

# Managed Competition with Prefunding: The Solution for Long-Term Care?

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THE CONCEPT OF MANAGED COMPETITION HAS FUNDAMENTALLY changed the health care debate, providing common ground for proponents of reform from across the political spectrum. Several variants of managed competition have been suggested (e.g., Ellwood et al. 1992), but all share a few basic tenets: a primary reliance on competition among insurance providers to promote quality care and to contain costs; regulation to prohibit insurers from denying coverage on the basis of health or employment status and to guarantee that consumers have the information necessary to make informed choices; and subsidies to make basic health insurance universally affordable. Within this broad framework, specific proposals differ on salient issues, such as how to finance subsidies and how generous to make the minimum benefits package.

Proposals for implementing managed competition have been largely silent on the subject of long-term care. The term "long-term care" encompasses a wide range of nontechnical and semiskilled assistance services for people with chronic physical or mental disabilities. These services range from help with taking a bath to full-time nursing-home care. Although most proposals include limited coverage of nonskilled nursing services for post-acute care episodes, this coverage would not

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extend to chronic long-term-care use, which accounts for the majority of long-term-care expenditures.

There are many reasons why the architects of managed competition may have chosen to avoid tackling this delicate issue. First, it is not obvious that this scheme, designed to overcome the problems of the acute care system, is appropriate for long-term care. Furthermore, long-term care is extremely expensive, and there is the risk of explosive demand growth if services are widely insured. Finally, the difficult task of reaching a consensus on health care reform would be further complicated by the political sensitivity and high cost of long-term care.

For some of these reasons and others, however, a strong argument can be made that a variant of managed competition—managed competition with prefunding—should be implemented for long-term care. There is widespread dissatisfaction with the current long-term-care delivery and financing system. These problems will be exacerbated by demographics in the next 30 to 50 years as the baby boomers age and the ratio of workers to retirees declines. If current trends continue, service delivery systems will remain fragmented, the future elderly will have insufficient savings to pay for their own long-term-care needs, and government spending on long-term care—and hence the tax burden placed on future generations—will skyrocket. I will make the case that managed competition with prefunding can provide a consumer-oriented delivery and insurance system, together with a financing mechanism that spreads the cost of long-term care equitably within and across generations.

This article is organized as follows: The next section discusses some of the current problems in the long-term-care financing and delivery system, which differ in several important respects from those of the acute care system. This discussion is followed by a description of how managed competition could be adapted to long-term care, taking these differences into account. The final section briefly explores several policy alternatives, concluding with a discussion of the feasibility of this plan in the current policy environment.

## Issues in Long-Term Care

In the United States and around the world, families continue to provide most long-term care on an uncompensated basis. Nevertheless, expenditures on formal long-term care are large and growing, totaling \$107.8

billion in 1993. Estimates based on results from the Brookings-ICF Long-Term Care Financing Model (Burwell et al. 1993) suggest that about 50 percent of costs are paid for out of pocket by the disabled and their families, 38 percent by federal and state governments through Medicaid, and the remainder by other public sources. The elderly use the majority of long-term-care services, with about 40 percent of the elderly spending time in a nursing home sometime during their lives. The cost of nursing-home care averages over \$30,000 per year, while fairly intensive home- or community-based care typically costs about half as much. Home care is less expensive for the mildly impaired because less intensive care is required, it excludes room and board charges, and it is subject to fewer regulations. It can be more expensive than nursing-home care, however, for the severely disabled who require intensive care. The duration of nursing-home stays, and hence costs, is highly skewed, with 68 percent of users staying less than three months and only 9 percent staying at least five years (Kemper, Spillman, and Murtaugh 1991).

Of the estimated five million Americans with a severe disability, 20 percent are under age 65 (Scanlon 1992). While people with disabilities of all ages share many of the same concerns about long-term care, there are important differences in their situation that public policy must address. Although the proposal here could be modified to include this younger population, my focus will be on the elderly.

To provide a context for my policy proposal, it is useful to begin with a discussion of two of the economic issues that are central to understanding the problems in the current long-term-care market: the state of the current private insurance market and the distortions created by the Medicaid system. Since a number of proposals have advocated some form of social insurance to address these problems, the pros and cons of social insurance are also discussed.

### *The Private Insurance Market*

One major difference between acute- and long-term care is that very little private long-term-care insurance is in force. The market was virtually nonexistent before the early 1980s, and although growing rapidly, today it covers fewer than 5 percent of the elderly. The absence of a better developed insurance market is somewhat surprising considering that long-term care is a common catastrophic expense. Observers dis-

agree on the potential for growth of the private insurance market if it is left to develop on its own. Because managed competition depends on a strong private market, it is important to understand the impediments to more rapid growth.

Affordability is one of the main concerns about long-term-care insurance. Annual premiums average \$1,500 for policies purchased by the elderly. Those over age 75 are least likely to find insurance affordable because they face higher premiums and, on average, have lower income and wealth. The high premiums are due to the significant probability of needing care that rises sharply with age (about 4 percent of people between 64 and 69 have chronic disabilities, whereas about 60 percent of people 85 and above are similarly disabled), adverse selection, and high marketing costs. Estimates of the fraction of the elderly who can afford long-term-care insurance differ widely, depending on how affordability is measured. If the calculation includes income, liquid assets, and home equity, insurance appears to be affordable to many more people than if income alone is considered. Cohen, Kumar, and Wallack (1993) emphasize the difficulty of establishing an objective definition of affordability. Statistics aside, disagreements about affordability often come down to a fundamental difference in ethical perspective. Some advocate counseling the lower- and perhaps middle-income elderly to rely on Medicaid rather than to buy insurance because these groups have little need for the estate protection provided by insurance. Others view providing for one's own long-term-care expenses as a social responsibility and hence recommend purchase by a broader group.

