

**Statement of
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**before the
Health Task Force
Committee on the Budget
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NOTICE

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Financing nursing home and other long-term care for people with chronic illnesses or functional disabilities is a national problem that will almost surely become more severe in coming decades. In 1986, total public and private spending for long-term care was over \$50 billion and expenditures promise to grow rapidly until at least well into the next century, in large part because of the rapid expansion in the very old population.

At the request of the Committee on the Budget, the Congressional Budget Office (CBO) is studying the issues involved in financing long-term care and analyzing numerous options for change. Although our final report has not been completed, we are pleased to share some of the preliminary results with you today.

This testimony addresses three specific topics:

- o Present and future spending for long-term care;
- o Problems with the current system for financing care and alternative approaches for change; and
- o Implications for the federal budget.

PRESENT AND FUTURE SPENDING FOR LONG-TERM CARE

Long-term care includes medical, rehabilitative, and supportive services given to chronically ill or functionally disabled persons who reside mainly

outside of hospitals--for example, nursing home care, adult day care in the community, and health and personal-care services performed at home or in domiciliaries. About two-thirds of functionally disabled people are elderly, and almost 90 percent of nursing home residents are age 65 or older.

Long-term care may be either formal or informal. Formal care denotes paid services or care received through the market, whereas informal care is free assistance given by families and friends of the disabled. Only about one-fourth of the functionally disabled elderly in the community currently receive formal care, such as nursing services or physical therapy. Clearly, if policy initiatives were to encourage substituting formal for informal care, spending for long-term care could grow considerably.

Present Spending

Table 1 shows that estimated total spending for long-term care was \$44.9 billion in 1985, with nursing home care accounting for 80 percent (\$35.8 billion) of this total. ^{1/} Payments for these formal long-term care services come almost equally from private sources (48 percent) and from federal, state, and local governments (52 percent). Medicaid pays for about 90 percent of the nursing home care funded through public sources, compared

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1. Although certain social services, such as home management and delivery of meals, are at times also included in the definition of long-term care, spending for them is not reflected in the estimates presented here. For example, about \$0.7 billion in federal payments for delivery of meals, transportation, and adult day care are excluded.

TABLE 1. ESTIMATED SPENDING FOR LONG-TERM CARE IN FISCAL YEAR 1985, BY TYPE OF SERVICE AND PAYMENT SOURCE (In billions of dollars)

Source of Payment	Nursing Home Care <u>a/</u>	Home Health Services <u>b/</u>	Total	Distribution of Total Spending by Source (In percent)
Total	35.8	9.1	44.9	100
Federal	10.9	3.5	14.4	32
Medicare	0.6	2.3	2.9	7
Medicaid	9.5	0.6	10.0	22
VA and other <u>c/</u>	0.8	0.6	1.5	3
State/Local	8.2	1.0	9.1	20
Medicaid	7.7	0.5	8.2	18
Other <u>d/</u>	0.4	0.5	0.9	2
Private	16.7	4.6	21.3	48
Out-of-Pocket	16.2	3.7	19.8	44
Other <u>e/</u>	0.6	0.9	1.5	3

SOURCE: Congressional Budget Office preliminary calculations based on estimates from the Actuarial Research Corporation.

NOTE: Details may not add to totals because of rounding.

- a. Nursing home care includes services provided in skilled nursing facilities, intermediate care facilities, combinations of skilled and intermediate nursing facilities, intermediate care facilities for the mentally retarded, and noncertified facilities providing some nursing care.
- b. The home health services included are: nursing care, speech therapy, physical therapy, occupational therapy, services provided by home health aides, and medical social services. Payments for adult day care, meals, and transportation services are excluded.
- c. Federal payments for home health services are also provided under the Older Americans Act and the Social Services Block Grant.
- d. Other state funding consists mainly of Medicaid-related payments for which there was no federal matching.
- e. Other private sources of payment include private organizations and private insurers.

with 3 percent through Medicare. In contrast, over half of publicly funded home-health care is financed through Medicare.

