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

CONTENTS

HEALTH STATUS

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. 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 2 for a discussion of health insurance supplementing Medicare coverage).

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 17.7 years in 1997 (table B–1). 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. Improvements for blacks have been greater than for whites; however, blacks' life expectancy at birth was still 6 years less than that for whites in 1997. 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 (table B–2). However, the proportion of overweight seniors seems to be increasing. Under the new definition for overweight that was adopted in 1998 by the National Institutes of Health (National Heart, Lung, and Blood Institute, 1998), the proportion of overweight seniors has climbed from about 55 percent in the 1971–74 time period to over 60 percent for females and over 68 percent for males in the 1988–94 time period.

TABLE B–1.—LIFE EXPECTANCY AT BIRTH AND AT 65 YEARS OF AGE, BY SEX AND RACE, SELECTED YEARS 1950–97

[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	74.7	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	68.9
1989	75.1	71.7	78.5	17.1	15.0	18.8	75.9	68.8
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	76.1	73.1	79.1	17.5	15.7	19.0	76.8	70.2
1997	76.5	73.6	79.4	17.7	15.9	19.2	77.1	71.1

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

Source: National Center for Health Statistics (1999a, Table 28, p. 139).

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]	67.2	67.1	57.3	78.3	71.8	60.8
High serum cholesterol	34.7	31.7	21.9	57.7	51.6	41.3
(Mean serum cholesterol level, [2] in mg/dL).	(226)	(221)	(212)	(250)	(246)	(233)
Overweight [3]	54.6	54.2	68.5	55.9	59.5	60.3

[1] 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.

[2] High serum cholesterol is defined as greater than or equal to 240 mg/dL (6.20 mmol/L). Risk levels were defined by the Second Report of the National Cholesterol Education Program Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults. National Institutes of Health, September 1993.

[3] Overweight is defined as body mass index greater than or equal to 25 kilograms/meter [2]. (In previous years, this table reflected a definition of overweight as body mass index greater than or equal to 27.8 for men and 27.3 for women, resulting in substantially lower proportions of the population being considered overweight.)

Note.—Data are based on measured height and weight of a sample of the civilian, noninstitutionalized population.

Source: National Center for Health Statistics (1999a, Tables 68, 69, 70, pp. 221–23).

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. Almost half report having arthritis, about 40 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 REPORTED CHRONIC CONDITIONS PER 1,000 ELDERLY PERSONS, BY AGE AND FAMILY INCOME, 1995

Chronic condition	All elderly	Age		Family income			
		65–74	75 and older	Less than $10,000	$10,000–$19,999	$20,000–$34,999	$35,000 and over
Arthritis	490	448	548	633	503	442	413
Cataracts	159	105	234	250	146	141	177
Hearing impairment	284	236	351	298	310	289	286
Deformity or orthopedic impairment	178	166	193	252	196	191	149
Hernia of abdominal cavity	55	54	55	57	55	56	70
Diabetes	126	133	117	212	98	144	94
Heart disease	308	268	364	333	308	335	229
High blood pressure [1]	403	392	420	482	432	381	328
Chronic sinusitis	153	157	149	188	194	156	125
Emphysema	34	36	32	50	36	39	21

[1] As self-reported in the 1995 National Health Interview Survey; the higher 1988–94 hypertension data in table B–2 are from physical examination of a sample population.

Source: National Center for Health Statistics (1998, Table 57, pp. 77–78 and Table 60, pp. 83–86).

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 (table B–4).

Family income is directly related to 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 1995, about 51 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 less de-

pendency in later life (Kolata, 1996). It should be noted that living longer is the demographic trend, but it is not known what the tradeoffs are between cost of care and quality of life.