The relatively unfavorable tax treatment of long-term-care insurance is another deterrent to purchase. Under current law, long-term-care insurance premiums are paid with after-tax dollars, and benefits are in principle taxable. This sharply contrasts with the favorable tax treatment of acute care insurance, which has contributed to the rapid growth of that market. The current tax treatment is especially unfavorable to the young and middle-aged, for whom premium rates can be as low as several hundred dollars a year. Because risk increases sharply with age, premiums collected in early years function primarily as savings to pay for expected costs later on. Because saving through a long-term-care insurance policy is tax disadvantaged relative to other forms of saving like pensions and IRAs, under current tax policy long-term-care insurance is an inefficient way to save for long-term-care expenses. To partially circumvent this problem, some whole life insurance policies now

offer optional riders that allow later conversion to long-term-care insurance. This appears to be a promising development that addresses both the tax and affordability problems. Recently several bills have been introduced in Congress that propose tax treatment for long-term-care insurance similar to that for accident and health insurance (e.g., H.R. 3103 by Representative Archer and S. 1698 by Senator Daschle). Interestingly, neither of these proposals addresses the problem that saving via a long-term-care policy is tax disadvantaged relative to pensions and IRAs. It is also noteworthy that past legislative attempts to introduce similar changes in the tax code have failed.

Several other factors also have contributed to the slow growth of this market. As I will discuss below, Medicaid, by providing a widely available public safety net for long-term care, creates a strong disincentive for the purchase of private insurance (Pauly 1990). Concerns about product quality, including overly aggressive sales tactics, insufficient information about coverage, and pricing policies that encourage high lapse rates and forfeiture as policyholders age, have led some consumer advocates to counsel the elderly against purchase. Insurers counter that product quality has improved markedly and that this trend will continue as established insurance companies continue to enter the business. Still, many advocates for the elderly remain skeptical of the available products and of the potential for improvement. Finally, long-term-care insurance involves hard-to-quantify risks that may make insurers reluctant to issue more open-ended policies that would be more attractive to potential purchasers (Cutler 1993).

### *The Role of Medicaid*

Medicaid expenditures on long-term care have grown rapidly in absolute terms and as a fraction of total Medicaid expenditures. In 1989 long-term care accounted for over 40 percent of Medicaid payments, but served fewer than 7 percent of Medicaid recipients (Little 1992). Despite federal assistance, which covers between 50 and 80 percent of costs, depending on state per capita income, Medicaid represents one of the largest and most rapidly growing budget items for most states. In order to qualify for Medicaid, single applicants must demonstrate that they have less than \$2,000 in liquid assets and that income net of medical expenses satisfies the SSI eligibility criteria. Apart from a \$30

per month personal needs allowance, any other income (for instance, from a pension or Social Security) goes to offset Medicaid's expenses. For those whose income or assets were too high to qualify for assistance when they first entered a nursing home, many states allow nursing-home residents to "spend down" to Medicaid, whereby the government picks up payments after private savings fall below the asset limit.

A number of distortions in the long-term-care delivery system can be attributed to governmental efforts to control Medicaid costs. Until recently, very little home care was provided under Medicaid, and even today many states offer assistance primarily for nursing-home care. This institutional bias has been criticized for compelling entrance to a nursing home of people who would be better off staying in their own homes. As well as reducing the quality of life, this policy is wasteful of public funds when home care can be provided less expensively. While most policy makers agree that the institutional bias is a serious problem, the difficulty is to design a system in which home care is more available but not overused. While most people with other alternatives avoid using nursing homes, subsidized home- or community-based care is likely to be elected by a much larger fraction of the eligible population, making costs difficult to control.

Another widely used cost-control policy has been to restrict the number of licensed nursing-home beds. The predictable result has been high nursing-home occupancy rates and long waiting lists in some areas. In the absence of competition to attract residents, nursing homes have had little incentive to improve services or to innovate. As the population ages and political pressure forces these regulations to be relaxed, some predict that the quality of nursing homes will improve markedly, with an accompanying increase in the demand for their services.

A further concern with Medicaid is equity: similarly disabled people living in different locations often receive very unequal treatment under Medicaid. In particular, the fraction of long-term care paid for by Medicaid varies widely across states, ranging from \$294 in New York per state resident to \$25 in Utah, and averaging \$102 (Burwell et al. 1993). In some areas professional Medicaid planners routinely instruct clients on how to transfer assets in order to meet the poverty standard. Although many of these practices are of questionable legality, states often lack the resources or motivation to stop them. Thus, in high usage states, Medicaid effectively functions as an inefficient form of social insurance, leaving residents little incentive to buy private insurance.

### *The Social Insurance Debate*

Social insurance differs from welfare in that eligibility is based on categorical status, such as age or disability. In practice most social insurance systems retain a significant element of means testing, for instance by making benefits taxable to higher-income recipients or by income-testing copayments or deductibles. Nevertheless, the stigma attached to welfare programs is absent. Two social insurance programs—Social Security and Medicare—have markedly improved the economic status of the elderly in the last half century. Advocates of social insurance for long-term care see it as completing this system of basic financial protections.

