PROTECTING THE ELDERLY AGAINST HIGH HEALTH CARE COSTS

by Thomas Rice and Jon Gabel

Prologue: The grim spectacle of Americans being financially devastated by a long and serious illness is a poignant reminder of the rougher edges of American capitalism. This truck in the social safety net visits older Americans most frequently because they suffer more sickness and thus are hospitalized more often. The federal government recognized this reality two decades ago when it crafted Medicare and Medicaid as health financing instruments for the nation's elderly and selected segments of its poor. But now, as health costs escalate, these changed circumstances prompted President Reagan in his recent State of the Union address to direct the Department of Health and Human Services (DHHS) to report by year end “on how the private sector and government can work together” to address the problems of catastrophic health insurance coverage. In this paper, researchers Thomas Rice and Jon Gubel examine the types of coverage that they assert will be most effective in providing protection for the elderly against the high costs of medical care. Rice and Gubel address some of the major questions that faced the DHHS as it developed a set of recommendations for President Reagan. Rice is an assistant professor of health economics at the University of North Carolina’s School of Public Health. He worked previously at the Stanford Research Institute. Gubel, a former senior researcher at the National Center for Health Services Research, is associate director for research and policy development at the Health Insurance Association of America.
Many elderly Americans face the risk that a long debilitating illness will strip them of their financial self-sufficiency and force them to live out their last years on welfare or dependent on their children. Of all groups in society, the elderly population is at the highest risk of incurring high health care expenses. One of every five elderly is hospitalized each year, and of those hospitalized, 22 percent will reenter the hospital within sixty days. On any given day 5 percent of the elderly are institutionalized in nursing homes; one of every four elderly will enter a nursing home during his or her lifetime. These levels of health care utilization, coupled with the high cost of medical care, put the elderly population at potential risk of financial disaster.

To help minimize this risk, Medicare was enacted in the mid-1960s, and since then a thriving market has developed for supplemental health insurance (popularly known as “Medigap” policies) to help pay for coverage not provided by Medicare. However, the elderly population remains at risk for large out-of-pocket expenses. Even with Medicare, Medicaid, and private health insurance coverage, 25 percent of their health care costs are paid out-of-pocket.

During his 1986 State of the Union address to Congress, President Reagan noted the magnitude of this problem and directed Health and Human Services Secretary Otis Bowen to come up with a plan by the end of 1986 that would protect the elderly against the financial burden of high-cost illnesses. Although the details of this plan have not been worked out, it is clear that the major concern is the type of services to be covered. Most likely, the plan will focus on extending Medicare coverage for acute illnesses, perhaps by increasing the maximum length of hospital stay covered by the program. Alternatively, the plan could focus on the costs associated with chronic illnesses such as nursing home stays. These services currently receive little coverage under both Medicare and Medigap policies.

In this article, we examine the types of coverage that will be most effective in providing protection for the elderly against the high costs of medical care. After providing some background information on current coverage levels and limitations, we analyze the health care utilization patterns of the elderly to determine the extent to which current Medicare and Medigap policies pay for high-cost illnesses. We then examine the out-of-pocket burden that remains and explore what types of additional coverage can reduce the chance of catastrophic financial losses. The findings are used to suggest ways in which the federal government can most effectively extend health care coverage for high-cost illnesses.

Current Coverage For High-Cost Illness

Medicare. Medicare was not designated to cover the total costs of care
for the elderly. The complex set of program benefits reflects the historical intent to help the elderly pay for medical services during acute illness. In 1984, Medicare payments accounted for less than 49 percent of the total health care bill of the elderly. Of the $30.2 billion direct out-of-pocket expenses incurred by the elderly, the largest component was for nursing home care (42 percent), followed by “other care,” for example, other professional services, drugs, and appliances (31 percent). Traditional big ticket expenses-hospital and physician services-constitute just 5 and 21 percent respectively.