TABLE B–4.—SELF-ASSESSED HEALTH STATUS OF THE ELDERLY, BY SEX AND FAMILY INCOME, 1995

[In percent]

Characteristic	All persons [1] (thousands)	Self-assessed health status [2]				
		Excellent	Very good	Good	Fair	Poor
Sex:						
Men	13,139	15.5	22.7	33.0	19.4	9.4
Women	18,327	14.9	23.1	34.0	19.7	8.3
Family income:						
Under $10,000	4,158	8.9	20.5	29.9	26.7	13.9
$10,000–$19,999	7,233	13.2	20.5	34.1	22.6	9.5
$20,000–$34,999	7,363	16.1	24.0	34.3	18.1	7.5
$35,000 and over	5,738	23.3	27.7	32.3	12.3	4.4
All persons 65+ years [3]	31,466	15.1	22.9	33.6	19.6	8.8

[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 (1998, Table 70, pp. 107–8).

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. 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 (NCHS), 1999a). In 1997, heart disease still accounted for 35 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 1997, cerebrovascular disease accounted for only 8 percent of all deaths in the 65 and older age group.

Alzheimer's disease 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. Reported death rates increased rapidly in the first decade of reporting, as the diagnosis gained more acceptance and as diagnostic procedures changed. The trend in mortality lev-

eled off from 1988 through 1992, then rose slowly from 1992 to 1995, and now seems to have leveled off again. This pattern may mean that reporting practices for Alzheimer's disease have stabilized (NCHS, 1999c and NCHS, 1999b). Alzheimer's affects approximately 4 million Americans at present, including about 1 in 10 persons over 65 (Alzheimer's Association, 1999). Some studies show that nearly half of all people age 85 and older have some form of dementia (National Institute on Aging, 1999). Death rates from Alzheimer's are also highly age related (NCHS, 1999b). 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. Future morbidity and mortality from Alzheimer's disease will increase as the population continues to age unless new treatments or a cure are found.

TABLE B–5.—DEATH RATES FOR LEADING CAUSES OF DEATH AMONG OLDER PEOPLE, BY AGE, 1997

[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	1,781	754	1,944	6,199
2	Malignant neoplasms	1,124	847	1,335	1,805
3	Cerebrovascular diseases	412	135	462	1,585
4	Chronic obstructive pulmonary diseases	277	165	360	562
5	Pneumonia and influenza	228	57	234	1,025
6	Diabetes	139	88	167	294
7	Accidents	92	46	103	276
8	Alzheimer's disease	65	11	73	299
9	Nephritis, nephrotic syndrome, nephrosis	64	26	74	218
10	Septicemia	53	23	60	178
	All other causes	839	358	916	2,904
	All causes	5,074	2,510	5,728	15,345

Source: National Center for Health Statistics (1999b, Table 7, pp. 24–26, and Table 8, p. 28).

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

Tables B–6 through B–8 illustrate for selected years how Medicare reimbursement, acute health care costs, and out-of-pocket liabilities of Medicare enrollees respectively have changed. The years chosen are 1975, 1980, 1985, 1990, 1995, and 2000. Constant 2000 dollar values were obtained using the Consumer Price Index for All Urban Consumers (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 10.7 percent, while the growth in total Medicare costs (including enrollees' share of costs) is 8.9 percent (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 79 percent by 2000. 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 1975–2000

[Incurred costs per hospital insurance or supplementary medical insurance enrollee]

Source	Year						Average annual rate of growth 1975–2000 (percent)
	1975	1980	1985	1990	1995	2000	
	In current dollars						
Hospital insurance:							
Reimbursement	$466	$920	$1,570	$1,981	$3,201	$3,431	8.3
Copayments	34	67	119	187	244	273	8.6
Total	500	986	1,690	2,168	3,445	3,704	8.3
Supplementary medical insurance:							
Reimbursement	186	399	766	1,307	1,819	2,378	10.7
Copayments	84	137	248	400	547	610	8.3
Balance billing	22	56	87	68	13	6	−5.1
Total	291	592	1,101	1,775	2,379	2,994	9.8
Total Medicare reimbursement.	651	1,318	2,336	3,288	5,020	5,809	9.7
Total costs under Medicare.	792	1,579	2,791	3,944	5,824	6,698	8.9
	In constant 2000 dollars						
Hospital insurance:							
Reimbursement	1,415	1,908	2,493	2,588	3,585	3,431	3.6
Copayments	105	138	189	245	273	273	3.9
Total	1,519	2,046	2,682	2,833	3,859	3,704	3.6
Supplementary medical insurance:							
Reimbursement	564	827	1,215	1,707	2,038	2,378	5.9
Copayments	254	285	394	523	613	610	3.6