Apart from logistical considerations, such as how to determine who is eligible for services, which agencies would administer the program, which services and providers qualify for reimbursement, and so forth, opponents of social insurance have several fundamental concerns. In a period of already strained government budgets, the most obvious is cost. Most proposals call for financing social insurance primarily with a payroll tax like that for Social Security and Medicare. Under such a “pay-as-you go” system, expenses for the current elderly would be covered primarily by taxes on current workers, who in turn would receive benefits financed by the next generation of workers. Estimates from the Brookings–ICF long-term-care model suggest that for a comprehensive social insurance program, public expenditures would have totaled \$58.9 billion in 1993 and would grow to \$118.8 billion by the year 2020 (in 1992 dollars). Among other things, these estimates are sensitive to uncertain assumptions about the response of demand for services to widespread insurance coverage. Relative to the private sector, political and legal constraints make it difficult for the government to raise prices in response to increases in demand. Thus, unless strict budget caps could be imposed and enforced, expenditures could well exceed initial estimates.

Many are also skeptical about the ability of a government bureaucracy to adapt to changing circumstances or to administer the program efficiently. Service needs are likely to change over time as technology, preferences, and health status change. Because long-term care involves a very wide range of personal services, and because most users can evaluate quality for themselves, flexibility in choosing and paying providers is critical. Others oppose social insurance for its distributional and incen-

tive effects. Families who care for their relatives would be taxed to pay for those who do not. As with any new entitlement program, it would be a windfall gain for the first generation of beneficiaries, who would have had little time to pay into the system. As I will discuss below, it would continue the sharp trend in the federal budget of transferring resources from young to old. Furthermore, by covering another major expense of aging, public long-term-care insurance would increase the disincentive from Social Security and Medicare to save for retirement, causing the already low U.S. savings rate to fall further.

### Managed Competition with Prefunding

In this section a case is made that managed competition with prefunding has the potential to accomplish the primary goal of social insurance—to provide universal insurance against catastrophic long-term-care costs—while avoiding many of the objections that have been raised. In particular, for a given level of insurance protection, it would involve a more limited role for government, more room for experimentation with new delivery models, and less wealth redistribution within and across generations than would social insurance.

#### *Financing via Prefunding*

Since the question of how society will finance long-term care in the coming decades will be central no matter what form the long-term-care delivery system ultimately takes, I will address it first. Because of the catastrophic nature of long-term-care expenses, properly structured universal insurance coverage would increase overall welfare. A significant fraction of the current elderly, however, cannot afford fairly priced public or private insurance. If current saving trends continue, the next generation of elderly will find themselves in a similar position. Thus, the problem of inadequate funding for long-term care can be seen as part of the larger problem of an inadequate savings rate.

The proposed financing scheme has two main components: First, people would have to save over their working lives to cover a portion of the expected cost of the minimum required level of insurance. Second, people would be required to begin purchasing long-term-care insurance around the time of retirement (e.g., at age 65) from one of a number of competing insurers.



Although requiring insurance to be purchased starting at a younger age might appear to be a less complicated alternative, the proposed two-step approach has the advantage of greater flexibility. From a purely economic perspective, requiring an insurance purchase at a younger age is actually a form of mandatory prefunding. The risk to the young of needing long-term care is small, so most premiums paid in early years would build up as savings inside the insurance fund. The main problem with buying insurance early is that it necessitates an extremely long-term contract between insurer and insured. In contrast, mandatory prefunding does not require specifying exactly what services will be covered in the future, nor what entity will ultimately provide the coverage. Maintaining this flexibility is extremely important because of the many uncertainties about the future (demand, technology, the ideal delivery model, among others). Prefunding allows time for the private market to expand or for a new public insurance program to be phased in. A potential advantage of buying long-term-care insurance at a younger age is that it reduces the adverse selection problem because it is harder to anticipate the need for care. However, discussions with insurers suggest that for people purchasing insurance in their early to mid-sixties, adverse selection is not a severe problem.

A critical issue is how to structure the savings requirement. Some would argue that from both a political and economic perspective, there is no distinction between mandated savings and a tax. A more optimistic view, however, is that a well-designed mandate would be met with less resistance than a traditional tax, particularly if the public were convinced of the need for a new financial arrangement. The savings mandate differs from a standard tax in that the money set aside remains attached to the individual, and that any excess accumulation reverts to the saver rather than to the government. Allowing the retention of excess funds encourages more careful investment choices and underscores that the savings are private. It also provides an important incentive to shop for the least expensive insurance plan that meets minimum standards and provides an acceptable level of service. To maximize flexibility, the earmarked savings could be invested in any approved investment vehicle such as savings accounts, approved mutual funds, and life insurance policies. The mandate could be designed to be much less of a burden on individuals, although more of a risk for the government, by also permitting savings in the form of home equity that could later be accessed through mechanisms like reverse mortgages. The target

savings rate should be set well below 100 percent of projected long-term-care costs because it would reduce the burden of the mandate and because most older people will have other resources to cover a portion of premiums.

In this prefunded system, progressivity would be maintained by limiting the required amount of savings each year to a graduated fraction of income. At the same time, a total savings cap would protect higher-income households from being forced to save more than necessary. As a consequence of the graduated annual savings rate, people with low average lifetime incomes will have accumulated insufficient savings when it comes time to buy insurance. For this low-wealth group, the government would pay the difference between the amount saved and the cost of the policy (also taking into account current income and other wealth), as well as perhaps later subsidizing deductibles and copayments. Because annual household incomes fluctuate widely, savings accumulated according to these rules provide a more equitable basis for determining subsidy levels than does income measured at a point in time.

One drawback of this subsidization policy is that it creates an incentive for people to put their mandated savings into high-risk investments, as the downside is limited. This suggests the need for some restrictions on investment choices, like those established for other government insurance programs, in order to discourage excessive risk-taking. For instance, ERISA restricts the investments of insured pension funds, and bank regulatory agencies restrict the investments of insured commercial banks. Conversely, some people would save less than anticipated owing to extremely conservative investment strategies. Although variation in investment choices will cause some dispersion in total savings across households, the current problem of grossly inadequate savings would be overcome by this prefunding mechanism.

