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A series of big ideas and policy concepts designed to foster conversation and debate within the policy community.

How to Think About Long-Term Care

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Abstract

More than two-thirds of Americans over age 65 will need some level of long-term care before they die, and the baby boom generation of 77 million is already beginning to retire. Responsible public officials need to be clear and honest about the coming costs and consequences of action—and inaction—and try to lay the groundwork for a genuine policy consensus. Solving the complex and costly long-term care problem will be difficult. There is no magic bullet, no simple formula, and no escape. Solving it will take good faith debate, serious bipartisan cooperation, a hard look at current policies and practices, and a prudential realignment of public and private roles and responsibilities. Inaction invites catastrophic public and private costs.

Washington's dizzying debate over the rising costs of huge federal entitlements, record spending, and dangerous debt obscures America's next and perhaps most difficult challenge: the financing and provision of long-term care.

Long-term care encompasses a broad and complex spectrum of medical and social services for frail and elderly Americans, or persons with disabilities. These services range from routine assistance with the tasks of daily living (e.g., bathing, eating, and mobility) to a variety of home health and community-based services to institutionalization in nursing homes. The large and rapidly growing cohort of aging citizens and the potential demand for these services underscore the urgency of this issue.[1]

The Problem

The problem today is that millions of individuals and families are failing to plan or prepare for a life-altering event—such as stroke, dementia, or some major mental or physical disability—which can wreak havoc on family life, personal wealth, and social relations. Various surveys show most younger and middle-aged Americans do not grasp the need

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The next financial tsunami about to hit America is long-term care. As the baby boom generation ages, the cost burden on both private households and programs such as Medicaid and Medicare will rise sharply. Moreover, questions about the moral obligations of children to their parents will intensify. Heritage Senior Fellow Robert Moffit discusses how we should navigate these complex issues.

to plan for such eventualities and underestimate the gravity of the financial risks of not preparing.

By 2030, the elderly population will grow roughly four times faster than the overall population, and more than two-thirds of Americans over age 65 will need some level of long-term care before they die.[2] The huge baby boom generation of 77 million is already beginning to retire. Thus, their children and grandchildren—indeed every living and yet-to-be-born taxpayer—are facing an enormous challenge.

The issue is not just the direct cost. Spouses, family, friends, relatives, and religious and community volunteers deliver *unpaid* long-term care worth hundreds of billions of dollars. This huge outpouring of dedication, fidelity, and love spares the taxpayers even larger burdens. Yet millions of persons with disabilities and frail elderly must rely on *paid* services of home health aides, visiting nurses, social workers, home health care services, adult day care and foster care, assisted living facilities, and nursing homes. If a person's mental or physical condition becomes so unmanageable or so severely disabled as to require institutionalization, the annual cost of residence in a nursing home can top $80,000.[3]

While ordinary Americans and their public officials often confess that they are overwhelmed by the complexity of health care policy, the long-term care problem is even more confusing and challenging. Without serious bipartisan cooperation, resolving the problem will prove even more difficult. Responsible public officials need to be clear and honest about the coming costs and consequences of action—and inaction—and try to lay the groundwork for a genuine policy consensus. In other words, they need to do the exact opposite of what they have done in the bitter national debate over health care reform.

Several key factors influence the cost and provision of long-term care. Financial factors include the level of personal savings and private financial resources and the affordability and availability of long-term care insurance. Medical factors include progress in arresting and treating mentally or physically disabling disease. The system of care is influenced by the presence or absence of family and community support, the accessibility to providers and institutional services, and the fiscal and managerial capacity of public agencies to intervene and provide care for those who cannot provide for themselves. Government clearly cannot resolve all of these issues and should not seek to do so, but public officials can and should help to forge a sound and flexible policy framework that enables them to be resolved.

The Scope of the Challenge

The public is insufficiently aware of and prepared for the problem. Surveys by the Employee Benefit Research Institute show that, for example, most working Americans (56 percent) have not done any planning with regard to how much money they will need in retirement, much less planning for long-term care.[4] This is particularly true for younger and even middle-aged workers. Among workers between 45 and 54 years of age, 46 percent have less than $10,000 in total savings and investments.[5]

At the same time, surveys indicate a psychological barrier that borders on denial. About three in 10 Americans age 40 or older say they would rather not even think about growing old. However, majorities in this latter age group do express some concern about losing their independence, their mental capacities, or the costs of care. One troubling finding is that a bare majority (51 percent) express "a little