TABLE B–6.—REIMBURSEMENTS AND OUT-OF-POCKET COSTS UNDER MEDICARE, SELECTED YEARS 1975–2000—Continued

[Incurred costs per hospital insurance or supplementary medical insurance enrollee]

Source	Year						Average annual rate of growth 1975–2000 (percent)
	1975	1980	1985	1990	1995	2000	
Balance billing	67	117	138	89	15	6	−9.2
Total	885	1,229	1,748	2,319	2,665	2,994	5.0
Total Medicare reimbursement.	1,978	2,735	3,708	4,295	5,623	5,809	4.4
Total costs under Medicare.	2,405	3,275	4,430	5,152	6,524	6,698	4.2
Percent of costs paid by Medicare.	82.3	83.5	83.7	83.4	86.2	86.7	0.2

Note.—Values after 1995 are projected; CPI–U was used to calculate constant dollars.

Source: Congressional Budget Office (2000).

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 2000 (table B–6).

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 86.7 percent in 2000 (table B–6). The share of costs paid directly by enrollees is shown in the third panel of table B–7. Total direct costs (excluding premiums) 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 2000, 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 (table B–8 for deductible amounts and monthly premium amounts under Medicare).

TABLE B–7.—ENROLLEE COSTS UNDER MEDICARE, SELECTED YEARS 1975–2000

[Incurred costs per hospital insurance or supplementary medical insurance enrollee]

Source	Year						Average annual rate of growth 1975–2000 (percent)
	1975	1980	1985	1990	1995	2000	
	In current dollars						
Hospital insurance copayments	$34	$67	$119	$187	$244	$273	8.6
Supplementary medical insurance copayments	84	137	248	400	547	610	8.3
Balance billing	22	56	87	68	13	6	−5.1
Total direct costs	140	260	455	656	804	889	7.7
Premium costs	80	110	186	343	553	546	8.0
Total enrollee costs	221	371	641	999	1,357	1,435	7.8
Enrollee per capita income [1]	5,158	8,431	12,767	15,454	16,460	24,381	6.4
	In constant 2000 dollars						
Hospital insurance copayments	105	138	189	245	273	273	3.9
Supplementary medical insurance copayments	254	285	394	523	613	610	3.6
Balance billing	67	117	138	89	15	6	−9.2
Total direct costs	426	540	722	857	901	889	3.0
Premium costs	244	229	295	448	620	546	3.3

Total enrollee costs	670	769	1,017	1,305	1,520	1,435	3.1
Enrollee per capita income [1]	15,663	17,489	20,269	20,190	18,438	24,381	1.8
	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	4.1	−0.3
Supplementary medical insurance copayments	10.6	8.7	8.9	10.1	9.4	9.1	−0.6
Balance billing	2.8	3.6	3.1	1.7	0.2	0.1	−12.9
Total direct costs	17.7	16.5	16.3	16.6	13.8	13.3	−1.2
Premium costs	10.2	7.0	6.7	8.7	9.5	8.2	−0.9
Total enrollee costs	27.9	23.5	23.0	25.3	23.3	21.4	−1.0
Enrollee-paid costs as a percent of enrollee per capita income [1]	4.3	4.4	5.0	6.5	8.2	5.9	1.3

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

Note.—Values after 1995 are projected. The CPI–U was used to calculate constant dollars.

Source: Congressional Budget Office, unpublished tables, March 2000.

TABLE B–8.—COPAYMENT AND PREMIUM VALUES UNDER MEDICARE, SELECTED CALENDAR YEARS, 1975–2000

	Year						Average annual rate of growth 1975–2000 (percent)
	1975	1980	1985	1990	1995	2000	
	In current dollars						
Hospital insurance:							
Hospital deductible	$92	$180	$400	$592	$716	$776	8.9
Supplementary medical insurance:							
Annual deductible ..	60	60	75	75	100	100	2.1
Monthly premium [1]	6.70	9.20	15.50	28.60	46.10	45.50	8.0
	In constant 2000 dollars						
Hospital insurance:							
Hospital deductible	279	373	635	773	802	776	4.2
Supplementary medical insurance:							
Annual deductible ..	182	124	119	98	112	100	−2.4
Monthly premium [1]	20.35	19.08	24.61	37.36	51.64	45.50	3.3

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

Note.—Values after 1995 are projected. The CPI–U was used to calculate constant dollars.

