IADLs, or both. An estimated 7.3 million elderly persons required assistance with ADLs and IADLs in 1994. This is nearly one-quarter of the Nation's elderly. Of this total, an estimated 5.7 million elderly persons resided in their own homes or other community-based settings and 1.6 million elderly were residing in nursing homes. Of the total residing in the community, 2.1 million had severe disabilities, needing help with at least 3 ADLs or required substantial supervision due to cognitive impairment or other behavioral problem. The remaining 3.6 million resided in the community with lower levels of disability.

The need for long-term care assistance is expected to become more pressing in years to come, given the aging of the population and especially the growing numbers of the age 85 and older population who are at the greatest risk of using long-term care. Estimates show that the number of elderly needing help with ADLs and/or IADLs may grow from 7.3 million to 10 to 14 million by 2020, and 14 to 24 million by 2060 (U.S. General Accounting Office, 1994, p. 8).

PAYING FOR LONG-TERM CARE SERVICES

Table B–11 indicates that sizable public and private funds are being spent on long-term care for the elderly—nearly $91 billion in 1995. Federal and State governments account for the bulk of this spending, $55 billion or 60 percent of the total.

TABLE B–11.—ELDERLY LONG-TERM CARE EXPENDITURES BY SOURCE OF PAYMENT, 1995

[In billions of dollars]

Source of spending	Amount
Nursing home care:	
Medicaid	$24.2
Medicare	8.4
Other Federal	0.7
Other State and local	0.6
Out-of-pocket payments	30.0
Private insurance	0.4
Total	64.4
Home and community-based care:	
Medicaid	4.3
Medicare	14.3
Other Federal	1.7
Other State and local	0.5
Out-of-pocket payments	5.5
Private insurance	0.3
Total	26.5
Total long-term care	90.9

Source: The Lewin Group for the Office of the Assistant Secretary for Planning and Evaluation.

Approximately 70 percent of long-term care spending on the elderly is for nursing home care. Examination of the sources of payment for nursing home care reveals that the elderly face significant uncovered liability for this care. Two sources of payment—the Medicaid Program and out-of-pocket payments—account for nearly 84 percent of this total.

Medicaid is the Federal-State health program for the poor. It limits its coverage to those people who are poor by welfare program standards or those who have become poor as a result of incurring large medical expenses. Medicaid Program data show that spending for the elderly is driven largely by its coverage of people who have become poor as the result of depleting assets and income on the cost of nursing home care. In most States, this spend down requirement means that a nursing home resident without a spouse can not have more than $2,000 in countable assets before becoming eligible for Medicaid coverage of their care. This is not difficult for persons needing nursing home care, with average cost in excess of $40,000 per year.

Table B–11 also indicates that nearly all private spending for nursing home care is paid directly by consumers out of pocket. At present, private insurance coverage for long-term nursing home care is very limited, with private insurance payments amounting to 0.6 percent of total spending for nursing home care in 1995. (Private long-term care insurance is discussed in additional detail below.)

While most persons needing long-term care live in the community and not institutions, comparatively little long-term care spending is for the home and community-based services that the elderly and their families prefer. In 1995, spending on home care for the elderly amounted to $26.5 billion, or 30 percent of total long-term care spending for the elderly in that year. This spending does not take into account the substantial support provided to the elderly by family and friends. Studies have found that about 65 percent of functionally impaired elderly living in the community rely exclusively on unpaid sources, generally family and friends, for their care. Surveys have found that eight of ten care givers provide unpaid assistance averaging 4 hours a day, 7 days a week. Many care givers are financially disadvantaged and one in three is in relatively poor health. Care giving frequently competes with the demands of employment and requires care givers to reduce work hours, take time off without pay, or quit their jobs.

The table also reveals that Medicare plays a relatively small role in financing long-term care services. Medicare, the Federal health insurance program for the elderly and disabled, is focused primarily on coverage of acute health care costs and was never envisioned as providing protection for long-term care. Coverage of nursing home care, for instance, is limited to short-term stays in certain kinds of nursing homes, referred to as skilled nursing facilities, and only for those people who demonstrate a need for daily skilled nursing care or other skills and rehabilitation services following a hospitalization. Many people who require long-term nursing home care do not need daily skilled care, and, therefore, do not qualify for Medicare's benefit. As a result of this restriction, Medicare paid for 13 percent of the elderly's nursing home spending in 1995.