1. Diane R. Calmus, "The Long-Term Care Financing Crisis," Heritage Foundation Center for Policy Innovation *Discussion Paper* No. 7, February 6, 2013, http://www.heritage.org/research/reports/2013/02/the-long-term-care-financing-crisis.
2. Janemarie Mulvey, "Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress," Congressional Research Service *Report for Congress*, April 13, 2012, p. 1, http://www.advanceclass.org/images/PDFs/CRS042312.pdf (accessed September 10, 2013).
3. The figure represents the cost of a private room. Ibid., p. 2. See also William A. Galston, "The Long Term Is Now," *Democracy Journal*, September 11, 2012, http://www.brookings.edu/research/opinions/2012/09/11-health-care-galston (accessed September 10, 2013).
4. Employee Benefit Research Institute and Matthew Greenwald and Associates, "Preparing for Retirement in America," Retirement Confidence Survey, 2012, p. 3.
5. Employee Benefit Research Institute and Matthew Greenwald and Associates, "Age Comparisons Among Workers," Retirement Confidence Survey *Fact Sheet* No. 4, 2012, p. 2, http://www.ebri.org/pdf/surveys/rcs/2012/fs-04-rcs-12-fs4-age.pdf (accessed September 10, 2013).

or no concern at all" about leaving debt to their family.[6] The same survey shows that 44 percent incorrectly believe that Medicare will somehow cover their long-term care needs, although many correctly assume that the taxpayers will eventually pick up much of the tab, mainly through Medicaid. Another recent survey found that Americans underestimate the true costs of care in a nursing home. This was true among both buyers (64 percent) and non-buyers (72 percent) of long-term care insurance coverage.[7] Perhaps not surprisingly, only about 11 percent of Americans age 55 and older own a private long-term care policy.[8]

Policymakers thus face a daunting set of formidable challenges in building consensus, fashioning a new public policy, and communicating it to the broader public. Among these challenges are:

- The enormous cost of long-term care,
- The inherent complexity and the diversity of long-term care needs,
- The need to design effective financing mechanisms, and
- The need to reinforce personal and family responsibility.

The Enormous Actual and Projected Costs. In 2011, researchers estimated *paid* care at $210.9 billion. Medicaid accounted for $131.4 billion (62.3 percent), followed by $45.5 billion (21.6 percent) in out-of-pocket spending, $24.4 billion (11.6 percent) in other private spending, and $9.7 billion (4.6 percent) in other public spending.[9] Moreover, the researchers estimated the economic value of *unpaid*, family-provided long-term care at approximately $450 billion annually.[10] At its inception in 1965, Medicaid mostly reimbursed nursing home care, but not care in the home. The program has since paid for some home-based care without any significant reduction in costs. According to a recent report by the Kaiser Family Foundation, home-based and community-based care accounts for 19 percent of total Medicaid spending on the elderly enrolled in long-term care, with state spending for these services ranging from just 7 percent in Florida and Kentucky to 58 percent in Alaska.[11] Total Medicaid spending on long-term care is projected to be $1.9 trillion for 2013 to 2023.[12]

The prevalence of certain severely debilitating age-related diseases could mean even larger future costs. The biggest such threat today is Alzheimer's disease. About 70 percent of the cost of caring for the 5.2 million Americans stricken with Alzheimer's disease is financed by taxpayers through Medicare and Medicaid. The yearly cost of caring for persons with Alzheimer's or other forms of dementia totals $203 billion. By 2050, it is expected to reach $1.2 trillion.[13]

The Inherent Complexity and the Diversity of Needs. Long-term care encompasses care for the young and persons with disabilities as well as for

6. T. Thompson et al., "Long-Term Care: Perceptions, Experiences, and Attitudes Among Americans 40 or Older," Associated Press, NORC Center for Public Affairs Research, April 2013, p. 2, http://www.apnorc.org/PDFs/Long%20Term%20Care/AP_NORC_Long%20Term%20Care%20Perception_FINAL%20REPORT.pdf (accessed September 10, 2013).
7. America's Health Insurance Plans, "Who Buys Long-Term Care Insurance in 2010–2011," March 2012, p. 22, http://www.ahip.org/WhoBuysLTCInsurance2010-2011/ (accessed September 10, 2013).
8. Mulvey, "Factors Affecting the Demand for Long-Term Care Insurance," p. 1.
9. National Health Policy Forum, "National Spending for Long-Term Services and Supports (LTSS), 2011," February 1, 2013, p. 3, http://www.nhpf.org/library/the-basics/Basics_LTSS_02-01-13.pdf (accessed September 10, 2013).
10. This is a 2009 dollar estimate. AARP Public Policy Institute, "Valuing the Invaluable: 2011 Update—The Economic Value of Family Caregiving in 2009," *Fact Sheet* No. 229, June 2011, http://www.aarp.org/relationships/caregiving/info-07-2011/valuing-the-invaluable.html (accessed September 10, 2013).
11. Henry J. Kaiser Family Foundation, "Medicaid's Role in Meeting the Long-Term Care Needs of America's Seniors," *Policy Brief*, January 2013, p. 3, http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8403.pdf (accessed September 10, 2013).
12. Dennis G. Smith and Michael Fogarty, "Medicaid's Role in Long-Term Care," PowerPoint presentation, McKenna, Long and Aldridge, June 2013, p. 3.
13. Alzheimer's Association, "2013 Alzheimer's Disease: Facts and Figure," 2013, p. 41, http://www.alz.org/downloads/facts_figures_2013.pdf (accessed September 10, 2013).