Source: Congressional Budget Office (2000).

Enrollees spend a slightly larger share of their income for Medicare's cost sharing and premium charges than they did in 1975 (table B–7). 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. However, the percentage declined to 5.9 percent in 2000.

OUT-OF-POCKET SPENDING BY MEDICARE BENEFICIARIES

In 1995, Medicare covered approximately 55 percent of the health care expenditures of program beneficiaries (57 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 12 percent of the health costs of the Medicare population while private insurance covered 9 percent and other sources (such as the Veterans Administration) covered an additional 5 percent. (For a discussion of supplemental coverage see section 2, Medicare.) However, beneficiaries still financed 19 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 per-

cent for hospital services to 49 percent for prescription drugs and 82 percent for dental care. Beneficiaries also paid approximately 32 percent of their long-term facility care costs out of pocket (Olin et al., 1999).

A recent estimate projected that out-of-pocket spending by the elderly would total about $2,430 or 19 percent of income in 1999. There is considerable variation among beneficiaries in actual out-of-pocket costs. Over half of beneficiaries (55 percent) were projected to spend less than $2,000 in 1999. Twenty percent were projected to spend between $2,000 and $3,000. The remaining 25 percent would spend over $3,000.

Payments for Medicare cost-sharing charges and items not covered by Medicare (such as prescription drugs and dental care) represented 54 percent of average out-of-pocket spending in 1999. The remaining 46 percent was for premium payments for Medicare part B, Medicare+Choice plans, and private insurance (table B–9).

TABLE B–9.—AVERAGE OUT-OF-POCKET SPENDING ON HEALTH CARE BY NONINSTITUTIONALIZED MEDICARE BENEFICIARIES AGE 65 AND OLDER, 1999 PROJECTIONS

[In percent]

Item	Percent
Goods and services:	
Prescription drugs	17
Dental	8
Nursing home care (short-term)	8
Physician, supplier, and vision	17
Outpatient hospital	3
Inpatient hospital	3
Total goods and services	54
Premiums:	
Medicare part B	19
Private insurance (including Medicare+Choice)	27
Total premiums	46
Total	100

Note.—Totals do not sum due to rounding.

Source: AARP (1999).

The average level of out-of-pocket spending varies by type of supplemental coverage. Beneficiaries with Medigap were projected to spend the most out of pocket, even more than those without any supplemental protection. (Persons with Medigap coverage also have higher Medicare costs than persons with no supplemental protection; see Section 2). Table B–10 shows the projected out-of-pocket costs for aged Medicare beneficiaries by source of supplemental coverage. It also shows what this spending represents as a percentage of income. Persons who are either covered under the Specified Low-Income Medicare Beneficiary Program or who have only part-year

Medicaid coverage were projected to spend the highest portion of their incomes on health care. (For a discussion of the specified low-income Medicare beneficiary population, see Section 2.)

TABLE B–10.—AVERAGE OUT-OF-POCKET SPENDING ON HEALTH CARE BY NONINSTITUTIONALIZED MEDICARE BENEFICIARIES AGE 65 AND OLDER, BY SUPPLEMENTAL HEALTH INSURANCE STATUS, 1999 PROJECTIONS

Source of supplemental coverage	Out-of-pocket costs	Percentage of income [1]
Medicare-only	$2,505	22
Employer	2,545	16
Medigap	3,250	26
Medicare+Choice	1,630	12
Medicaid	280	5
Qualified Medicare beneficiary [2]	840	13
Specified low-income Medicare beneficiary [2]/part year Medicaid	2,630	30
All beneficiaries	2,430	19

[1] Average out-of-pocket spending as a percent of income is calculated as the average of each beneficiary's share of income spent out of pocket for health care.
[2] Full year coverage.