To better understand the out-of-pocket expenses of the elderly, it is useful to review what services Medicare does and does not cover. Medicare coverage is provided under two separate parts of Title 18 of the Social Security Act. Services covered under Part A consist primarily of payment for hospital inpatient services, skilled nursing home services, and home care services. Part B coverage includes payment for services provided by physicians and other suppliers of medical services. Out-of-pocket expenses fall into two categories: limitations on Medicare payments for covered services such as deductibles and coinsurance; and services that Medicare does not cover.

Most noteworthy examples of the former are the initial deductible for hospitalization, currently at $492 for each spell of illness; daily deductibles of $123 for days sixty-one to ninety of hospitalization; and a daily deductible of $246 for each of the sixty “lifetime reserve” days available to beneficiaries. Medicare patients must also pay a $61.50 per day copayment for the twenty-first to one hundredth days of covered care in skilled nursing facilities. For Part B services there is a $75 annual deductible and a 20 percent coinsurance payment for each service. If the physician is unwilling to accept the Medicare “reasonable charge” as payment in full, the patient is also responsible for the difference between the physician’s billed charges and the Medicare reasonable charge.

Among the medical care services that Medicare fails to cover are skilled nursing care over 100 days, and any custodial and intermediate long-term care services. Other uncovered services include outpatient prescription drugs, routine physical exams, eyeglasses and hearing aids, and nonsurgical dental care.

The special problem of nursing home services. The most important of these gaps in Medicare coverage, and perhaps the least well-understood, concerns Medicare’s nursing home coverage. At first glance, it would appear that the Medicare benefit of 100 days of posthospital skilled nursing care could provide substantial protection. Certainly, most elderly are not aware of the Medicare limitations. A recent survey conducted for the American Association of Retired Persons found that 79 percent of the elderly believe that Medicare will help finance a nursing home stay lasting a month or longer, and 50 percent think that private
health insurance policies will.\textsuperscript{7} Furthermore, among those venturing a guess, two-thirds believe that Medicare will cover 50 percent or more of these costs. These estimates are very inaccurate; although precise figures on the proportion of stays covered by these two payment sources are not available, Medicare pays for less than 2 percent of the elderly's nursing home bills, and private insurance covers only 1 percent.\textsuperscript{8}

In another study, conducted for the Health Care Financing Administration (HCFA) using 1982 data, McCall, Rice, and Sangl found that only 36 percent of the elderly knew that they will not be fully covered by Medicare for a six-month nursing home stay, and only 32 percent of those who owned Medicare supplement policies correctly knew whether or not their policy covered skilled nursing facility (SNF) care.\textsuperscript{9}

How is it that Medicare covers so little nursing home care? The most obvious reason is that Medicare requires a nursing home stay to meet several conditions to be eligible for coverage. These include that: the stay be in a Medicare-approved skilled nursing facility, which excludes intermediate care facility (ICF) services; skilled nursing care be judged as necessary on a daily basis for the patient's rehabilitation; care succeed a hospital stay of at least three days and admission to the nursing home begin within thirty days of discharge from a hospital or another SNF; and a physician must authorize the care.

In practice, it is much more difficult for a stay to meet all Medicare conditions (and therefore be covered for the 100-day maximum period) than it might appear. First, as Feder and Scanlon report, many areas of the country lack SNFs, and often, existing SNFs do not apply for Medicare certification, In 1978, the number of Medicare SNF beds per aged person varied by a factor of fifty among the states.\textsuperscript{10} Furthermore, stays in Medicare-certified SNFs often are not covered because they do not qualify as requiring daily skilled care or therapy that will lead to a patient's rehabilitation. Medicare often terminates coverage for stays quickly. For example, in 1977, for stays covered by Medicare, coverage lasted an average of twenty-eight days when in fact the average stay lasted twice that long. These cut-offs occurred in part because patients soon reached their "rehabilitation potential," and subsequently needed "maintenance therapy," which is not considered to be skilled care.\textsuperscript{11} Furthermore, nursing homes may be reluctant to submit marginal claims to Medicare because they are sometimes financially liable if such claims are denied.