Almost all private payments for long-term care are made out-of-pocket by patients or their families. Currently, less than 3 percent of spending comes from private insurance.^{2/} The income-tax system subsidizes out-of-pocket expenditures by moderate and high-income individuals and families, however, through the deduction for extraordinary medical expenses.

Future Spending

In coming decades, spending for long-term care is expected to increase significantly under current law, as the result of several factors. Demographic trends will determine growth of the population at risk for long-term care, while morbidity and functional disability rates will affect the share of that population needing services. Spending for services will also depend on how quickly the prices of services rise--they have risen faster than general inflation for the last two decades--and on the "intensity" of care--that is, the real goods and services provided per unit of service--which has also been growing. Projections of spending vary substantially since, even under current law, most of these factors are subject to

2. The market for private long-term care insurance has shown signs of rapid growth between 1984 and 1987, although from a very small base. The number of policies in force has grown from 150,000 to over 400,000 during this period.

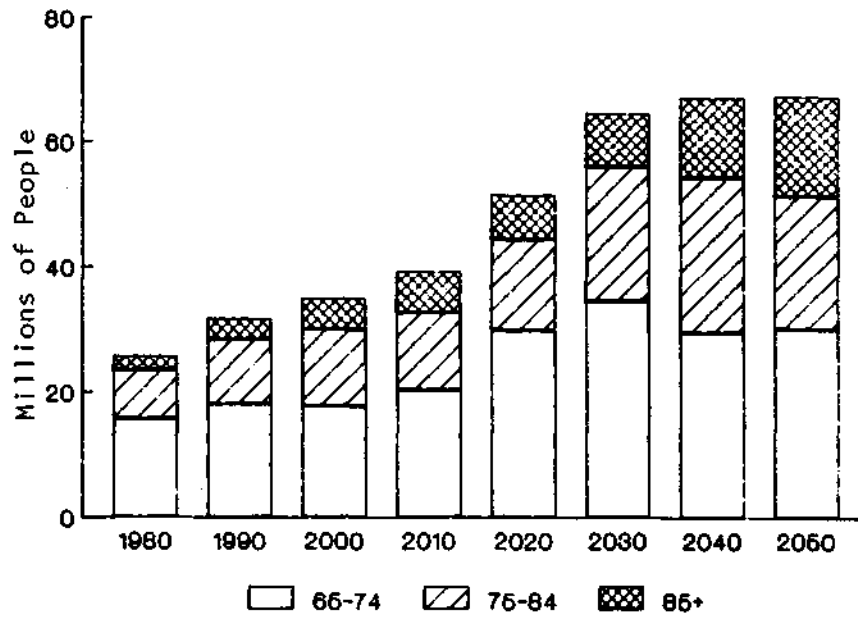
considerable uncertainty in the long run. But the dramatic growth in the number of very old people almost guarantees a rapid rise in spending.

The top panel of Figure 1 shows demographic shifts in the size and age structure of the elderly population between 1980 and 2050. The number of elderly is expected to surge upward until 2030 as the "baby boom" reaches retirement age, rising by 36 percent over 1980 levels by the turn of the century, and more than doubling by 2030. Even more important, the elderly will become ever more concentrated in the oldest group--age 85 and above--through 2050, with their numbers growing dramatically. This population is expected to increase from 1980 levels by 115 percent by 2000, 280 percent by 2030, and 605 percent by 2050. Thus, the very old will account for 13 percent of the population age 65 and older in 2030 and 24 percent in 2050, compared with only 9 percent in 1980.