Source: AARP Public Policy Institute: Out-of-Pocket Spending on Health Care by Medicare Beneficiaries Age 65 and Older: 1999 Projections, IB#41, December 1999.

Out-of-pocket spending patterns differ considerably by source of supplementary coverage. For example, Medicare-only beneficiaries were projected to spend a relatively small share of their health care goods and services dollars on prescription drugs and dental care; the majority of their spending is for items and services that would otherwise be covered under supplemental coverage. Conversely, beneficiaries who have employer-sponsored coverage are projected to spend a larger portion of their goods and services dollars on drugs and dental care. Medicare+Choice enrollees incur relatively low out-of-pocket costs for both goods and services and premiums (table B–11).

Out-of-pocket spending tends to rise with income. However, the share of income spent on health care falls as income rises (table B–12). Overall, persons below 100 percent of poverty spend 33 percent of their incomes on out-of-pocket health care costs. However, poor persons without Medicaid coverage were projected to spend 49 percent of their incomes out of pocket for health care (AARP, 1999).

TABLE B–11.—OUT-OF-POCKET HEALTH CARE SPENDING FOR NONINSTITUTIONALIZED MEDICARE BENEFICIARIES AGE 65 AND OLDER, BY TYPE OF SPENDING AND INSURANCE COVERAGE, 1999 PROJECTIONS

	Total	Medicare only	Employer	Medigap	Medicare+ Choice	Full year Medicaid	Full year qualified Medicare beneficiary	Full year specified low-income Medicare beneficiary/part year Medicaid
Part B and private insurance premiums:								
Medicare part B premium contributions [1]	$455	$465	$500	$525	$525	0	0	$160
Private insurance/HMO premium contributions	645	0	630	1,360	195	$30	$65	270
Subtotal of part B and private insurance premiums	1,100	465	1,130	1,885	720	30	65	430
Health care goods and services:								
Inpatient hospital	65	355	35	30	35	45	25	90
Outpatient hospital	60	175	60	45	25	5	20	210
Physician/supplier/vision	400	655	465	415	200	65	275	400
Nursing facility	200	285	280	30	145	50	125	1,030
Dental	195	140	230	200	250	5	110	30
Prescription drugs	410	430	345	645	255	80	220	440
Subtotal for health care goods and services	1,330	2,040	1,415	1,365	910	250	775	2,200
Average out-of-pocket spending	2,430	2,505	2,545	3,250	1,630	280	840	2,630

[1] The average part B premium contribution represents an average premium cost over the entire year. The average contribution differs between each group because of differences in the number of months that each group's average enrollee was enrolled in Medicare.

Note.—Out-of-pocket health care spending excludes home care services and long-term nursing facility care. Numbers are rounded to the nearest $5. Numbers may not sum to total because of rounding.

Source: AARP (1999).

TABLE B–12.—AVERAGE OUT-OF-POCKET SPENDING ON HEALTH CARE BY NONINSTITUTIONALIZED MEDICARE BENEFICIARIES AGE 65 AND OLDER BY INCOME LEVEL AND AS A PERCENTAGE OF INCOME, 1999 PROJECTIONS

Income level (as a percentage of poverty)	Spending	Percentage of income
<100 percent	$1,770	33
100 to <125 percent	2,080	25
125 to <200 percent	2,420	24
200 to <400 percent	2,480	17
400 to <600 percent	2,700	13
600 percent and above	2,605	8
All persons	2,430	19

Source: AARP (1999).

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 is often measured by assessing limitations in a person's capacity to manage certain functions 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, getting around inside the home, and transferring from a bed to a chair. 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, shopping, light housework, telephoning, and money management. 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 57 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 AGE 65 AND OLDER

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 5.3 million elderly persons required assistance with ADLs and IADLs in 1994. This is about 16 percent of the Nation's elderly. Of this total, an estimated 3.9 million elderly persons resided in their own homes or other community-based settings and 1.4 million elderly were residing in nursing homes. Of the total residing in the community, 30 percent, or 1.2 million had severe disabilities, needing help with at least 3 ADLs. The remaining 2.7 million resided in the community with lower levels of disability (Spectur et al., 1998).