the aged and infirm. It is not simply the provision of health care, even though it is formally categorized as a function of the Medicaid program, that provides the largest single share of government funding. It also requires provision of a broad array of social services to a wide and radically diverse population, comprised of elderly, frail, and persons with disabilities. The innumerable needs of these population groups differ greatly, and most are very capable of expressing clear preferences about their care options and the settings in which that care is to be delivered. In a somber warning to policymakers, Dr. Philip Brickner and his colleagues note,

> The vast and shifting range of physical ability, intellectual capacity, and social settings of those whom we consider old requires sophistication in program design. Another lesson learned, one of grave human and ethical value, is that all of us, at any age, should remain free to make our own major life decisions, a stand that must ever be supported and strengthened or we are all at risk.[14]

Designing Financing Mechanisms Compatible with Effective Delivery. As with health care policy, delivery of long-term care often suffers from a lack of coordination and a failure to personalize care. While many caregivers work diligently and heroically to provide the best possible care to their patients, the system itself is not patient centered because the economic incentives for caregivers often are not neatly or normally aligned with the needs of patients. Financing mechanisms and incentives profoundly affect the delivery of care by pressuring providers to do what is reimbursable, but what is reimbursable is not always best for the patient.

Government financing in particular is disjointed, duplicative, and fragmented. Medicaid, Supplementary Security Income (SSI), Title II of the Older Americans Act, and Title XX of the Social Services Block Grant authorize federal funding for long-term care services, but each has different rules, terms, and conditions governing the long-term care service payments. The U.S. Department of Health and Human Services (HHS) has 12 agencies and offices in addition to the Centers for Medicare and Medicaid Services (CMS) that exercise some responsibility for research, regulation, or oversight over long-term care.[15]

This federal complexity is replicated to a degree at the state level, generating higher and unnecessary administrative costs within the public sector. For example, California has the Department of Health Care Services, which administers the state's Medi-Cal program (California's Medicaid program), and eight other departments and agencies that administer long-term care programs.[16] The multiple agencies, streams of funding, and separate rules and regulations further complicate the work of caregivers and exacerbate the problems of those needing care.

Reinforcing Personal and Family Responsibility. Policymakers need to reinforce personal and family responsibility, while reducing the growing pressure on taxpayers and recognizing the burdens on individuals. Individuals and their families need to assume the primary responsibility for the financing and delivery of long-term care, not government officials and taxpayers. Those who can save and otherwise provide for themselves should be encouraged to do so. Those who cannot will of necessity depend on others, including the wider community. Taxpayers will face ever-greater burdens if the poor state of public awareness, personal savings, and the private long-term care insurance market is not reversed. As a result, millions of frail elderly and persons with disabilities will become dependent on public provision of care by overworked, overstressed, and underpaid caregivers, subject to the vicissitudes of federal and state budgetary politics.

Two Broad Approaches

Among policymakers and analysts in academia and think tanks, there are two broad schools of thought about how to address solving America's long-term care problem. For the sake of conceptual convenience, this paper calls them the "public-sector" expansionists and the "private-sector" expansionists. Yet adherents of both broad approaches

14. Philip W. Brickner et al., *Long Term Health Care: Providing a Spectrum of Services to the Aged* (New York: Basic Books, 1987), p. xv. This remains a magisterial treatment of the subject.
15. SCAN Foundation, "Organization of Long-Term Care in the Government," *Technical Brief* No. 2, November 2010, p. 2, http://thescanfoundation.org/organization-long-term-care-government (accessed September 10, 2013).
16. Ibid., p. 4.

support some mixture of public-sector and private-sector roles and responsibilities. The differences are more of emphasis, reflected in the financing arrangements and policy priorities. For example, both schools broadly share the goal of ensuring high-quality and person-centered care for those who cannot provide for themselves, but their mechanisms and the financing of achieving this goal are very different.