For similar reasons, Medicare pays for only limited—albeit rapidly growing—amounts of community-based long-term care services, through the program's home health benefit. To qualify for home health services, the person must be in need of skilled nursing care on an intermittent basis, or physical or speech therapy. Most chronically impaired people do not need skilled care to remain in their homes, but rather nonmedical supportive care and assistance with basic self-care functions and daily routines that do not require skilled personnel. When added together, Medicare's spending for nursing home and home health care for the elderly amounted to approximately 25 percent of total program spending in 1995.

Three other Federal programs—the Social Services Block Grant (SSBG), the Older Americans Act, and the Supplemental Security Income (SSI) Program—provide support for community-based long-term care services for impaired elderly people. The SSBG provides block grants to States for a variety of services for the elderly, as well as the disabled and children. The Older Americans Act also funds a broad range of in-home services for the elderly. Under the

SSI Program, the federally administered income assistance program for aged, blind, and disabled people, many States provide supplemental payments to the basic SSI payment to support selected community-based long-term care services for certain eligible people, including the frail elderly. However, since the funding available for these three programs is limited, their ability to address the financing problems in long-term care is also limited. In addition to these Federal programs, a number of States devote significant State funds to home and community-based long-term care services.

As noted above, the Medicaid Program, a means-tested Federal-State health program for the poor, is the major source of public support for long-term care for the elderly. It funds a broad range of long-term care services needed by the elderly, including nursing home care, home health care, personal care, and various home and community-based services.

Long-term care spending, and especially nursing home spending, account for the great bulk of Medicaid's spending for the elderly. As shown in table B–12, below two-thirds of total Medicaid spending for the elderly, or $24.1 billion of $36.5 billion, was for nursing home care in fiscal year 1995. Much smaller amounts were spent for various home care services—$3.0 billion, or 8 percent of total spending for the elderly, in fiscal year 1995. Together these two categories of long-term care spending amounted to three-quarters of total spending for the elderly.

TABLE B–12.—FEDERAL AND STATE MEDICAID SPENDING FOR PEOPLE ELIGIBLE ON THE BASIS OF BEING AGE 65 OR OLDER, FISCAL YEAR 1995

[Amounts in millions of dollars]

Service category	Payments	Percent of total
Nursing homes	$24,146	66.2
Home care services	2,990	8.2
Prescription drugs	2,861	7.8
Inpatient hospital	2,034	5.6
Inpatient mental health	1,178	3.2
Intermediate care facility	637	1.7
Physician services	617	1.7
Outpatient hospital	508	1.4
Clinic services	258	0.7
Other practitioner	96	0.3
Laboratory and radiology	73	0.2
Dental services	61	0.2
Rural health clinics	11	0.0
Other services	1,011	2.8
Total expenditures	36,482	100.0

Source: Congressional Research Service analysis of data from the HCFA form 2082.

Medicaid's spending for long-term care for the elderly is driven by its coverage of persons who need nursing home care and who are not poor by cash welfare standards, but who qualify under a spend down option and other more liberal financial eligibility

standards that States may use for covering persons needing institutional care and having higher levels of income. One of these is the medically needy option. Medically needy persons have incomes too high to qualify for cash welfare, but incur medical expenses that deplete their assets and incomes to levels that make them needy according to State-determined standards. States may also use a special income rule, referred to as the 300 percent rule, for extending Medicaid eligibility to persons needing nursing home care. Under this rule, States are allowed to cover persons needing nursing home care so long as their income does not exceed 300 percent of the basic Supplemental Security Income (SSI) cash welfare payment (in 1997, 300 percent of $484, or $1,452 a month).

A June 1996 study, "Spending Down to Medicaid: New Data on the Role of Medicaid in Paying for Nursing Home Care" (Wiener, Sullivan, & Skaggs) confirms that Medicaid's coverage of nursing home care provides a significant safety net for the middle class as well as for the poor. This study calculated three different measures of Medicaid spend down using surveys that tracked persons who were discharged from nursing homes as well as current residents of facilities during a 5-year period.