How to adjust for the possibility of early death, marital and employment status, and other demographic factors also must be considered. In the case of early death, one possibility is to allow any accumulated savings to become part of the deceased's estate, in which case the money should be taxed similarly to other bequests. An alternative would be to transfer some portion of these savings into an insurance pool that would be divided among insurance providers, for instance in proportion to the number of enrollees. This would lower the average cost of insurance and hence the required prefunding rate.

As with all insurance products, long-term-care insurance is more valuable for some easily identified demographic groups than for others. In particular, women and the unmarried are more likely eventually to require these services. In general it is not desirable to condition premiums on sex or other characteristics that are not a source of moral hazard because such discrimination reduces the extent to which insurance serves to spread risk. Whether to condition the savings requirement on marital status, which some would argue contains an element of moral hazard, is an issue that would have to be resolved politically. A related question is whether to link required savings to individual or to household income. In keeping with the trend toward treating income as household property, a savings requirement based on household income and the number of adult members or total family size seems sensible. A simple splitting rule could then divide these savings in the event of divorce.

Any estimate of the required dollar savings rate is sensitive to a number of assumptions including (a) the age at which savings begins, (b) the lifetime cost of long-term care, (c) the real return on investments, and (d) the real rate of inflation for long-term-care costs. In practice, target savings rates would need to be periodically revised as new information about these factors became available. Appendix 1 illustrates the required savings rate under a variety of assumptions centered around current cost trends. This analysis suggests that people on average would need to save from \$40 to \$80 a month over their working years in order to cover 80 percent of their expected long-term-care expenses. Of course the longer the savings period, the lower the required annual payment. For instance, the estimated savings rate for prefunding starting at age 55 is almost four times that for prefunding starting at age 35. The present time represents a window of opportunity to begin such a program because most baby boomers still have over 20 working years to accumulate savings.

### *Managed Competition for Long-Term Care*

Assuming that this prefunding plan is adopted, under a system of managed competition the elderly would be required to purchase long-term-care insurance from one of a number of competing providers, making coverage for low-wealth individuals affordable through public subsidy.

A crucial feature of managed competition is that insurers are prohibited from screening for preexisting conditions and are compelled to accept all applicants. Regulations would also be necessary to determine the minimum coverage level, discourage risk selection, and establish minimum quality standards. Regional purchasing cooperatives would negotiate with providers, furnish performance and cost information to consumers, and have a role in determining provider eligibility.

The reasons for adopting managed competition for long-term care in many ways parallel those for acute care. Because of the public commitment to provide a minimum level of services to all who need them, it is appropriate for everyone to be insured up to some basic level. A regulated private insurance approach emphasizes individual choice and responsibility, and relies primarily on market incentives to control costs and to maintain flexibility. By integrating the poor into the mainstream system through a premium voucher, the incidence of discriminatory treatment is likely to be reduced. Finally, if some form of managed competition is eventually adopted for acute care, setting up a parallel or integrated system for long-term care would facilitate coordination and discourage cost shifting.

Translating this conceptual framework into a workable proposal clearly would require a very detailed analysis of each component of the system: administrative, jurisdictional, legal, and financial. Here the discussion is restricted to just a few of the major design issues.

*Defining the Minimum Benefit.* Conceptually, the minimum benefit should only include coverage for services that, via the political process, society determines to be an entitlement. Although this definition is likely to evolve over time, the implicit standard in the current welfare system can serve as a starting point for a new system. At present, the severely disabled effectively are entitled to a level of institutional care that meets quality standards set by the states. This suggests including a significant portion of the expected cost of a similar level of institutional care in the minimum benefit.

Those who believe that most institutional care could be replaced with home- and community-based care may oppose universal insurance for institutional care, arguing that it will perpetuate the institutional bias in the present system. However, by setting the insured portion of institutional expenses below 100 percent of expected costs (e.g., at 70 to 80 percent), copayments and deductibles can be used to discourage excessive use. The bias can be further reduced by excluding the room

and board component of institutional costs from coverage, and by insuring some home care. More convincingly, studies to date have found little evidence that increased access to home- and community-based care reduces the cost of institutional care. Until a viable substitute is agreed upon, it is appropriate to insure against these high expected costs.

What should be included in the minimum benefit aside from catastrophic institutional coverage? Rather than enumerating a list of covered services in legislation or regulation, a less complicated and more flexible approach is to stipulate a dollar value of the minimum annual premium and then let providers compete (within regulatory limits) to design packages of services to offer in exchange for that premium. For instance, the minimum premium for noninstitutional insurance could be set at \$300 per year starting at age 65. In exchange for the premium, one insurer might offer a managed care plan under which the insured would work with a case manager to determine a schedule of appropriate home care services up to a specified coverage limit. For members of retirement communities that provide long-term-care services internally (e.g., continuing care retirement communities), the benefits could be used to offset a portion of the organization's expenses.

Other insurance companies are likely to offer pure indemnity payment plans. Under such a plan, any noninstitutionalized insured satisfying the disability criterion, as verified by the insurance company or by a certified independent third party, would receive a fixed monthly payment to spend or save without restriction. This would be especially attractive to those planning to rely on family-provided care. Given the wide array of possible private arrangements, policies that stipulate a cash indemnity payment for a given level of disability may prove to be the easiest to design and administer. Of course recipients could elect to use the indemnity payments to enroll in a managed care plan, but these arrangements need not be made through the insurer or purchasing cooperative. Interestingly, the fastest growing private insurance products currently in the market are based on such a cash indemnity model.