Public-Sector Expansion. The "public-sector" approach is to expand the government's role in long-term care. This could take the form of a new government mandate or a new federal long-term care entitlement, possibly set up as a new social insurance program funded by an additional federal payroll tax.

CLASS Failure. With the enactment of the Affordable Care Act of 2010, Congress and the Obama Administration tried, but failed, to create a new long-term care program under the Community Living Assistance Services and Support (CLASS) program.[17] The law provided for a single daily cash benefit of $50, indexed to inflation. The money could be used to purchase medical or non-medical services at home or in an institutional setting. It was to be a voluntary program of government insurance, but Congress specified that the premiums must be set in a way that would be actuarially sound.

However, even before the program was implemented, analysts at the Congressional Budget Office (CBO) and the Office of the Actuary at CMS stated that the program faced such a threat from adverse selection that it would be fiscally unsustainable. It soon became apparent to HHS officials that the CLASS program was unworkable. The HHS Secretary reluctantly declared it so, and Congress, as part of the 2013 fiscal cliff agreement, formally repealed what had already become a dead letter. However, with the repeal of the CLASS Act, Congress created a special 15-member Commission on Long-Term Care, tasked with producing within six months a report on how to address the issue of long-term care. On September 18, 2013, the commission issued its report and offered a series of recommendations, but could not come to consensus on the most important issue: long-term care financing.[18] Next steps in forging a new long-term care policy rest primarily with Congress, and with the nation's governors and state legislators.

Several of those who believe that government should take an expanded public role have explored alternative approaches to the CLASS voluntary entitlement model. Given the inherent problems of adverse selection in a voluntary, CLASS-type program, Howard Gleckman of the Urban Institute has argued that Congress should enact a second individual mandate on Americans to purchase long-term care coverage.[19] Others have argued for creating a new public-private partnership. For instance, William Galston, a senior fellow at the Brookings Institution, argued in a 2008 paper in favor of an individual mandate for persons to purchase private long-term care insurance, effective when they reach age 40. Such insurance plans would be offered in a national, federally regulated market with premiums for low-income and moderate-income persons offset with government subsidies. The standard benefit would cover long-term care services for five years, after which Medicaid would pick up the full costs. In Galston's view, the mandate would jump start the long-term care insurance market, reduce or eliminate adverse selection, and reduce both Medicare and Medicaid costs.[20]

Issues and Problems. A new social insurance program for long-term care would be financed through an additional federal payroll tax. As a technical matter, a universal program, financed with such a mandatory tax, could resolve the adverse selection problem in the current long-term care insurance market. The bigger problem is that over time such an arrangement would almost certainly incur huge unfunded obligations similar to those in Social Security and

17. Patient Protection and Affordable Care Act of 2010, Public Law 111–152, § 8002.

18. In chapter three of their report, the commissioners outlined the two main competing approaches: the expansion of private financial protection and the creation of a new social insurance program. Commission on Long-Term Care, *Report to Congress*, September 18, 2013, pp. 57–61, http://www.ltccommission.senate.gov/Commission%20on%20Long-Term%20Care%20-%20Final%20Report%20-%209-18-13.pdf (accessed September 24, 2013).

19. Howard Gleckman, *Caring for Our Parents: Inspiring Stories of Families Seeking New Solutions to America's Most Urgent Health Crisis* (New York: St. Martin's Press, 2009).

20. William A. Galston, "Reviving the Social Contract: Economic Strategies for Health Insurance & Long-Term Care," Brookings Institution, February 28, 2007, pp. 11–12, http://www.brookings.edu/research/papers/2007/02/28socialcontract-opp08 (accessed September 10, 2013).

especially Medicare. As Urban Institute researchers have demonstrated, the Social Security and Medicare benefits for average wage-earning individuals and couples are substantially greater than the taxes they paid into these systems.[21]

The problem is not merely the economics of such a proposal, but the politics. A new entitlement to long-term care would be another official promise of a "guaranteed" benefit. The relentless dynamics of entitlement politics is evident in Medicare's richly documented history of intense political pressure to expand benefits and subsidize beneficiaries more generously. Thus, there is good reason to believe that the cost of long-term benefits would outstrip the financing as future Congresses bow to such pressure. This expansion would likely take the form of adding mandated services, a broad set of medical and social services that can be highly specific given the wide range of long-term care needs. This would be a prescription for ever-higher long-term care costs, as well as another major federal regulatory expansion.