The first method used by the study examined discharged and current residents who were private payers at admission and calculated the proportion who were Medicaid at discharge or at the end of the followup period. More formally, the numerator for this method is all persons who are eligible for Medicaid at some point during their nursing home stays and the denominator is all persons who start their nursing home stays as private payers. The second method examined discharged and current residents who were Medicaid at discharge or at the end of the followup period and determined what proportion were private pay at the beginning of their nursing home stay. The numerator for this method is all persons receiving Medicaid at discharge or at the end of a followup period who began their stays as private-pay residents, while the denominator is all persons receiving Medicaid at discharge or at the end of the followup period. The third method examined total discharged and current residents and calculated what proportion began their stays as private-pay residents but were Medicaid eligible at discharge or at the end of the followup period. Here the numerator is all persons receiving Medicaid at discharge or at the end of the followup period who began their nursing home stays as private-pay residents, while the denominator is all persons who have nursing home stays.

The study found:

1. For discharged nursing home residents, approximately one-third of those admitted as private-pay residents eventually spent down to Medicaid (spend down method 1). Just over one-quarter of Medicaid discharged residents began their nursing home stays as private-pay residents (spend down method 2). About one-seventh of all discharged nursing home residents spent down to Medicaid at some time during their stays (spend down method 3).
2. For current residents, almost half of those admitted as private-pay residents eventually spent down to Medicaid (spend down method 1). Just over one-quarter of current residents eligible

for Medicaid at some point began their nursing home stays as private-pay residents (spend down method 2). One-fifth of all current residents spent down at some point during their stays (spend down method 3).

PRIVATE LONG-TERM CARE INSURANCE

Private long-term care insurance is generally considered to be the most promising private sector option for providing the elderly additional protection for long-term care expenses. Long-term care insurance is a relatively new, but rapidly growing, market. In 1986, approximately 30 insurers were selling long-term care insurance policies of some type and an estimated 200,000 persons were covered by these policies. By 1987, a Department of Health and Human Services Task Force on Long-Term Health Care Policies (1987) found 73 companies writing long-term care insurance policies covering 423,000 persons. As of December 1995, the Health Insurance Association of America (Coronel & Kitchman, 1997) found that more than 4.35 million policies had been sold, with 125 insurers offering coverage. (Note that this is a cumulative total of policies sold; fewer persons would be covered, due to failure to pay premiums because of death, a change in income, a decision not to continue coverage, etc.)

Although growth has been considerable in a short period of time, the private insurance industry has approached this potential market with caution. Insurers are concerned about the potential for adverse selection in long-term care insurance, where only those persons likely to need care actually buy insurance. In addition, they point to the problem of induced demand for services that can be expected to be generated by the availability of new long-term care insurance. With induced demand, sometimes also referred to as moral hazard, individuals decide to use more services than they otherwise would because they have insurance and/or will shift from nonpaid to paid providers for their care. In addition, insurers are concerned that, given the nature of many chronic conditions, persons who need long-term care will need it for the remainder of their lives, resulting in an open-ended liability for the insurance company.

As a result of these risks, insurers have designed policies that limit their liability for paying claims. Policies have been medically underwritten to exclude persons with certain conditions or illnesses. In addition, most plans provide indemnity benefits that pay only a fixed amount for each day of covered service. If these amounts are not updated for inflation, the protection offered by the policy can be significantly eroded by the time a person actually needs care. Today payment amounts can generally be updated for inflation, but only with significant increases in premium costs.

These design features of long-term care insurance have always raised issues about the quality of coverage offered purchasers of policies. The insurance industry has responded to these concerns by offering new products that have provided broadened coverage and fewer restrictions. In addition, the National Association of Insurance Commissioners (NAIC) has established a model act and model regulations for long-term care insurance products sold within their

jurisdictions. All States have adopted at least some portion of these standards to protect purchasers of these policies.

One of the key issues outstanding in the debate on the role private insurance can play in financing long-term care is the affordability of coverage. HIAA reports on the premium costs of policies representing 80 percent of all policies sold in the individual and group association markets in 1995. For policies paying $100 a day for nursing home care and $50 a day for home health care, with lifetime 5 percent compounded inflation protection and a 20-day deductible period, average annual premiums in 1995 were $1,881 when purchased at the age of 65 and $5,889 when purchased at the age of 79. Many elderly people cannot afford these premiums.