In another study, Smits, Feder, and Scanlon examined the consistency of Medicare coverage decision by asking the individuals responsible for Medicare coverage decisions at the Medicare intermediaries, professional standards review organizations (PSROs) and the Health Care Financing Administration (HCFA) whether or not they would approve Medicare coverage for nine hypothetical nursing home patients.\textsuperscript{12} The authors found that there was little agreement among respondents as to whether a
particular stay would be covered by Medicare, and for how long. For example, in one hypothetical case, “a demented patient with severe obstructive uropathy, renal failure, and a heart condition [with] a supra-public catheter in place,” exactly half of the respondents said they would have ruled in favor of Medicare coverage, and half would have ruled against it. Clearly, there is a need for Medicare to clarify coverage standards so that both nursing homes and beneficiaries will know whether they will receive reimbursement.

**Medigap policies.** To protect themselves against the financial consequences of health care expenses that are not covered by Medicare, about two-thirds of the elderly have purchased private supplemental insurance. We used the 1980 National Medical Care Utilization and Expenditures Survey to examine the characteristics of owners and nonowners. Exhibit 1 shows the proportion of the elderly who owned a private policy, by income and race, as well as those having private supplemental insurance or Medicaid.

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**Exhibit 1**
Proportion Of Elderly With Private Health Insurance Or With Private Health Insurance Or Medicaid

![Bar chart showing the proportion of elderly with private health insurance or with private health insurance or Medicaid by income and race.](chart)
Exhibit 1 shows large disparities in ownership of private policies by both income and race. Whereas about 75 percent of whites with incomes above $7,500 owned a policy, only half with incomes less than $7,500 did. Within income groups, racial differences were extremely large—at least twenty-five percentage points in each category. However, if one considers Medicaid as a form of supplemental coverage, which it is, the picture changes dramatically. Although some differences by race and income persist, they are small. What this means is that although a large number of the needy elderly do not have private policies, the Medicaid program picks up many of those who do not. Thus, Medicaid serves a critical function for the poor elderly, one that should certainly be continued and perhaps be enhanced. Nevertheless, about one-fourth of the poor elderly have neither private nor public supplementation.

Typical policies cover most deductibles and copayments that are not covered by Medicare. Although Medigap policies have received some bad press, many appear to be competitively priced, and even Consumer Reports recommends that the elderly purchase a policy. As previously noted, the largest component of out-of-pocket costs among the aged population is nursing home care. One reason for this is that Medigap policies tend to pay very little of this bill—approximately 1 percent of total nursing home costs for this age group. This occurs because Medigap policies typically will cover a stay only if it is covered by Medicare, and cut-off coverage when Medicare cuts off coverage. Although some Medigap policies cover stays up to 365 days, typically they do so only if Medicare covers the stay through the entire 100-day coverage period, which, as noted below, is rare. Even a policy that provides a full year of coverage could cut off benefits after the 100th day if the nursing home stay no longer met the medical requirements of Medicare eligibility.

Data And Methods

Although there has been a great deal of interest in high health costs of the elderly, research has been stymied by the absence of a national data base that contains information about all health care costs for the elderly population. The most recent national health care cost study, the National Medical Care Utilization and Expenditure Survey (NMCUES), conducted in 1980, contains utilization, cost, and demographic data from a nationally representative sample of the elderly. However, it only covers sample members’ costs that were incurred outside of long-term care institutions. This presents a major problem for examining high health care costs for the elderly because 42 percent of out-of-pocket costs for this group are attributable to nursing home use. NMCUES was not designed to collect these costs.
To obtain the necessary information on nursing home costs, we turned to the most recent data available: the National Nursing Home Survey (NNHS). This survey collected data on a nationally representative sample of nursing home residents and discharges. The NNHS resident file collected utilization, cost, and demographic information on a sample of persons who were residents in a nursing home on a particular day in 1977. The NNHS discharge file collected similar data on a sample of persons who were discharged from nursing homes in 1976.