There would be other associated costs, too. As economist Jonathan Gruber of MIT and others have long argued persuasively, government expansion of health care programs crowds out private provision of health care services. With long-term care insurance, research shows that this is already the case. For example, economists Jeffrey Brown of the University of Illinois and Amy Finkelstein of Harvard University found:

> [Medicaid's long-term care coverage] can explain the lack of private insurance coverage for at least two-thirds and as much as 90 percent of the wealth distribution, even if comprehensive, actuarially fair private policies were available. Medicaid's large crowd-out effect stems from the very large implicit tax (on the order of 60 to 75 percent for a median wealth individual) that Medicaid imposes on the benefits paid from private insurance policies.... An implication of our findings is that public policies designed to stimulate private insurance demand will be of limited efficacy as long as Medicaid continues to impose this large implicit tax.[22]

Government expansion of health care programs crowds out private provision of health care services.

The CBO essentially agrees with the Brown-Finkelstein conclusion.

> The availability of Medicaid benefits for long-term care skews people's decisions about purchasing private insurance coverage. Many people who believe that they could meet the financial qualifications for Medicaid may view it as a substitute for private insurance.[23]

Stephen Moses, President of the Center for Long-Term Care Reform, states bluntly: "In America today, you can ignore the risk of long-term care, avoid the premiums for private insurance, wait to see if you ever become chronically ill, and if you do need expensive long-term care someday, the government will pay for it."[24] The CBO observes that the disincentives that undermine the market for long-term care insurance would need to be reversed by tightening eligibility for Medicaid and the Medicare home health benefit.

In terms of public opinion, selling Americans on the creation of another federal entitlement financed through another federal mandate or a new social insurance tax would be a tall order. According to a survey conducted on behalf of America's Health

21. C. Eugene Steuerle and Stephanie Rennane, "Social Security and Medicare Taxes and Benefits over a Lifetime," Urban Institute, updated June 2011, http://www.urban.org/UploadedPDF/social-security-medicare-benefits-over-lifetime.pdf (accessed September 10, 2013).
22. Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," National Bureau of Economic Research *Working Paper* No. 10989, December 2004, p. 1, http://www.nber.org/papers/w10989 (accessed September 10, 2013).
23. Congressional Budget Office, "Financing Long-Term Care for the Elderly," April 2004, p. xi, http://www.cbo.gov/publication/15584 (accessed February 14, 2013).
24. Robert E. Moffit, Richard Teske, and Stephen Moses, "How to Deal with the Coming Crisis in Long-Term Care," Heritage Foundation *Lecture* No. 658, April 27, 2000, p. 14, http://www.heritage.org/research/lecture/how-to-deal-with-the-coming-crisis.

Insurance Plans (AHIP), 75 percent of respondents age 50 and older said that it is *not* the federal government's responsibility to pay for the long-term care needs of "all" people, but 73 percent of those respondents did agree that the federal government should encourage expansion of private long-term care insurance by making premiums tax deductible. Among persons who did not buy long-term care policies, the support for a federal program was only slightly higher at 31 percent, while the support among long-term care policy purchasers was only 19 percent.[25]

Private-Sector Expansion. The "private-sector" approach would educate the public and seek to reinvigorate economic incentives for more Americans to provide for their retirement, encourage the private provision of care, and re-energize the private long-term care insurance market. Most advocates of this approach believe that this can only be accomplished by reorganizing the existing Medicaid program, refocusing its resources, and redefining the conditions of Medicaid eligibility for long-term care services.

Issues and Problems. In principle, there are reasons to feel that far-reaching steps could be taken to expand private-sector financing and provision of long-term care services. In practice, advocates of the private-sector approach also face some formidable obstacles.

The first is simply the lack of public awareness. If Americans do not appreciate the need for private planning, then it is hard to imagine a vigorous private market. Regrettably, most younger, working Americans apparently do not think about long-term care. High hopes of younger, working Americans taking the personal responsibility to plan and prepare for their future are undermined by the widespread belief among them that they will not need long-term care or the false impression that existing government programs, such as Medicare or Medicaid, automatically solve that this far-off problem that may never arise. Of course, Medicare does not address long-term care, and the Medicaid "solution" imposes terms and conditions that most Americans would consider less than desirable.

A second problem confronting private-sector advocates is the sorry state of the existing market for private long-term care insurance. Today, private insurance finances only a small portion of long-term care. Even among the population age 45 and older, only 7 million to 9 million Americans own a private long-term care insurance policy.[26]

This may seem strange. After all, obtaining insurance coverage for long-term care might seem to be prudent, given the unpredictability of an adverse event, such as a disabling accident or the onset of Alzheimer's and its potentially catastrophic consequences. Insurance would provide a large measure of independence and protect precious assets and income. Moreover, the insurance product itself has improved over the years in its range of coverage, from assisted living to home care and nursing home care. Most plans also include inflation protection. The vast majority of customers are satisfied with their coverage and service, and 95 percent of all claims are paid.[27]

Struggling Private Market. Nonetheless, within the past two decades, the number of insurance companies offering such coverage has plummeted from well over 100 to just a few. The group market (largely employment-based coverage) has shrunk dramatically, and the individual market is also in sharp decline.