In deciding how much to restrict the variation across qualifying policies, the basic tradeoff is between choice and simplicity. Limiting variation makes it easier for consumers to understand and compare benefits and reduces the opportunity for risk selection and fraud by insurers. There are some areas in which standardization is clearly called for. As I mentioned above, everyone should have a minimum level of catastrophic nursing-home coverage. Secondly, the maximum disability cri-

teria that trigger service eligibility should be set by regulation, either at the state or national level. (The most common criterion to determine disability status is by limitations in activities of daily living [ADLs]). The reason to mandate the maximum disability criterion for the minimum benefits package is to ensure that those with severe disabilities receive the services they are entitled to. However, insurers could be allowed to compete for customers by offering policies with a lower trigger than the regulatory maximum (e.g., two ADLs instead of three). A uniform policy should also govern who determines eligibility for benefits (e.g., doctors or case managers) and who they work for (e.g., the insurer, the purchasing cooperative, or the state). A gray area is whether restrictions need to be placed on deductibles and copayments. For instance, it would be inappropriate for an individual without substantial savings to buy a policy with a \$30,000 deductible, but such purchases could be prevented with counseling and information rather than by placing a blanket prohibition on high deductibles. In general there is no easy formula; the costs and benefits of any proposed restriction must be weighed and reassessed over time.

*Preexisting Conditions and Adverse Selection.* A central feature of managed competition is that it prohibits insurers from excluding people with preexisting conditions. Although such a rule prevents overt discrimination, insurers still have an incentive to offer policies that discourage certain enrollees, for instance by offering low-quality care for expensive conditions. Designing a regulatory structure to mitigate this problem is one of the major challenges for managed competition. The proposed solution in the context of acute care is to institute a system of "health risk adjusters," whereby providers with relatively healthy enrollees make transfer payments to companies with relatively sick enrollees. Exactly how risk adjusters for acute care should be structured remains an unresolved issue. Some believe that conditioning on just a few demographic variables (e.g., age, sex, major chronic conditions) would be sufficient to avoid most selection problems, while others envision a more complex transfer scheme. If these adjusters are set correctly, providers that specialize in providing efficient and high-quality service for expensive conditions are rewarded because they receive a transfer payment based on the average cost of treating this condition, even if their own costs are lower. For long-term care, risk adjusters would establish transfers between insurers based on the fraction of disabled insureds collecting benefits and the severity of their disabilities. Much effort has

already been devoted to quantifying the severity of disability in order to allocate public benefits. These classification systems, together with predictive demographic information like age and sex, would be a natural starting point for a risk-adjustment system for long-term care. The transfer formula would then be updated periodically as new information became available. The task of establishing and administering these transfers would be performed by a national or regional board, as I will discuss below.

The issue of how to maintain the ability to switch between insurers in the presence of preexisting conditions is central for long-term care because of the high persistence of disability. Additional complications also arise owing to the prefunding implicit in long-term-care premium payments (as opposed to acute care premiums, which are based on expected annual expenses). Because of the prefunding implicit in premium payments, a portion of past premiums and accumulated interest must follow anyone choosing to switch providers. The example of whole life insurance suggests that this amount can be determined actuarially. In the case of whole life, each premium payment is divided into two components. The first is the term premium—the expected insurance costs incurred in the current year based on the age and other characteristics of the insured. The second component augments the “cash value” of the policy and serves as partial prepayment of future term premiums. These excess funds are invested by the insurance company in market assets. Long-term-care premiums can similarly be divided into two components, and the cash value at the time of a switch would be available for transfer to the new insurer. Because the risk adjustment system would compensate for the level of disability year by year, the transfer could be made independent of the disability status of the insured.

Although dissatisfied consumers must be able to switch between insurers for competition to be meaningful, it should be recognized that too much flexibility would reduce the extent to which people could effectively insure by exacerbating adverse selection problems. For instance, in a managed care setting insurance opportunities are enhanced by the case manager’s ability to allocate resources to those who need them most. People with more severe disabilities receive services financed in part by those with less severe disabilities, even within the same broad category of disability (e.g., three or more ADLs). If switching insurers were costless, anyone with a currently low level of disability would have a strong incentive to switch to an insurer whose benefits

depended only on a broad disability category (e.g., one who makes cash indemnity payments). This would increase the cost of managed care plans because they would attract the most severely disabled members of each disability class. One way to discourage this type of strategic switching is to levy a financial penalty on those who switch insurers too often or without a legitimate grievance. Another is to have limited open enrollment periods.

*Solvency and the Government as Insurer of Last Resort.* Because of the long-term nature of these contracts, special provisions would be needed to ensure continuity of coverage in the event of an insurer bankruptcy. Two types of insolvency risk could arise under managed competition: (a) firm-specific risk caused by factors like poor management practices or fraud; and (b) systemic risk caused by industrywide errors such as underestimating the growth of insurance-induced demand for services or increases in life expectancy.

Consumers can be protected against nonsystemic failures much as they are for most other types of insurance: by solvency regulation and guarantee funds. Standard solvency regulations include capital requirements to provide insurers with a buffer against unexpected costs and restrictions on investment activities to curtail risk taking. For insurance companies that go bankrupt despite these precautions, state guarantee funds, financed by the remaining firms in the industry, protect policyholders by paying claims against insolvent firms. In the case of long-term-care insurance, the claim would include the cash value of the insurance policy as well as current expenses, thereby providing the replacement insurer with an appropriate level of reserves. Because in many instances bankruptcy can be expected to affect the insurer but not the service provider (e.g., the nursing home or home care agency), disruption to the insured is likely to be minimal.