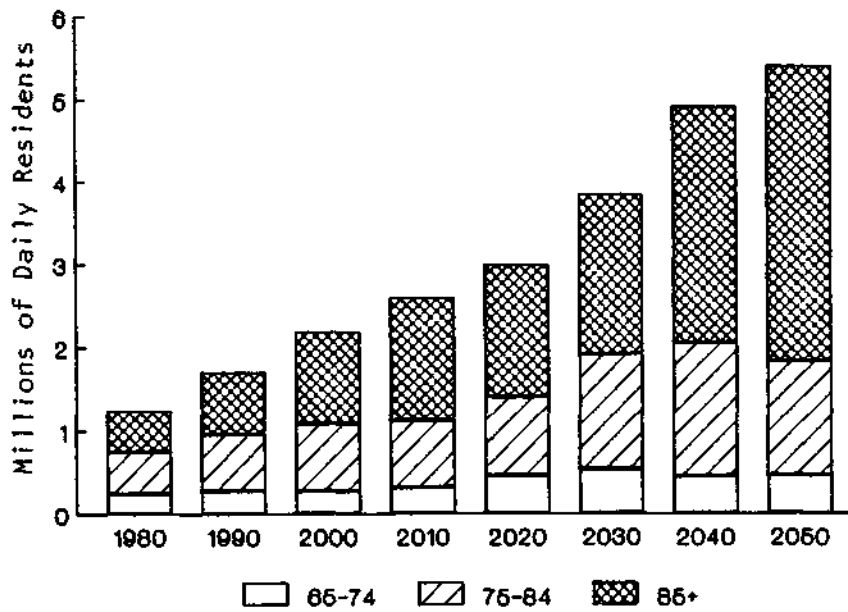
This increasing concentration in the oldest age category has important implications for the use of long-term care. People age 85 and older are almost 20 times more likely to be residents of nursing homes than those age 65 to 74. Specifically, about one of every five people in the oldest group is in a nursing home today. As shown in the bottom panel of Figure 1, if rates

Figure 1.

GROWTH OF THE ELDERLY POPULATION BY AGE GROUP, 1980-2050



PROJECTED ELDERLY IN NURSING HOMES BY AGE GROUP, 1980-2050



SOURCE: Bureau of the Census, *Projections of the Population of the United States, by Age, Sex, and Race: 1983 to 2080* (Series P-25, no. 952, May 1984) and Congressional Budget Office calculations.

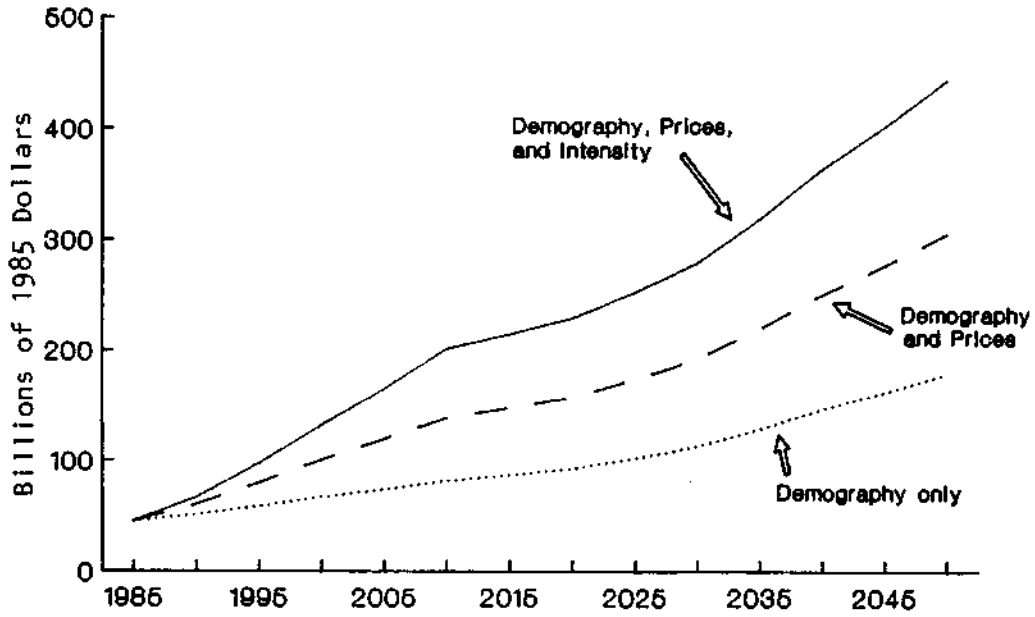
of nursing home use remain the same, about 2.2 million elderly in the year 2000 and 3.8 million in 2030 will reside in nursing homes, compared with 1.2 million in 1980. 3/