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. The Lewin Group, Inc. estimates show that the number of elderly needing help with ADLs and/or IADLs may grow from 5.5 million in 2000, to 7.4 million in 2020, a 42 percent increase.

PAYING FOR LONG-TERM CARE SERVICES

Table B–13 indicates that sizable public and private funds are being spent on long-term care for the elderly—estimated at $98 billion in 2000. Medicaid and Medicare account for the bulk of this spending, $55 billion or 56 percent of the total.

TABLE B–13.—ELDERLY LONG-TERM CARE EXPENDITURES BY SOURCE OF PAYMENT, 2000

[In billions of dollars]

Source of spending	Amount
Institutional care:	
Medicaid	$31.0
Medicare	11.2
Other public payors	(1)
Out-of-pocket payments	28.2
Long-term care insurance	0.3
Total	70.7
Home and community-based care:	
Medicaid	4.9
Medicare	8.1
Other public payors	2.8
Out-of-pocket payments	11.3
Long-term care insurance	0.2
Total	27.3
Total long-term care	98.0

[1] Less than $1 million.

Source: Lutzsky et al. (1999).

Approximately 72 percent of long-term care spending on the elderly is for institutional care. Examination of the sources of payment for nursing home care reveals that the elderly face significant uncovered liability for this care—an estimated 40 percent of institutional care is paid by the elderly themselves out of pocket. Medicaid accounts for another 43 percent of institutional care.

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 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 costs often in excess of $50,000 per year.

Table B–13 also indicates that nearly all private spending for nursing home care is paid directly by consumers out of pocket. Private insurance coverage for long-term nursing home care is very limited, with private insurance payments estimated to be only about 0.3 percent of total spending for nursing home care in 2000. (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 2000, spending on home and community-based care for the elderly is estimated to be about $27 billion, or 27 percent of total long-term care spending for the elderly. This spending does not take into account the substantial support provided to the elderly by family and friends. Research has found that about 57 percent of functionally impaired elderly living in the community rely exclusively on unpaid sources, generally family and friends, for their care. Only 7 percent of the impaired residing in the community rely totally on paid providers for care.

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 is estimated to pay for only 15 percent of the elderly's nursing home spending in 2000.

For similar reasons, Medicare pays for only limited 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. Medicare's spending for home health care for the elderly is estimated to be about 27 percent of home and community-based long-term care in 2000.

Three other Federal programs—the Social Services Block Grant, 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 Social Services Block Grant 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, States devote significant State funds to home and community-based long-term care services. One study indicated that 39 States reported one or more State-only

funded home and community-based service programs for the elderly in 1996. These State programs spent more than $1.2 billion on services (Kassner and Williams).

MEDICAID SPENDING ON LONG-TERM CARE

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 persons of all ages. It funds a broad range of long-term care services, including nursing facility care, home health care, personal care, and various home and community-based services.

Table B-14 shows Medicaid spending for major long-term care services for persons of all ages for 1990 and 1997. Medicaid spending for long-term care almost doubled in 7 years, increasing from $30.2 billion in 1990 to $56.8 billion in 1997. Nursing home care accounted for the majority of Medicaid spending on long-term care in both years, but declined slightly as a proportion of the total over the period. In fiscal year 1997, nursing facility care represented 58 percent of total long-term care spending; intermediate care facilities for the mentally retarded represented 17 percent; and home and community-based services represented almost 25 percent.

TABLE B–14.—MEDICAID SPENDING ON SELECTED LONG-TERM CARE SERVICES, 1990 AND 1997

[In billions of dollars]

Long-term care services	1990		1997	
	Amount	Percent	Amount	Percent
Nursing facility care	$18.4	60.9	$33	58.1
Intermediate care facilities for the mentally retarded	7.7	25.5	9.7	17.1
Home and community-based services [1]	4.1	13.6	14.1	24.8
Total	30.2	100	56.8	100

[1] Includes home and community-based waiver services, home and community-based services for the frail elderly, personal care, and home health services, and other community-based services.

Source: Urban Institute estimates based on data from HCFA–64 reports.