The insurance industry believes that affordability of premiums can be greatly enhanced if the pool of those to whom policies are sold is expanded. The industry has argued that the greatest potential for expanding the pool and reducing premiums lies with employer-based group coverage. Premiums should be lower in employer-based group coverage because younger age groups with lower levels of risk of needing long-term care would be included, allowing insurance companies to build up reserves to cover future payments of benefits. For example, the policy described above had an average annual premium of $798 when purchased at the age of 50. In addition, group coverage has lower administrative expenses.

According to HIAA, employer-based activity has increased steadily over the years. By the end of 1995, over 530,000 policies had been sold across 1,260 employers. These employer-based plans covered employees, their spouses, retirees, parents, and parents-in-law. In addition, the number of long-term care riders that permit conversion of at least some portion of life insurance policies to long-term care benefits has grown from 1,300 policies in 1988 to a cumulative total of 334,000 in 1995.

But just how broad-based employer interest is in a new long-term care benefit is unclear. Many employers currently face large unfunded liabilities for retiree pension and health benefits. Employers are also concerned about benefit costs for their labor force. Of those employers sponsoring a long-term care insurance plan, less than half were making contributions to the premium cost of a policy, and almost all of those who had made contributions were very small firms (under 100 employees), buying a base policy from the same long-term care insurance company (Unum), with an option for employees to upgrade the policy. The majority of employers sponsoring plans require that the employee pay the full premium cost of coverage.

Those advocating private long-term care insurance as a solution to long-term care financing issues have argued that the uncertain tax treatment of long-term care insurance in the Tax Code has been a hindrance to market acceptance. In addition, tax incentives may encourage more employers to offer a long-term care insurance benefit and may help reduce the high premium costs of policies for some elderly persons. Over the years, numerous bills were introduced to clarify the tax treatment of long-term care insurance and long-term care expenses in the Tax Code. The substance of these proposals was included in Public Law 104–191, the Health Insur-

ance Portability and Accountability Act of 1996, as signed into law August 21, 1996.

Effective January 1, 1997, Public Law 104–191 amends the Tax Code to treat private long-term care policies and long-term care expenses the way health insurance policies and health care expenses are currently treated under the Code. These changes have several different dimensions.

1. Amounts received under a qualified long-term care insurance plan will be considered medical expenses and excluded from gross income. (Per diem policies that pay benefits on the basis of disability and not actual services used, however, would be subject to a cap. The amount of the dollar cap is $175 per day per person, indexed for inflation. In the event that a person has both a per diem disability policy and another policy that reimburses for services actually used, then this cap amount is reduced by the amount of reimbursements and payments received by anyone for the cost of qualified long-term care services for the chronically ill individual. If more than one person receives payments for services needed by the insured person, then all such persons are treated as one person for purposes of the dollar cap. If payments under long-term care insurance plans exceed the dollar cap, then the excess is excluded from income subject to taxation only to the extent the individual has incurred actual costs for long-term care services in excess of the dollar cap. Amounts in excess of the dollar cap, with respect to which no actual costs were incurred for long-term care services, are fully includable in income and subject to taxation.)
2. Contributions of an employer to the cost of qualified long-term care insurance premiums will be excluded from the gross income of the employee, and will, therefore, be exempt from tax to the employee (so long as they do not exceed certain annual dollar limits that vary with the insured person's age). This favorable tax treatment, however, is not extended to employer-sponsored cafeteria plans or flexible spending arrangements. (Long-term care insurance premiums paid by an employer would continue to be tax deductible as a business expense for the employer, as they are under current law.)
3. Out-of-pocket (i.e., unreimbursed) long-term care expenses (including premium costs within age-adjusted limits) will be allowed as itemized deductions, to the extent they and other unreimbursed medical expenses exceed 7.5 percent of adjusted gross income.
4. Self-employed individuals will be allowed to include the premium costs of long-term care insurance in determining their allowable deduction for health insurance expenses. Only amounts not exceeding age-adjusted limits can be included. The deduction for health insurance expenses rises from 40 percent of the amount paid in 1997 to 80 percent in 2006 and years thereafter.

A qualified long-term care insurance plan is defined as a contract that covers only long-term care services; does not pay or reimburse expenses covered under Medicare; is guaranteed renewable; does not provide for a cash surrender value or other money that can be

paid, assigned, or pledged as collateral for a loan, or borrowed; applies all refunds of premiums and all policyholder dividends or similar amounts as a reduction in future premiums or to increase future benefits; and meets certain consumer protection standards. Policies issued before January 1, 1997, and meeting a State's long-term care insurance requirements at the time the policy was issued would be considered a qualified plan for purposes of favorable tax treatment.