Figure 2 illustrates the possible influences of three factors--demography, medical care prices, and intensity of services--on projected spending for long-term care. Even if the demographic trends depicted in Figure 1 were the only contributor, spending for long-term care in constant 1985 dollars would rise by about 50 percent by 2000, as shown by the bottom line in the figure, provided that rates of use remained the same as now. If, in addition, the 1975-1984 differential in medical care inflation over general inflation were to continue until 1995 and then taper to zero by 2015, spending would follow the middle path--more than doubling between 1985 and 2000. Finally, if in addition to both these factors, the 1975-84 trend of increasing intensity per unit of service were to persist until 1995 and then taper to zero by 2015, spending for long-term care would almost triple by 2000. Under this last illustration, if the federal share of the total did not change, federal spending in 1985 dollars might rise from about \$14 billion to \$42 billion by the year 2000.

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3. In contrast, the nonelderly population is expected to grow much more slowly and little change is expected in the proportion of those using long-term care services. In fact, the number of nonelderly who are institutionalized has declined slightly in recent years.

Figure 2.

PROJECTED SPENDING FOR LONG-TERM CARE UNDER THREE DIFFERENT ASSUMPTIONS, 1985-2050



SOURCE: Congressional Budget Office calculations.

NOTE: See text of testimony for details.

Many other factors not illustrated in Figure 2 might also affect the growth of spending on long-term care. For example, improvements in medical knowledge and technology could substantially lower or raise expenditures for long-term care. Such improvements could reduce morbidity or, alternatively, they could extend life expectancy without commensurate reductions in morbidity. If historical trends continue toward the elderly recipient spending more days in nursing homes and having more home health visits, then expenditures would rise above the illustrated levels. Moreover, long-term social changes can also influence spending. For example, the rising proportion of women in the labor force is limiting the availability of informal care. 4/

MAJOR ISSUES AND ALTERNATIVE APPROACHES FOR THE FUTURE

Because the use and cost of long-term care are expected to grow, concern about current mechanisms of financing has heightened. Opinions about the most appropriate policy response vary dramatically, however.

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4. Beyond the factors noted here, others that will affect spending on long-term care are uncertain. The illustrations assume that the increased demand for services would be satisfied, but state regulation of the supply of nursing home beds might, in fact, slow the growth of spending. On the other hand, changes in the economic status of the elderly and the pace at which long-term care insurance develops might expand the demand for formal long-term care and, hence, raise spending.

Current Issues

Perhaps the most widespread concern about financing long-term care is that elderly people who expected to enjoy a moderate standard of living during retirement find themselves living in or near poverty when forced to pay for expensive long-term care services. ^{5/} In part, this outcome stems from a lack of knowledge. Most elderly people believe that Medicare covers nursing home care, but in fact it does so only under extremely stringent conditions that people seldom meet for more than a short period following a serious illness. Moreover, although private insurance is the usual response to the problem of services being high in cost but being needed by only a portion of the population, it has not yet developed sufficiently to support the costs of long-term care. Thus, most of the elderly have no resort but to "spend down" until they are eligible for free services under Medicaid. In such cases, spouses of elderly people who must be institutionalized often find that the high cost of care has exhausted their assets.

Geographic variation in the Medicaid program is another major concern. States have considerable flexibility, for example, in setting the income limits for eligibility. Consequently, people with incomes near poverty are eligible if they live in some states but not in others. In addition, the long-term care services that Medicaid covers vary considerably from state to state, in part because their coverage is often at the state's option.