Our first task was to combine NMCUES and NNHS data so that we could have a data source representing the entire elderly population that includes both their institutional and noninstitutional health care costs. In the second step, we estimated what proportion of these costs are paid out-of-pocket, by Medicare and Medicaid, by supplemental health insurance policies, and by other payers.

The methodology we have employed is rather detailed and is only discussed briefly here. To ensure that the assumptions we employed are valid, we compared some of our results with aggregate national health expenditure data from HCFA.

Creating the data set. There are two problems associated with using NMCUES and the NNHS to create a data set representing the entire elderly population. First the surveys were conducted in different years; NMCUES in 1980, the NNHS resident file in 1977, and the NNHS discharge file in 1976. We addressed this problem by projecting 1976 and 1977 population growth rates (by age, sex, and race), health care inflation, and the growth in the number of nursing home beds to 1980. All results therefore apply to 1980.

The second problem is that the use of all records from each of these files would result in some double counting. To address this, we have developed a methodology that eliminates double counting people who are likely to appear on more than one of these data sets. An example of such a person would be someone who was discharged from a nursing home during the year, and living at home the remainder of the year.

Computing health care costs and payments. The second step necessary for examining who pays for high health care costs was to calculate total health care during 1980 for each sample member, broken down by type of service and payer. This process had to be conducted separately for each of the three data sources, since each contains somewhat different information about health care costs. The major problem we encountered was the lack of information on health insurance ownership from the National Nursing Home Survey files. We dealt with this by projecting policy ownership rates from the NMCUES data, and by making some assumptions about Medicare and Medigap coverage for nursing home stays. In all cases, we attempted to be conservative, attributing the benefit of the doubt in favor of Medigap policies. It should also be noted that
there is one type of health care cost that is not covered by any of our data sets—the costs of acute care among the elderly who were in nursing homes part of the year.

Study Results

Exhibit 2 presents 1980 estimates of the number of elderly in each of two groups: those who were not in nursing homes during the year, and those who were. In each of these charts, the elderly population is further subdivided according to the percentage who fall into each of several categories representing their total health care costs. Ninety-two percent of the elderly population were not in nursing homes; the remaining 8 percent that were in nursing homes represent 1.86 million people. The two groups have substantially different patterns of total health care costs. Whereas almost three-fourths of the noninstitutionalized elderly had total costs of less than $1,000, this was true of only 14 percent of those in nursing homes. Similarly, less than 10 percent of the noninstitutionalized had costs above $5,000 compared to over 60 percent of those who were in nursing homes. Clearly, elderly persons who enter nursing homes are at considerable financial risk.

Exhibit 2
Total Health Care Costs By Nursing Home Status

<table>
<thead>
<tr>
<th>Not in nursing home</th>
<th>In nursing home</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,001-10,000</td>
<td>$10,000+</td>
</tr>
<tr>
<td>5.8%</td>
<td>3.0%</td>
</tr>
<tr>
<td>$1,001-5,000</td>
<td>Less than $500</td>
</tr>
<tr>
<td>17.9%</td>
<td>29.2%</td>
</tr>
<tr>
<td>$501-1,000</td>
<td>$501-1,000</td>
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<td>15.3%</td>
<td>6.7%</td>
</tr>
<tr>
<td></td>
<td>$1,001-5,000</td>
</tr>
<tr>
<td></td>
<td>24.8%</td>
</tr>
<tr>
<td></td>
<td>$5,001-10,000</td>
</tr>
<tr>
<td></td>
<td>32.2%</td>
</tr>
</tbody>
</table>

Total health care costs. Exhibit 3 examines the payment sources for all health care costs among the entire elderly population. We have divided the population into six categories, with the last including all those...
who had total health care costs in excess of $7,500. The chart indicates that as total health care costs rise, the proportional burden of out-of-pocket costs lessens until the $7,500 level. At this point, the trend reverses: the proportion on out-of-pocket costs rises substantially, from 17.1 to 24.0 percent, and costs paid by third parties fall by a similar magnitude. The most dramatic fall occurs in the private insurance category. The proportion of total costs paid by private insurance rises gradually, from 7.3 percent of costs for those who have total costs of less than $500, to 19.1 percent of costs for those having costs in the $5,001 to $7,500 range. However, for individuals with health care costs above $7,500, insurance policy payments drop to only 8.7 percent of the total. Given that the methodology we employed always attempted to err on the side of giving the benefit of the doubt to Medigap policies, Medigap policies clearly become less and less useful when costs reach this very high level.