Unlike firm-specific failures that, in most instances, could be absorbed by the capital of the industry, large and unanticipated industrywide losses would likely bankrupt a fully private guarantee fund. Such a systemwide failure is extremely unlikely at present because private insurance policies are guaranteed renewable, but there is no restriction on rate increases, leaving companies with limited exposure. Under the proposed system, however, if costs were to rise sharply it would be politically infeasible to revoke coverage of those who could no longer afford a basic policy. As in the savings and loan crisis, the government would be forced to step in, subsidize the system, and modify the rules in order to improve the control of costs.



*Moral Hazard and Cost Containment.* The rapid growth in acute care expenditures has been attributed to factors that presently do not apply to long-term care: tax subsidies that encourage overinsurance; a fee-for-service payment mechanism that encourages the provision of unnecessary services; Medigap insurance that gives Medicare recipients first-dollar insurance coverage; and new high-cost technologies. In contrast, long-term-care costs are increasing primarily because the population is aging and living longer and because the price of these labor-intensive services is increasing faster than the overall rate of inflation. The institutional bias created by Medicaid may also lead to cost increases by inducing more people to enter nursing homes.

If long-term care becomes widely insured, as it would under managed competition, extreme care must be taken to avoid the problems that have led to the explosion of acute care costs. The foremost concern is that widespread insurance will induce a large increase in the demand for services, particularly if noninstitutional services are covered. Because so much care currently is provided informally by the family, there is the potential for high growth in the demand insured services. It should be emphasized, however, that some increase in the use of supplemental market services is likely to improve the general welfare, as the time currently spent by family caregivers also is a valuable resource.

The moral hazard problem can be mitigated to some extent by limiting tax deductibility, by setting appropriate copayments and deductibles, and by instituting a strong gatekeeping mechanism. Limiting tax deductibility and allowing the retention of excess savings implies that consumers face the marginal cost of the policy chosen. Because copayments and deductibles would be paid out of personal funds rather than out of earmarked savings, companies could adjust these charges to discourage excessive use. In fact, one advantage of managed competition over a more centralized approach is that insurance companies have an incentive to experiment with various pricing structures in order to reduce moral hazard. Having a strong gatekeeper is important because of the difficulty of objectively measuring disability, and hence the potential for abuse. If, for instance, the insurers are allowed to select the doctors who can certify disability (presumably with some mechanism for appeal), service usage will be lower than if people have the right to obtain certification from their personal physician.

In any system where the minimum benefit is politically determined, another factor that could lead to rapid cost growth is the tendency to expand coverage, either by lowering the disability standard to include a

larger population or by increasing the scope of insured services. This "disability creep" has resulted in extremely high rates of disability in countries like the Netherlands that offer very generous benefits, and it is credited with a growing rate of disability in the United States as well. While this is certainly a risk under managed competition, the fact that individuals would have to pay the marginal cost of their own insurance would likely create a greater constituency for cost containment than under a publicly funded program.

*Administration and Regulation.* Several models have been proposed for the institutional structure of the national board and purchasing cooperatives in the context of acute care. Typically, national board members would be selected by the President in consultation with the Secretary of the Department of Health and Human Services. The national board would determine the minimum benefits package, set minimum quality standards, and oversee the system. Every state would have one or several noncompeting purchasing cooperatives, where people would go to obtain information about available policies and consumer satisfaction statistics, to enroll for insurance, and to seek adjudication when disputes arise. A similar structure seems appropriate for long-term care, with the board as the logical entity to determine the maximum disability triggers as well.

As for acute care, opinions are likely to differ on the optimal organizational structure. Among the central issues are the following:

1. whether the board should be composed entirely of consumer advocates or whether it should represent a more diverse group including also providers and insurers
2. the division of responsibility and decision-making authority between state and federal governments
3. governance of the purchasing cooperatives (e.g., are they state agencies or private, nonprofit organizations? is the management elected or appointed?)

Because there is little experience to guide these decisions, it would be prudent to allow for some variation across states in the details of organizational structure.

*Integration with the Acute Care System.* In the event that managed competition is adopted for both acute and long-term care, the question arises of how much to integrate the two systems. In a fully integrated

system, insurance providers could specialize in either acute or long-term care, in which case people would contract with two separate organizations. Other providers might choose to offer both types of services under the same umbrella (e.g., Kaiser might run a system of extended care facilities in coordination with their HMOs). Alternatively, long-term care could be set up with a separate national board, a separate system of purchasing cooperatives, and so forth.

Integration of the acute- and long-term-care system has both advantages and disadvantages. Arguments in favor of integration include administrative efficiency, the convenience of one-stop shopping, the potential for more continuity of care, and a reduction in cost-shifting between the two systems that could reduce total public and private costs by encouraging a more efficient use of resources. For instance, coordination could reduce the number of unnecessary hospitalizations of nursing-home residents. At the same time there are potential drawbacks to combining the two systems. Long-term care is distinct from medical care, and many view the hierarchical medical model as inappropriate for long-term care. While the medical model need not dominate in an integrated system, there is concern that it might, resulting in mismanagement of long-term-care resources. Integration would also increase the risk that the financing of the two systems would be combined and the benefits of prefunding lost. Ideally, of course, the systems would be sufficiently integrated to capture the benefits of coordination while maintaining enough separation to avoid these potential problems. Since both systems are changing rapidly, the degree to which integration is desirable and feasible should become more apparent over time.

*Managing the Transition.* Planning a smooth transition from the current system of Medicaid and out-of-pocket payments to prefunded managed competition presents some serious challenges. Issues include how fast to phase in benefits, how to avoid making any cohort worse off than under the status quo, and the effect on the current elderly. Keep in mind that, despite these complexities, the potential for net social gain exists for two basic reasons: improved insurance arrangements and a more equitable sharing of costs between generations. If, however, full insurance is phased in too quickly or is heavily subsidized, the objective of reducing the financial burden on future generations will not be achievable.