The proportion of total Medicaid long-term care spending for intermediate care facilities for the mentally retarded declined over the period from 26 percent to 17 percent of long-term care spending. This continues a trend toward deinstitutionalization of persons with mental retardation and developmental disabilities in favor of care in community-based settings that began during the 1970s.

From 1990 to 1997, the proportion of total spending devoted to home and community-based services increased from almost 14 percent to 25 percent (from $4.1 billion in 1990 to $14.1 billion in 1997). This shift reflects, in part, greater use by States of Medicaid waivers for home and community-based services. Section 1915(c) of the Medicaid statute allows the Health Care Financing Administration to waive certain statutory requirements in order to assist

States in financing care at home and in other community-based settings for persons, who, without these services would be in institutions. States have flexibility to define the specific populations with disabilities and services to be covered. A wide range of services may be provided to persons with disabilities of all ages, including case management, respite services for care givers, and personal care services.

Medicaid's spending for long-term care 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 SSI cash welfare payment (300 percent of $512, or $1,536 per month in 2000).

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 considered by some to be a promising private sector option for providing the elderly with protection against the high cost of long-term care and/or reliance on public sector programs such as Medicaid. Although it is a relatively new insurance product, the market has grown rapidly. In 1986, approximately 20 insurers were selling long-term care insurance policies of some type, and an estimated 200,000 persons owned a policy. By 1987, a U.S. Department of Health and Human Services (DHHS) Task Force on Long-Term Health Care Policies found 73 companies writing long-term care insurance policies covering 423,000 persons. As of June 1998, the Health Insurance Association of America (HIAA) reported that more than 5.84 million policies had been sold, with 119 insurers offering coverage (Coronel, 2000). (This is a cumulative total of policies ever sold, not policies currently in force.)

Individuals who purchase long-term care insurance policies are protected against some or all of the costs of personal care if they become unable to carry out certain activities of daily living such as eating, bathing, dressing, toileting, continence, and transferring in and out of bed or a chair. Policies may also pay for care for those with cognitive impairments such as Alzheimer's disease. Care in a variety of settings may be covered, including assisted living or nursing facilities or the individual's own home. Policies vary with regard to features such as the number of functional losses that trigger payment of the benefit; limits on the amount of the payments the policy will make to the caretaker or facility (e.g., a specified dollar amount per day); whether payments are a flat daily amount regardless of documented expenses or are paid only as reimbursement for approved expenditures; the length of time over which benefits are paid (such as 1 year, 3 years, or for life); a waiting period between the qualifying impairment and commencement of payment; conditions under which benefits may be forfeited if premium payments lapse; and adjustment in payment amounts to account for inflation between the time the policy is purchased and the commencement of benefit payments.

Long-term care insurance policies may be sold by an insurance carrier to an individual based on that individual's age and health-

related factors, or may be sold to a group such as employees of a firm. The policies may be priced on the basis of substantial "underwriting," meaning the carrier asks the applicant for detailed information regarding his or her medical history, or policies may be sold with little or no underwriting. Underwriting is used by carriers to protect against the "adverse risk selection" that could occur if individuals were sold a policy when they were likely soon to need long-term care.

Affordability

One of the key issues outstanding in the debate on the role private insurance can play in financing long-term care is affordability. The cost an individual pays for a long-term care insurance policy with a certain benefit package is determined by the individual's age at the time he or she purchases the policy. Generally, premiums remain fixed throughout the policyholder's lifetime. (Under certain circumstances, a carrier may raise rates for all policyholders.) The younger the individual is when a policy is purchased, the lower the premiums are.

The HIAA examined the cost of 80 percent of all policies sold in 1997 to individuals and to groups. The 1997 annual premium cost of policies paying $100 per day for nursing home care and $50 for home care, with lifetime 5 percent compounded inflation protection and a 20-day deductible period were $1,850 if purchased at the age of 65, rising to $5,880 if purchased at age 79. Many elderly individuals cannot afford to purchase policies at such rates. Although some believe that long-term care insurance can potentially shift long-term care costs from the public sector to private insurers, others question the extent to which this market will continue to expand if the product is perceived as very costly, particularly among older individuals who are more likely to be concerned about needing long-term care.