5. The cost of residence in a nursing home averages about \$25,000 annually. For comparison, the median per capita income of elderly people is now about \$10,000; in 1982, 90 percent of the disabled elderly living in the community had family incomes of less than \$25,000.

Another issue is whether the incentives and regulations in the current system promote the most efficient provision of services. Although many experiments in alternative methods of payment are under way, some people are concerned that providers do not now have sufficient incentives to constrain the cost of care. Moreover, in their efforts to control soaring health-care costs, several states have limited the number of nursing home beds and the supply of other long-term care services. These actions keep prices paid by current users higher than they would otherwise be and prevent prospective users from obtaining services for which they would be willing to pay. 6/

Even though the incomes of the elderly are projected to rise in real terms over the coming decades, few will be able to pay out-of-pocket for long-term care without rapidly depleting their assets, potentially causing their spouses to live near or in poverty. Thus, as the elderly population expands, more and more of them--and their children and grandchildren-- will be affected by the existing system's problems, if they are not resolved.

Alternative Approaches for the Future

Since Medicaid began in 1966, the public and private sectors have shared responsibility for financing long-term care--the public sector primarily

6. Other areas of concern include the quality of care and the extent to which needs for care are not being met.

through Medicaid support for the lowest-income people; the private sector primarily through direct payments by disabled individuals and their families. As total long-term care expenditures rise, society will continue to debate how this responsibility should be divided.

The remainder of this statement discusses three alternative points of view on what the government's role should be in financing long-term care:

- o Continuing the current system with only small modifications;
- o Expanding the government's role only to the extent that it can facilitate private solutions; and
- o Having the government take primary responsibility for assuring access to long-term care.

The first view suggests that government support is at about the right level and that benefits are targeted correctly now. Individuals and families are seen as responsible for their own care, with the government involved primarily as a payer of last resort, when the family's resources have been exhausted. In this view, current problems could be resolved with little structural change in the financing and delivery of care, although minor modifications might be made to existing provisions. But many families would still face financial ruin from the costs of long-term care.

The second approach is based on the belief that the private sector is best equipped to finance long-term care, but that the government needs to facilitate development of the insurance mechanisms necessary for most of the population to avoid financial catastrophe. For example, public subsidies might speed expansion of the market for long-term care insurance. On the other hand, some groups would remain uncovered. Currently disabled people would probably not be insurable, for instance, and the elderly with low and moderate incomes might not be able to afford the premiums. In the worst case, such subsidies might be paid primarily to those who would have purchased insurance in any case, with the result that coverage would be expanded only slightly but at the expense of a substantial loss of tax revenues or an increase in government spending.

The third approach would assure universal coverage for long-term care by making it a federal responsibility, thereby expanding care for disabled individuals who do not now receive it. Moreover, the families of those needing long-term care, especially spouses of elderly disabled people, would no longer face financial ruin. On the other hand, the proportion of society's resources allocated to long-term care would rise, both because those who are currently underserved would receive more care and because some of the care that is now provided informally by families and friends would be replaced by more intensive formal services.

IMPLICATIONS FOR THE FEDERAL BUDGET

To illustrate the impact of the three different approaches to financing future long-term care, two possible options are specified under each approach.^{7/} Table 2 briefly describes these options and their impacts on total spending for long-term care and on the federal budget.

Under the first approach, two options would make only incremental changes in current public programs: one would combine federal funding for long-term care into block grants to states; the other would modify Medicaid's eligibility rules to allow spouses of institutionalized people to retain more of the couples' incomes or assets. As for the second approach in which the government facilitates private-sector solutions, one example is a federal "stop-loss" program that would pay for long-term care after a person's spending or length of stay in an institution had passed certain high thresholds. Another example is an income-related voucher or refundable tax credit that would provide a partial subsidy for individuals who purchase private long-term care insurance. The third approach is illustrated by a federal mandate of employment-based insurance coverage and by a fully public long-term care insurance program. The Appendix provides more detail about each of these examples.