When examining these figures, it is important to keep in mind that comprehensive coverage of health expenses implies that the proportion of out-of-pocket expenses will decline as costs rise. For example, if out-of-pocket costs are 30 percent of the total for someone with $1,000 in expenses, this burden - $300 - rarely would be called catastrophic. However, if another person with $10,000 in costs had to pay 30 percent out-of-pocket, this expenditure - $3,000 - could in fact have catastrophic consequences. This makes the trend in the out-of-pocket column more disturbing, particularly for low-income individuals. When total costs reach the $7,500 level, the proportion paid out of pocket does not simply remain the same; rather, it increases by almost 50 percent.

We have also combined our six total cost categories to allow us to
compare our figures to aggregate HCFA data for 1977. Because our data bases differ from those employed by HCFA, it is important to show that our method of estimating costs and payments is valid. The results we derive are, in fact, similar to HCFA’s, except that they reflect our efforts to tailor the assumptions to err on the side of overestimating third-party coverage. We found that out-of-pocket costs represent 26.7 percent of total costs, whereas HCFA data estimate this to be 29.3 percent. Our figures show that public third parties pay 60.9 percent of total costs; HCFA data indicates 64.2 percent. The major difference is for Medigap policies: our data show that private insurance pays 12.0 percent of total costs, whereas HCFA data show only 6.4 percent.

By subdividing the group of people with expenditures above $7,500, we can get a better idea of why out-of-pocket costs rise for persons who have total costs in excess of $7,500 a year (Exhibit 4). Out-of-pocket costs continue to rise up to the $10,001-12,500 category, where they reach a maximum of 29.8 percent, and then start to decline for the two higher categories. Conversely, the proportion of costs paid by Medigap policies, which reaches a low of 6 percent in the $10,001-12,500 grouping, rises sharply after that. This apparently occurs because annual expenditures above $12,500 were more likely to be the result of long hospital stays. Unlike those in nursing homes, hospital stays are more likely to be covered by Medicare and supplemental insurance. This is further evidenced in Exhibit 4 by the fact that Medicare’s share rises from 27 percent in the $10,001-12,500 category to over 47 percent in those total expenses above $15,000.
**Nursing home costs.** Exhibit 5 shows who paid for nursing home stays in the different cost categories. The three lowest categories are not included because they are similar to each other, with out-of-pocket costs representing about 40 percent in each. Here, we see that out-of-pocket costs fall as a proportion of total costs until the $7,501-10,000 level, and then rise dramatically reaching 50 percent level in the two categories above $12,500. Most of this increase is due to the fact that Medicaid’s proportion declines by a similar magnitude over these ranges. This occurs in turn because daily costs tend to be higher for patients in nursing homes that have a high proportion of private patients. Consequently, more of these patients fall into the highest cost categories, and by definition, Medicaid usually does not pay for these stays.

The pattern shown by Medicare and Medigap policies is especially noteworthy. Medicare actually pays a fairly high percentage of costs in the categories not shown: for example, 33 percent in the $1,000-2,500 category. However, the Medicare share falls precipitously, to less than 5 percent for all categories above $5,000. This is important because, as shown in Exhibit 2, over 60 percent of the institutionalized patients had stays costing more than $5,000. Finally, Medigap policies pay less than 4 percent of costs in each category, even those not shown. These percentages for Medicare and Medigap policies also illustrate the fact that our assumptions do give them the benefit of the doubt, since the percentages we record are somewhat higher than those listed in the national expenditure data cited above.