Employer-based group coverage

The insurance industry has argued that long-term care insurance coverage could be more affordable and coverage expanded if insurance were purchased at group rates by individuals still in their working years. Because the premiums for most employer-based group plans are paid by the employee (or other covered group member) rather than by the employer, employees are price sensitive with regard to their premiums. Some say that because employer-based group plans may be 15 to 30 percent less costly than policies purchased individually, focusing expansion of coverage on employer-sponsored group policies can address the price issue (Cutler, 1999). Employment-based group premiums are lower because: (1) marketing can be targeted to younger individuals who generally have lower rates; (2) savings can be achieved through lower administrative costs and lower commissions; and (3) employers can bargain for reduced profit percentages and improved benefits. For example, the policy described above, which cost a 65-year-old $1,850, would cost a 50-year-old employee purchasing it under an employer-based group plan $888 on average.

According to the HIAA, employer-based activity has increased steadily over the years. By mid-1998, over 800,000 policies had

been sold across 2,185 employers. These employer-based plans may cover 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 in 1988 to a cumulative total of 345,000 in 1998.

President Clinton proposed in 1999 that the Federal Government, as the Nation's largest employer, set an example for other employers and establish a long-term care insurance program under which private group insurance would be available to Federal workers, retirees, and certain relatives, and for which the policyholder would pay the full cost of the premium. Several bills were introduced in the 106th Congress to authorize a long-term care insurance program for Federal employees, retirees, and their relatives.

Tax qualified plans and Tax Code requirements

The Internal Revenue Code (IRC), as amended by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Public Law 104–191), detailed below, sets certain standards for qualified insurance contracts issued after December 31, 1996. The standards include provisions in the 1993 National Association of Insurance Commissioners' model act and model regulations regarding reporting and disclosure of the terms and conditions of the policies and consumer protections for individuals purchasing a policy. Failure to meet these requirements may result in imposition of a Federal tax penalty on the carrier.

The IRC requires the insurance policies to meet minimum standards regarding the eligibility rules that trigger payment of benefits (e.g., the inability of a "chronically ill" individual to perform two out of six specified ADLs for at least 90 days, with qualified policies required to include five of the following six specified ADLs: eating, toileting, transferring, bathing, dressing, and continence) and the definition of services for which benefits are payable (e.g., diagnostic, preventive, therapeutic kinds of services as well as maintenance and personal care). Like payments made to policyholders from other kinds of accident and health insurance policies, long-term care insurance payments are not taxable income to the policyholder if the payments are made in accordance with the minimum eligibility and benefit rules of the IRC. However, payment of benefits to or on behalf of an individual who does not meet the eligibility rules (e.g., is unable to perform only one of the listed ADLs) might result in the benefits being taxable. (Tax-qualified policies may have eligibility requirements that are more stringent than the minimum standards in the IRC.)

Individuals who itemize their deductions may deduct part or all of their premiums for tax-qualified long-term care policies to the extent that premium payments plus their other deductible medical expenses exceed 7.5 percent of annual adjusted gross income. The amount that may be deducted depends on the policyholder's age.

HIPAA provision details

Public Law 104–191 amended the Tax Code to treat private long-term care insurance the way health insurance policies and health

care expenses are treated under the Code. These amendments 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 $190 per day per person in 2000, 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. Employer-paid premiums for qualified long-term care insurance policies are excluded from the gross income of the employee, and are, therefore, exempt from taxation. This favorable tax treatment, however, is not extended to employer-sponsored cafeteria plans or flexible spending arrangements. (Long-term care insurance premiums paid by a private 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. The age-adjusted limits on the amount of the annual premium that is deductible range in 2000 from $220 for persons age 40 or under to $2,570 for persons over age 70. These limits are indexed for inflation.
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 (regardless of whether the individual itemizes other deductions). 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. The tax treatment of nonqualified policies, which some consumers may prefer because they may be more generous, is uncertain.

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 (the Health Insurance Portability and Accountability Act of 1996, HIPAA) 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 DHHS) 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. 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 speci-

fied requirements. The exclusion is limited to payments for long-term care services not compensated for by insurance or otherwise.

Expanding coverage

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 DHHS 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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