There are several reasons for this:

First, as the demand has shrunk, especially among younger and lower-risk individuals, the supply of insurance has become more expensive. This form of adverse selection makes insurance less affordable and available. Reforms of the insurance market might remedy these problems, but it is not obvious what those reforms need to be.

Second, the recent condition of the financial markets has undermined the safe investment strategy of long-term care insurance. Low interest rates and poor rates of return on these insurance investments have made existing lines of business increasingly

25. America's Health Insurance Plans, "Who Buys Long-Term Care Insurance in 2010–2011?" p. 44.

26. SCAN Foundation, "Who Pays for Long-Term Care in the U.S.?" *Fact Sheet*, January 2013, http://www.thescanfoundation.org/who-pays-long-term-care-us (accessed September 10, 2013).

27. Marc A. Cohen, "Long-Term Care Insurance: A Product and Industry in Transition," presentation to the Senior Issues Task Force of the National Association of Insurance Commissioners, National Harbor, MD, November 28, 2012, p. 14, http://www.naic.org/documents/committees_b_senior_issues_2012_fall_nm_ltc_hearing_presentations_cohen_revised.pdf (accessed September 10, 2013).

unprofitable. Within the long-term care insurance market, Gleckman observes that insurance companies are finding that enrollees are not dropping coverage at the expected ("lapse") rates, thus increasing claims and costs. Premiums are increasing while profits are declining, and companies are exiting the market.[28]

Third, insurance firms have found it difficult to cope with federal and state regulations, which often duplicate or conflict with each other. With a new and innovative long-term care product, firm representatives may need to spend two years obtaining approval for sale in all 50 states. Of course, Congress could provide a partial remedy by facilitating the expansion of a national market for long-term care insurance, regulating these interstate products under the Commerce Clause of the Constitution, as they do the sale and transportation of so many other products and services throughout the United States.

Although traditional American family life has been weakened in the past several decades, most of America's long-term provision will still be donated by family, friends, and communal caregivers.

Finally, the effectiveness of the private-sector approach depends on the health of civil society; a vibrant role of religious, charitable, and communal associations; and, most importantly, the strength and endurance of family life. This fundamental institution as a foundation for obligation and care has been severely tested by divorce and the growth of cohabitation, the distance separating parents and adult children, the changing social and economic role of women, and changing morals and mores. This should be a concern for aging baby boomers, who may find themselves dependent on a shrinking pool of potential caregivers. Although traditional American family life has been weakened in the past several decades, most of America's long-term provision will still be donated by family, friends, and communal caregivers, and the kind of care that they offer is irreplaceable. Researchers at George Washington University observe, "Regardless of the dollar amount assigned to family care giving, public programs are unlikely to assume financial or programmatic responsibility for the types, range, and amount of care provided by family caregivers."[29] For private-sector advocates, a chief task is to preserve and enhance this vast contribution while fashioning a public policy that will not inadvertently discourage or displace it.

Opportunities for Consensus

Despite the inevitable sharp philosophical disagreements on various aspects of long-term care policy, there is actually fertile ground for consensus. In other words, it is very possible to avoid a replay of the poisonous politics of the Affordable Care Act and the mistake of CLASS. Consensus on the broad goals of a new long-term care policy is possible around three broad strategies:

- **Encouraging personal responsibility and maximizing personal freedom.** There is wide agreement that the provision of care should be personalized and delivered in accordance with personal preferences and in settings of personal choice. Furthermore, when Americans need assistance with daily living, they often want that assistance in their own homes, strongly preferring help from family members, friends, and relatives, not from strangers. Most Americans would prefer to "age in place" and avoid institutionalization. This is a widely shared goal among policy experts and citizens alike. Likewise, well before mental or physical decline advances too far, patients should be able to express preferences on end-of-life care and how they wish to die, including the use of advanced directives in strict accordance with their ethical, moral, and religious convictions.

- **Maximizing the flexibility of public and private institutional care to cope with the diversity of needs and innovations in the delivery of care.** This is a practical issue, not an ideological

28. Howard Gleckman, "What's Killing the Long-Term Care Insurance Industry," *Forbes*, August 29, 2012, http://www.forbes.com/sites/howardgleckman/2012/08/29/whats-killing-the-long-term-care-insurance-industry/ (accessed September 10, 2013).