If any new strategy for long-term care financing becomes law in the future, numerous decisions must be made about eligibility, types of

7. Consideration of more than a few of all the spending and tax treatment options that have been suggested for changing long-term care financing is beyond the scope of this short statement.

TABLE 2. ILLUSTRATIVE OPTIONS FOR LONG-TERM CARE (LTC): ESTIMATED IMPACTS AS IF FULLY IMPLEMENTED IN 1985

Illustrative Option ^{a/}	Target Population	Changes in Primary Financing Sources ^{b/}		Percentage Increase in Spending for LTC Services Over Current Law ^{c/}	
		Public	Private	Total	Federal
Modify Current Programs:					
- Comprehensive block grants to the states to replace current federal financing of LTC.	People with state-defined low incomes.	Any lower administrative costs used to "fund" additional services.	None.	0-1	0
- Income or asset protection for "community" spouses of institutionalized people. ^{d/}	Spouses of institutionalized people.	Higher outlays by federal and state Medicaid programs.	Less paid out-of-pocket.	0-1	1-3
Encourage Private Solutions:					
- Federal "stop-loss" program to pay for LTC after a high spending or length-of-stay threshold was passed. ^{d/}	Entire population.	Larger federal outlays for "stop-loss" and smaller federal and state outlays for Medicaid.	Less paid out-of-pocket; more paid through individual LTC insurance premiums.	5-15	20-45
- Income-related voucher or refundable tax credit for purchasing LTC insurance. ^{d/}	People age 45 and older.	Higher federal outlays or reduced federal revenues for subsidies.	Less paid out-of-pocket; more paid through individual LTC insurance premiums.	5-25	20-40
Assure Universal Coverage:					
- Federally mandated employment-based LTC insurance coverage. ^{d/}	Workers (active and retired) and spouses.	Lower federal and state outlays for Medicaid.	Less paid out-of-pocket; more paid through employer-employee LTC insurance premiums.	25-45	0-10
- Public LTC insurance program.	Entire population.	Larger federal outlays.	Much less paid out-of-pocket.	30-50	150-275

SOURCE: Congressional Budget Office.

- a. See the Appendix for more detailed descriptions of these options.
- b. The financing aspects are compared with current law and policies. Under current law, most public funding for LTC comes from the Medicaid program that involves both federal and state revenues; private sources are 97 percent out-of-pocket financing.
- c. The estimates apply to spending in a single year (1985), assuming that the options had been fully implemented by then. In some cases, the impact on the federal budget would occur through lower tax revenues, rather than higher spending. Both outcomes would raise the federal budgetary deficit unless offsetting actions were also taken.
- d. The Medicaid program would continue for people meeting its income and asset criteria who were not otherwise covered.

long-term care services to be covered, financing sources, reimbursement methods, mechanisms for assuring high quality care, and the locus of administration. This brief testimony does not address the trade-offs involved in designing a particular policy, even though each illustration had to be specific in order to estimate the amount of spending that would be involved and the impact on the federal budget.

Table 2 shows that, if these options had been fully implemented in 1985, total spending on long-term care would have remained essentially the same as under current law or increased by as much as 50 percent. The amount of increase depends mainly on whether individuals would make voluntary decisions about purchasing long-term care insurance or whether participation would be mandatory. As a final caution, bear in mind that, because total expenditures are expected to rise substantially in future decades under current law, many of these approaches would considerably expand spending for formal services.

In contrast, the impact on the federal budget would be determined mainly by the extent to which the federal government assumed responsibility for long-term care and the extent to which that responsibility was met directly, instead of requiring others to fund it. Federal outlays would be affected least by options

that would require others to pay for long-term care. For example, despite their similar impacts on the total spending for long-term care, mandating employment-based insurance coverage would not increase federal spending, although federal tax revenues might be lower. In contrast, a fully public long-term care system might increase federal outlays by as much as 275 percent.