A complete analysis of the possible transition paths requires detailed data on the wealth distribution within each cohort, projections of how

this distribution will evolve over time, the age distribution of long-term-care expenses, the projected size of each cohort, and so forth. At a more conceptual level, it is useful to think of the population as falling into three broad groups:

1. those under 40, who have time to accumulate sufficient savings to participate in a fully phased-in system
2. the middle-aged, for whom mandatory prefunding could only cover a fraction of expenses
3. the current elderly

Members of the youngest group have ample time for savings to accumulate and for insurance and provider markets to mature. A complicating factor, however, is that in addition to saving for their own future insurance purchases, this group must also pay a portion of the taxes used to fund the residual welfare system. Notice that these residual welfare payments would be lower than under the status quo because a large portion of the middle-aged group will have had time to accumulate substantial savings. The total financial obligation of the youngest group can be effectively limited by lowering their mandated savings rate. With a lower mandated rate, this group would also have to be partially subsidized by future generations, but to a much lesser extent than in the absence of some prefunding. By phasing in a fully prefunded system over a relatively long time period, the impact on the transitional generations can be substantially reduced.

The currently middle-aged would also be required to prefund part of their long-term-care expenses, with the mandated rate adjusted to take into account the cost of the residual welfare system. For any reasonable rate of mandated savings, the older segment of this group could not accumulate enough to pay for their expected lifetime insurance costs. Because of this, it would be sensible to increase the minimum benefit package gradually over the first two decades of the program, so that each cohort is only required to purchase a policy commensurate with its average mandated savings. To encourage the voluntary purchase of additional insurance coverage by the middle class during the phase-in, so-called partnership policies could be adopted nationally, or insurance purchases could be otherwise subsidized. Partnership policies allow private long-term-care insurance policyholders to retain higher asset levels if they exhaust their private coverage and switch to Medicaid. Hence

Medicaid functions much like back-end social insurance (Rivlin and Wiener 1988, 214). Currently New York, Connecticut, California, and Indiana have adopted this type of policy, which was pioneered by the Robert Wood Johnson Foundation.

By design this plan transfers fewer additional resources to the current elderly than proponents of social insurance might advocate. Nevertheless, in the transition the elderly would benefit from reform of the residual welfare system, product developments in the private insurance market, the introduction of partnership policies, improved service delivery systems, and the availability of more information.

### Policy Alternatives and Conclusion

The failure of the Clinton administration's proposal for implementing managed competition and the current political climate may cause the solution offered here to appear out of date. A more optimistic interpretation of events, however, is that a modest version of managed competition may still be viable. This is evidenced by the strong bipartisan support for bills like (H.R. 3103), which mandates that private insurers cover persons with preexisting conditions and who have lost or changed jobs. It remains to be seen whether this type of mandate, without any supporting mechanism to reduce the resulting adverse selection problems, is workable. Nevertheless, it suggests the possibility of a major political intervention in the health care system along the lines of managed competition. Furthermore, the financial instability of the Medicaid and Medicare systems will eventually necessitate fundamental changes in long-term-care policy, so it is useful to consider the directions that such reform could ideally take.

One way to evaluate my proposal for a mandatory, universal prefunded insurance system is to compare it with a set of alternatives along the dimensions of prefunding/no prefunding and mandatory/voluntary. I conclude with a discussion of these alternatives.

#### *Non-Prefunded Alternatives*

An alternative to prefunding is to rely on higher future payroll, value-added, or other taxes on the working population to pay for the public portion of long-term-care financing. This is the status quo for financing

Medicaid and Medicare. To shift more of the burden to the elderly, in principle additional funds could be provided by increased taxes on Social Security or increases in estate taxes. Proponents of such a pay-as-you-go policy argue that it spreads the financial burden widely over the population and can be tailored to meet policy objectives like progressivity. Private expenditures for services and/or insurance would be financed out of current income and savings.

There are a number of serious drawbacks to pay-as-you-go funding relative to a prefunded system. Most notable are its adverse distributional consequences. Pay-as-you-go financing would continue the trend of transferring wealth from younger workers, many of whom are relatively poor and have children to support, to older retirees. Spending on the elderly grew from 15.9 percent of federal outlays in 1965 to 28.3 percent in 1990, and was projected to reach 33.9 percent by 1995 (U.S. House of Representatives 1992). Although reducing the poverty rate among the elderly has been a major achievement of social policy in the postwar period, recent gains have been largely at the expense of future generations. Just taking into account the expected future costs and benefits of current government programs, it is estimated that a person born today will pay about twice as much in taxes net of benefits than people alive currently (Kotlikoff 1992). This transfer from the poorer young to the wealthier old would be exacerbated by pay-as-you-go financing of long-term care. The pay-as-you-go system also contains intragenerational inequities because thrifty citizens and their children effectively pay for the long-term-care expenses of their more profligate neighbors who choose not to save or who manage to transfer assets. These intragenerational transfers are largely avoided with prefunding.

How much would pay-as-you-go financing of long-term care add to the redistribution of wealth across generations? The number of people over age 65 per 100 people aged 18 to 64 is expected to double from 20 in 1990 to 40 in 2050, and the number of people over age 85 is expected to quadruple (U.S. Senate 1991, 18). Thus there will be roughly twice as many retired people to support per person of working age. To get a rough idea of the dollar cost, the Health Care Financing Administration estimates that nursing-home-care expenditures will total \$639.2 billion in the year 2020, with an additional \$127.4 billion spent on home health care. Assuming that, as at present, 50 percent of these costs are paid from public sources, and assuming that these public costs will be shared evenly by the estimated 179 million people between ages 18 and

64, each would pay \$2,141 annually. While productivity growth and inflation will make this sum a smaller fraction of income than it is at present, it still represents a heavy tax burden.