29. National Health Policy Forum, "National Spending for Long-Term Care Services and Supports," p. 5.

one. As far as possible, those closest to the patient should control the delivery of care, and public policies should give officials maximum flexibility in designing customized and innovative practical solutions to inherently difficult long-term care problems. Such approaches could include developing new insurance products, perhaps combining life and health insurance with coverage for long-term care. They would include new care delivery models, including community-based care, routine medical case management programs for the very old and frail designed to prevent unwanted institutionalization, and senior assisted-living or residential facilities that offer a continuum of care from routine medical to social services.

- **Balancing the need for a new long-term care policy with controlling the rising costs of federal entitlements.** America is coping with its largest debt (as a percentage of the national economy) since World War II. Record spending is generating budget crises at the federal and state levels. Meanwhile, existing federal entitlements, mainly Social Security and Medicare, are generating trillions in unfunded liabilities, while new spending on Medicaid and the Affordable Care Act will impose large new obligations on the public purse. Current and future taxpayers thus face almost unimaginable burdens. Policymakers need to find a way to fashion a policy for long-term care that does not exacerbate this situation.

Principles for a New Policy Agenda

Public policy generates consensus when it fixes what is broken and preserves what is working and when it is flexible and accommodates existing arrangements and improves them without disrupting or destroying them. With this and the three goals above in mind, policymakers seeking broad support should be guided by three clear principles.

1. Every person who is able to work and save should do so and provide most or all of his or her own long-term care in retirement.

Policy should encourage private financing and provision and discourage public financing and provision except for those who simply cannot provide for themselves.

Today's exemptions of various personal assets weaken personal responsibility, especially the overly generous federal home equity exemption (now more than $800,000), which eases the path to Medicaid eligibility. Policymakers should not only revisit and tighten eligibility requirements, but also encourage personal savings through tax reform while taking steps to expand the insurance market for long-term care.

The need for long-term care is unpredictable, and its personal and financial consequences can be catastrophic. Thus, insurance is the most appropriate basis for protection, especially for middle-class Americans.[30] For persons between the ages of 50 and 59, the average annual premium for an individual policy is $2,089 ($1,029 at group rate). For those between age 40 and age 49, the premium is $1,818 ($545 at group rate). Between age 30 and age 39, the premium is $1,229 (just $249 at group rate).[31] This means the product is affordable for millions of Americans who are not buying it and could be even more affordable if policymakers took reasonable steps to improve the market. Such steps could include facilitating a national market in such insurance, promoting insurance "partnership programs" in the states,[32] simplifying and streamlining regulation, allowing tax deductions for these insurance purchases, and providing clear (plain English) and comparative information on the benefits of such coverage as well as the costs and consequences of not having it.

2. Just as parents assume parental responsibility for their children when they are incapable

30. Based on the Current Population Surveys of the Census Bureau, those with a "middle-class" income earn between $39,418 and $188,255 annually. The average buyer of long-term care insurance is 59 years old and has an income of $82,000 and $142,000 in liquid assets. Long-Term Care Financing Collaborative, "The Middle: Income, Assets, and LTSS Needs," Convergence Center for Policy Resolution.

31. Dr. Marc Cohen, personal communication with the author, June 12, 2013.

32. A partnership program would allow a subscriber to insure privately and protect assets worth hundreds of thousands of dollars (catastrophic coverage), but still allow Medicaid coverage after the exhaustion of that coverage. These policies clearly reduce reliance on Medicaid and allow persons to protect their assets from catastrophic long-term care costs. Such programs exist in 40 states, but they have not been used as broadly as policymakers had hoped. See Calmus, "The Long-Term Care Financing Crisis," pp. 11–12.

of caring for themselves, adult children should normally assume the responsibility to care for their parents when they are no longer capable of caring for themselves.

While the primary responsibility for long-term care provision rests with the person, the secondary responsibility rests with the family, particularly the children of frail and elderly or disabled parents.

Families already provide the primary care for aged and infirm parents and relatives. This principle of familial responsibility is and should remain the norm, as it has been for centuries. Surveys show that the public overwhelmingly supports such familial responsibility. For example, a 2012 Pew Research Center survey found that, regardless of respondents' attitudes about the role of government, 75 percent of Americans say that children have a responsibility to give elderly parents financial assistance if they need it. Only 23 percent disagree.[33]

Public policy should encourage family provision of care and not interfere with or discourage it. As Dr. Brickner and his colleagues have observed:

> Family supports are an essential base for any system of long term care. On the level of public policy, without the involvement of natural supporters in the care of the frail aged, costly paid programs would have to be enlarged. On the individual level, participation in the daily care plan by those who cherish the patient is positive.[34]

For practical and prudential reasons, policy in this area should be a state responsibility because the characteristics of American populations differ widely from state to state. State legislators are best equipped to formulate policies in accord with the prevailing values and the sentiments of their people. Policymakers should craft policies to encourage children to care for their parents, while recognizing that some children simply do not have the ability or the means. Making the necessary distinctions and drawing the lines is always difficult, but writing general laws that allow prudential exceptions is the high art of statecraft.