Qualified long-term care services are defined as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which are required by a chronically ill individual, and are provided according to a plan of care prescribed by a licensed health care practitioner. However, amounts paid for services provided by the spouse of a chronically ill person or by a relative directly or through a partnership, corporation, or other entity) will not be considered a medical expense eligible for favorable tax treatment, unless the service is provided by a licensed professional.

Chronically ill persons are those individuals unable to perform, without substantial assistance from another individual, at least two of six specified ADLs for a period of at least 90 days due to a loss of functional capacity. The six specified ADLs include bathing, dressing, transferring, toileting, eating, and continence. Furthermore, the number of ADLs that are taken into account under a plan may not be less than five of those specified above. In other words, a plan does not meet the definition if it requires that an individual be unable to perform two out of any four of the activities listed in the bill. Public Law 104–191 also defines chronically ill persons as including those having a level of disability similar (as determined by the Secretary of the Treasury in consultation with the Secretary of HHS) to the level of disability specified for functional impairments, as well as those requiring substantial supervision to protect them from threats to health and safety due to severe cognitive impairment. Persons are required to be certified by a licensed health practitioner within the preceding 12-month period in order to meet these definitional requirements.

Public Law 104–191 also amends the Tax Code to extend favorable tax treatment to accelerated death benefits received by chronically ill persons (as defined above) and terminally ill persons under life insurance policies. Many life insurance policies now contain clauses or riders allowing part of the value of death benefits to be paid because of impending death instead of waiting until actual death. These accelerated death benefits are calculated based on the benefits that would be paid at death, discounted to the time of actual payment based on the projected time of death and an agreed discount rate. Under current tax law (i.e., before January 1, 1997), benefits paid because of the death of the insured are generally not taxable, but the proceeds from cashing in or selling a life insurance policy are taxable if they exceed the cost of the policy, just as for the sale of any asset. For the chronically and terminally ill, Public Law 104–191 excludes from gross income, and taxation, (1) amounts received as accelerated death benefits and (2) amounts received for the sale or assignment of a life insurance policy to a qualified viatical settlement provider, i.e., companies which are

regularly engaged in the trade or business of purchasing or taking assignment of life insurance policies on the lives of insured persons who are chronically or terminally ill and which meet certain specified requirements. The exclusion is limited to payments for long-term care services not compensated for by insurance or otherwise.

In addition to Tax Code clarifications, one other suggestion has been offered for enhancing the affordability and appeal of long-term care insurance. Various States have been exploring an option for encouraging people to purchase insurance according to a level of assets they wish to protect, rather than according to some standard of comprehensive coverage. Under this approach, persons might decide, for example, that they wish to protect $50,000 of assets. A policy paying out $50,000 for incurred long-term care expenses would have a lower premium cost than a policy paying 4 years of nursing home care at $80 a day. As a result, more persons might be able to afford coverage. To encourage individuals to consider long-term care insurance as assets protection, States would extend to those persons buying qualified policies the protection of Medicaid without requiring them to deplete assets to levels normally required under law (generally, $2,000 for a single individual). These persons would be able to retain assets at the level that corresponds to their private insurance payouts and obtain Medicaid coverage for the care they need, after their private policies had ceased providing coverage.

Eight States (California, Connecticut, Illinois, Indiana, Iowa, Maryland, New York, and Washington) have received approval from the Department of Health and Human Services to operate programs linking Medicaid and private insurance. Most States have implemented programs that protect a dollar of assets for each dollar a qualified long-term care policy pays out.

What impact this approach will have on the marketability of private insurance for long-term care is unclear, since operating experience at the present time is very limited. States, however, hope to reduce reliance of middle-income elderly on Medicaid for their long-term care needs, and believe they will save money by delaying that point when the elderly would have to turn to Medicaid for protection. The linkage might also discourage persons from sheltering assets because they would have insurance, both private and public, to protect assets from the catastrophic expenses of nursing home care. The actual cost/savings experience of these programs will not be known for many years, since persons purchasing private insurance in the early years of retirement would not generally require services until they were 80 or older.

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