A more subtle issue is whether there is a difference in the incentives created by a savings mandate and a tax. Although a detailed analysis is beyond the scope of this article, it is clear that both financing methods have the undesirable effect of discouraging work effort, and hence of reducing aggregate output and wealth. The hope is that because the mandated savings provide some private benefits, the work disincentive effect of the mandate will be smaller. Whether a savings mandate would significantly increase the aggregate savings rate is also uncertain, although some increase in aggregate savings would result from the forced savings of households that save little or nothing now. To the extent that people already save in anticipation of long-term-care expenses, however, the mandated savings would simply replace voluntary savings, so the net effect for this group would be small. Independent of the financing mechanism, the incentive to save is reduced by higher anticipated insurance coverage because it makes future cash needs lower and less variable.

### *Voluntary Alternatives*

An alternative to mandatory prefunding is to rely on tax incentives or subsidies to encourage voluntary prefunding and the subsequent purchase of private insurance. Such a policy would resemble past proposals to provide tax preference for savings set aside for medical expenses (e.g., medical IRAs). Past proposals generally have not required that these savings be used to buy insurance. It should be emphasized that for long-term care, subsidizing savings without requiring an insurance purchase would be inefficient because it would not address the problem of the catastrophically high cost of an extended nursing-home stay.

There are a number of good reasons to favor a voluntarily prefunded system over a mandate. Opponents of mandates worry that they would create a large financial burden. Because a mandate is similar to a tax, it reduces the incentive to work. There is also concern that if the money were required to be put into a government trust fund (which is not the recommendation here), it would likely be diverted to other uses. The mandate also would increase the perception that the government should

be responsible for providing long-term care. Finally, some believe that people should have the right to opt out of the insurance system entirely and provide for themselves.

Although I share many of these concerns, past experiments with subsidized savings suggest that modest subsidies have little effect. Subsidies large enough to change behavior, particularly in the face of the disincentive provided by Medicaid, may be prohibitively expensive. This problem will be exacerbated by likely improvements in the public safety net, such as increased funding of home care. Furthermore, society's commitment to a public safety net means that opting out of the insurance system is not really an option even under the status quo. Voluntary insurance purchase has a related set of problems. Again, the public safety net discourages purchase. Adverse selection problems are exacerbated because those anticipating the need for care would be the most likely to purchase insurance, which would raise the average premium and further discourage enrollment.

### *Concluding Comments*

I have outlined how the idea of managed competition can be applied to long-term care. The justification for mandating private long-term-care insurance is similar to that for acute care: It would ensure a minimum level of universal coverage, spread the individually catastrophic cost of long-term care over a broad population base, rely on the incentives of the private market to hold down costs and offer consumers a variety of products, and eliminate many of the distortions caused by the rules of the current Medicaid program. There are also a number of good reasons to adopt a mandatory prefunding strategy. Prefunding would solve most of the affordability problem for the elderly once the system is phased in, and would largely eliminate the moral hazard problem created by a public safety net without eliminating protection for the poor. It would minimize intergenerational wealth transfers because each cohort would finance most of its own care.

Of course there are many impediments to implementing such a program. Perhaps most formidable is the political opposition such a proposal would encounter. There is also the practical problem of setting up and financing the infrastructure that would be responsible for making and enforcing the rules. Nevertheless, there is a growing awareness that



the status quo cannot be sustained, opening up the possibility that the public would accept some elements of this plan. Finally, it should be emphasized that the justification for mandatory prefunding does not depend on the existence of either a viable private insurance market or the adoption of managed competition. Rather, the purpose of prefunding is to ensure that long-term care can be equitably paid for, whether it is ultimately provided by the public or private sector.

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## Appendix 1 Required Prefunding Rates

This appendix illustrates the average monthly savings rate required to cover 80 percent of the expected present value of long-term-care expenses at age 65. Because these estimates are sensitive to the assumed interest rate and to the age at which prefunding begins, a range of possible values is considered. In these calculations, the interest rate represents the real return on investments minus the real rate of inflation for long-term care. For instance, if investments yield 3 percent and long-term-care costs rise 1 percent faster than the overall rate of inflation, the appropriate interest rate is 2 percent.

Consistent with current estimates, we assume that the present value of average nursing-home expenses is \$30,000, and that the present value of average home- and community-based care (PV-LTC) is \$15,000. Thus the target savings at age 65 is  $\$45,000(.8) = \$36,000$ . The annual and monthly prefunding required is found by applying the standard annuity formula.

CASE 1  
Required Savings Rates when Real Interest Rate Is 1 Percent

Age begin to save	Years to age 65	PV-LTC cost	Annuity amount	Monthly amount
25	40	24,180	736	61
30	35	25,413	864	72
35	30	26,709	1,035	86
40	25	28,072	1,275	106
45	20	29,504	1,635	136
50	15	31,009	2,236	186
55	10	32,590	3,441	287

CASE 2  
Required Savings Rate when Real Interest Rate Is 3 Percent

Age begin to save	Years to 65	PV-LTC cost	Annuity amount	Monthly amount
25	40	11,036	477	40
30	35	12,794	595	50
35	30	14,832	757	63
40	25	17,194	987	82
45	20	19,932	1,340	112
50	15	23,107	1,936	161
55	10	26,787	3,140	262