CONCLUSION

The need for long-term care services will require a growing share of society's resources in the coming decades. Demographic trends alone will almost certainly bring about this need, and it will be exacerbated if the price of medical care and the intensity of services increase at past rates. In addressing problems with the current system for financing long-term care, two major decisions must be made. First, the total amount of national resources to use in providing long-term care must be determined. Second, the division between private and public means of financing and controlling the long-term care system must be resolved.

APPENDIX. DESCRIPTIONS OF ILLUSTRATIVE OPTIONS

This Appendix describes major features of the options shown in Table 2--for example, who would be eligible, which benefits would be available, how would they be financed, and how would the option be administered?

Comprehensive Block Grants to the States

This incremental option would use federal funding for long-term care that is now available through Medicaid, the Older Americans Act (OAA), and the Social Services Block Grant (SSBG) and combine it under one grant to the states. States would be required to use the federal funds for long-term care services for people with the lowest incomes and assets. Thus, eligibility would not change significantly from current law, except that funds now provided under the OAA and the SSBG would be more highly targeted. States would generally have discretion in determining which benefits would be covered and how the program would be administered. Federal payments in future years would be indexed to the CPI for medical services. States' contributions would have to be sufficiently large to maintain the same share of financing for long-term care as now occurs under Medicaid.

Income or Asset Protection for "Community" Spouses

This option, which is designed to address the problem that is often termed "spousal impoverishment," would change Medicaid's eligibility requirements

for a special group--married couples with one spouse residing in the community and the other residing in a nursing home. Right now, the value of a couple's liquid assets (specifically excluding their home) must fall below extremely low limits to be eligible for Medicaid. Under this variant, the "community" spouse would be allowed to keep one-half of the liquid assets, up to a maximum, say, of \$12,000. Alternatively, or in addition, the income of the spouse living in the community could be protected by raising the income-eligibility cutoff above the current Supplemental Security Income level. As under current laws, states would have some discretion in determining which benefits were provided, financing would be shared between the states and the federal government, and the states would administer the program.

Federal "Stop-Loss" Program

This option would create a federal program to pay for long-term care for individuals whose expenses had exceeded a dollar threshold--such as \$100,000--or whose total time in institutions had exceeded a specified length--for example, four years. It would encourage the development of private long-term care insurance, since the insurer's risk would be limited by the federal program's thresholds. To constrain the cost of this program, states would be required to maintain their current Medicaid efforts. The program might be administered by a federal entity, existing state Medicaid agencies, or private contractors.

Income-Related Voucher or Refundable
Tax Credit for Purchasing LTC Insurance

Under this option, the federal government would provide income-related vouchers or refundable tax credits for individuals who purchased private long-term care insurance. The size of these vouchers or tax credits might range, for example, from 50 percent of the insurance premium paid by low-income individuals to zero for those with high incomes, subject to a maximum amount. People 45 years or older could qualify, provided their insurance policies met certain minimum standards, regarding such factors as cost sharing and coverage of nursing home care and home health benefits. Because federal outlays or forgone revenues would be only partially offset by lower spending for Medicaid, the federal budgetary deficit would rise, unless offset by higher taxes or lower spending for other purposes.

Mandated Employment-Based Long-Term Care Insurance

Under this option, employers would be required to provide long-term care insurance for full-time employees and their spouses, who would share in paying the premiums. The insurance policies would have to meet minimum standards regarding factors such as covered services and amounts of benefits. Medicaid would continue to finance long-term care for people who meet its income and asset criteria and who are not otherwise covered.

Public Long-Term Care Insurance Program

The federal government would be directly responsible for financing long-term care for the entire population under this option. When fully implemented, enrollment would be mandatory for all workers and retirees 45 years of age and over. All services in certified nursing homes or by home health agencies would be covered, except care in intermediate-care facilities for the mentally retarded, which would continue to be covered under a federal-state Medicaid program. Benefits would be subject to an initial deductible and to coinsurance payments. The program could be financed in many different ways--for example, through payroll tax contributions by employers and employees, premiums, or general revenues.