Law should reflect culture and social life in this matter. Family life, marriage and divorce laws, inheritance and property laws, and cultural, social, and even religious values vary greatly from state to state. What seems sensible in Salt Lake City, might seem utterly unthinkable in San Francisco. Close-knit Italian neighborhoods such as South Philadelphia are culturally quite distant from the chic, upper-income communities of suburban Los Angeles. Thus, crafting equitable and effective rules to encourage family responsibility will necessarily be a delicate enterprise. State filial support laws—enforcing financial support for aged or disabled parents among adult children—have enjoyed limited popularity and success. Where they can be enacted and enforced, state officials should do so. But state officials should also explore new options: targeting more effectively adult children who try to use Medicaid as a guarantor of their inheritance at the expense of the taxpayer; clarifying rules governing the legal profession to ensure rightful representation of the aged and to prevent collusion between lawyers and adult children, whose interests may be very different from their aged parents; and revisiting the current use of trusts, annuities, and other forms of estate planning that secure Medicaid eligibility and ensure greater burdens on the taxpayers.

3. Policymakers should avail themselves of the unique advantages of federalism.

The U.S. Constitution provides the best policy framework for a rational division of labor. As the national government has responsibility for general concerns, it should focus on those few and specified matters common to all states, such as receipt and use of federal monies. The states, for their part, are constitutionally authorized to focus on particular concerns, and the complexity of demand and supply for long-term care services in very different communities makes them ideal as the primary policymakers on the ground.

Federal and state officials share legal and programmatic responsibility for long-term care. For example, Medicaid is mostly administered by the

33. Kim Parker, "The Big Generation Gap at the Polls Is Echoed in Budget Tradeoffs," Pew Research Center, December 20, 3012, http://www.pewsocialtrends.org/2012/12/20/the-big-generation-gap-at-the-polls-is-echoed-in-attitudes-on-budget-tradeoffs/ (accessed September 10, 2013).

34. Brickner et al., *Long Term Health Care*, p. 203.

states and mostly financed by the federal government. It serves radically different populations, providing mostly acute care for poor and low-income women and children, plus continuous and custodial care for the frail, elderly, and those with disabilities. As a result of historical circumstance, Medicaid has become the central vehicle for government financing of long-term care services.

The interaction between the two levels of government and the variety of long-term care providers and their patients increases complexities. With the delivery of care subject to both state and federal regulations, the result is confusion for many citizens and beneficiaries. They often have no idea which programs cover what. Meanwhile, caregivers need to wrestle with daunting and different reimbursement and regulatory requirements.

States exercise primary authority over private long-term care insurance markets. They are also responsible for the licensing of various providers and the standards of medical care. Long-term care is delivered in state-licensed agencies and institutions. Both the profound diversity in long-term care needs and services—ranging from the young with disabilities to the frail elderly—and the wide range of circumstances governing care delivery make national standardization impractical. Setting broad goals to protect the integrity of federal dollars is one thing; imposing highly prescriptive, top-down standardization is quite another. It serves no one to stifle innovation in financing and delivery, thus ensuring continued inefficiency, ineffectiveness, and waste.

A revitalized and streamlined federalist division of labor, including streamlined administration and regulation, would build and improve on current practice. States historically have determined Medicaid eligibility and executed program administration. States must abide by federal rules and regulations on state administration as a condition of federal funding, but when they seek greater flexibility, innovation, or the promotion of alternative care or more imaginative options for care delivery, they must seek federal waivers from existing rules, which may or may not be granted.

A more rational division of labor between state and federal authorities would much better serve beneficiaries. National responsibility should focus on financing, and state authorities should focus on developing and implementing innovative policies to secure high-quality care delivery. Current state inhibition and uncertainty should end. In such tough areas of public policy, America needs more bold experimentation, not less. The states can pursue such experimentation, while creating a hospitable environment for private-sector innovation.

Solving the complex and costly long-term care problem will be difficult. There is no magic bullet, no simple formula, and no escape. Solving it will take good faith debate, serious bipartisan cooperation, a hard look at current policies and practices, and a prudential realignment of public and private roles and responsibilities. Inaction invites catastrophic public and private costs. Given the gravity of the challenge ahead, another failure in public policy is the most expensive alternative.

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