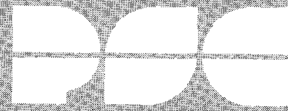
Gerald Faverman, Ph.D. • *Chairman of the Board*
Craig Ruff • *President*
May 6, 1988



HEALTH POLICY BULLETIN

FOCUS: LONG-TERM CARE INSURANCE

The costs and utilization of long-term care (LTC) are sky-rocketing. According to U.S. Senator Lawton Chiles (D-Florida), the $45 billion spent on long-term care in 1985 will grow to about $80 billion by 1995. The picture becomes even more gloomy as the baby boomers age: about 19 percent of the population (59 million people) will be aged 65 or over by the year 2030, in contrast to 12 percent today. Average annual costs for nursing home care today are $22,000; the cost probably will reach $55,000 per year by 2018. Little of this is covered by Medicare, and seniors must become impoverished before Medicaid will pay for nursing home care. In Michigan, where the average stay in a nursing home is 15 months, combined income and financial assets statistics show that 61 percent of singles and 38 percent of couples are impoverished after one year in a nursing home. Significantly, home health care impoverishes the elderly at virtually identical rates.

The Reagan administration has promoted private LTC insurance as a way of heading off the impoverishment of older persons, the bankruptcy of Medicare, and the escalation of Medicaid costs. Current LTC insurers cover only one percent of the nation's LTC costs. Alice Rivlin of the Brookings Institution believes private insurance will cover only 7 to 12 percent of the population by 2018, mainly because it covers too little or costs too much. Still, almost eighty companies now sell LTC insurance.

The thirteen policies rated best by *Consumer Reports* in its May 1988 issue averaged about $60 per month in premiums at age 65. Most policies require hospitalization prior to nursing home care; many will pay for basic (custodial) care only after admission to a skilled nursing facility. Some policies will pay home health benefits only after prior hospitalization, skilled nursing home admission, and discharge to the patient's residence; the person who is discharged to home directly from the hospital gets no financial help. Many policies also have limits on daily benefits for all covered care. In the absence of sufficient historical and reliable LTC actuarial data, regulators and insurers are treading a fine line between keeping premium costs down for consumers and protecting against unknown future payouts.

What is most disheartening is that the policies available offer no coverage for the other kinds of care needed by many elderly people: homes for the aged, adult foster care, adult day care, and respite care.

Who, then, should buy LTC insurance and why? According to Wayne Tanner, a regulation officer in the Michigan Insurance Bureau, "people shouldn't buy it unless they have plenty of assets to protect. Most people don't have enough assets to make it worthwhile."

Expanding coverage of Medicare and Medicaid, which together foot the bill for just under half of the nation's long-term care, has been proposed as a public sector answer. Harry Schwartz, Ph.D., a health care writer, has gone so far as to recommend abolishing Medicare and broadening Medicaid. The Center for the Study of Social Policy endorsed separating Medicaid into two distinct programs: acute care and long-term care. In a recent speech, Gerald Faverman, chairman of Public Sector Consultants, proposed that funding for expanded public assumption of LTC coverage could come from extending the 7.51 percent social security payroll tax to all wage and

Public Sector Consultants, Inc.
Knapp's Centre • 300 S. Washington Square
Suite 401 • Lansing, MI 48933 • (517) 484-4954

salary income. Currently, only the first $45,000 in individual income is subject to the tax. This would raise at least $25 billion additional dollars to be used for long-term care.

FOCUS: GUARANTEED HEALTH INSURANCE The 600,000 Massachusetts residents who have no health insurance will be insured under a new universal plan. The state plan, which will be phased in over four years, will enable uninsured persons (10.3 percent of the population) to buy basic health insurance coverage; premiums will be related to income. Uninsured workers will pay 25 to 30 percent for coverage; the unemployed with income will pay less; and the unemployed without income and students will pay nothing.

The legislation does not require employers to provide health insurance; instead, starting in 1992, the state will impose on all employers a surtax of 12 percent of the first $14,000 in wages and salary of each employee (about $1,680 per employee). Companies may deduct the cost of employer-paid insurance from the surcharge. Approximately two-thirds of all Massachusetts employers currently offer health insurance to their workers; hence, most companies are not expected to make payments to the state-administered trust fund, which will receive the tax payments and help finance the insurance benefits. Firms employing five or fewer workers are exempt from the law.

Gail L. Warden, president and chief executive officer of Henry Ford Health Care Corporation, commented that the plan "focuses on retail, fast food, and other establishments who have a deliberate strategy of not providing insurance benefits as a way of keeping their costs down." He also noted the Massachusetts plan could be quite expensive; it is estimated that by 1992, the year the guaranteed health insurance plan is fully operational, state government will have put at least $613.7 million into the program.

A nonbinding referendum in 1986 asking Massachusetts voters if they supported universal health insurance passed by an overwhelming margin. Opposition came from the state chapter of the National Federation of Independent Business, which objected that many small businesses could not afford the premium for health insurance, and from the Associated Industries of Massachusetts, which felt the law would hinder the state's ability to retain existing businesses and attract new ones.

OF INTEREST In the next thirty days, look for

- the House to pass HB 4103 (requiring health facilities to report validated positive AIDS virus and antibody tests to the MDPH), HB 4980 (requiring organ, tissue, and fluid donations to be tested for AIDS), HB 5189 (requiring written informed consent before AIDS testing and providing for confidentiality of test results), and HB 5026 (authorizing courts to require HIV carriers known to be engaging in behavior that can spread the disease to participate in counseling, education, or treatment programs);

- the Certificate of Need Subcommittee of the House Public Health Committee to work on HB 5145 (reforming basic CON law), SB 64 (changing thresholds), and HB 4525 (permitting swing beds). A fourth bill, to be introduced by Rep. Brotherton, will modify the health planning statute. It is likely that all four bills will be tie-barred; and

- the Senate to send antismoking bills to the House.

--Frances L. Faverman
Editor

©1988