Once again, we have combined all cost groups to allow comparison to national expenditure data. Our figures show that 41.3 percent of nurs-
ing home costs are paid out of pocket, compared to HCFA's 1977 estimate of 49.2 percent. Our figure for Medigap policies is 2.8 percent, while the national data indicates that they pay for only 0.8 percent of nursing home costs. Other third parties are also shown to be given a small benefit of the doubt.

The purpose of these charts is not to give precise point estimates. As we noted in the methodology section, no one data set can address the question we raise, so to compute our estimates we had to make a number of assumptions. What is important is the pattern that we see: as costs of health care—particularly nursing home care—rise, the portion of costs paid by third parties falls. This means that in absolute dollars, the burden of out-of-pocket costs becomes especially high.

Exhibit 6
Out-Of-Pocket Costs By Type Of Service
Out-of-pocket costs. The final, and perhaps the most important, issue addressed in the analysis concerns what types of services are responsible for high out-of-pocket expenditures incurred by the elderly. Exhibit 6 shows the proportion of total out-of-pocket costs among group members that are attributable to the various medical services. For example, among people with out-of-pocket costs less than $500, about 41 percent of their total out-of-pocket costs were attributable to physician services, and a similar amount was for drugs/other services.

Exhibit 6 indicates that individuals with low out-of-pocket costs are spending their money primarily on physician, drug, and dental services. Among those with out-of-pocket costs of less than $500 annually, 95 percent are attributable to three types of services. This proportion is somewhat lower in the next two cost categories, but still remains relatively high: 85 percent for those with costs between $500 and $1,000, and 70 percent for people with out-of-pocket liabilities between $1,000 and $2,000.

It is not surprising that hospital and nursing home care leads to almost no out-of-pocket liabilities for those with total health care costs less than $500, since it is unlikely that a person who has been in either institution could have been discharged without any health care expenses during the year. Not surprisingly, their proportions gradually rise in the next two categories; for example, among those with expenses between $1,000 and $2,000 annually, hospital costs account for one-fifth of out-of-pocket liabilities, and nursing home costs for a tenth.

A dramatic change occurs in the category of people with out-of-pocket expenses over $2,000 a year; nursing home costs are responsible for over 80 percent of these costs, and hospital care for only 10 percent. Thus, for the one million elderly subject to these very high financial liabilities, nursing home care is the overwhelming cause. Hospital, physician, dental, and drug costs account for a very small proportion of their expenses. The fact that high out-of-pocket costs for the elderly are almost entirely from nursing home stays has profound implications for federal policy.

Conclusions

Our results support the notion that additional coverage is needed by some of the elderly. Even though the vast majority of Medicare beneficiaries have supplemental coverage, either privately through Medigap policies or publicly through Medicaid, many are faced with very high out-of-pocket costs. We found that proportion of costs paid out-of-pocket rises as total health expenses rise beyond $7,500 a year, and that about one million elderly persons must pay more than $2,000 in out-of-pocket costs annually.
There are of course, many ways in which Medicare benefits can be modified. Perhaps the most talked-about change is one in which Medicare's hospital benefits are extended to cover stays of unlimited duration, and which removes the sizable copayments from stays over sixty days in length. To finance such a change, and to deter the unnecessary utilization of hospital services, some copayments (in addition to the $492 initial deductible) for short stays would be assessed. Furthermore, there might be an increase in the monthly premium paid by each beneficiary.

Nevertheless, our study results indicate that extending Medicare coverage in this fashion will do very little to remove the burden of high-cost illness for the elderly population. Perhaps surprisingly, we found that nursing home, not hospital, costs are responsible for a substantial portion of the current out-of-pocket liability borne by the elderly. Because neither Medicare nor supplemental health insurance policies provide practically any coverage for the nursing home, there would have to be a major overhaul of Medicare to eliminate the financial burden of high-cost illness.

Some might argue that government and private third parties should not increase their payments for nursing home care because a large portion of the associated costs is not for medical care per se, but rather for custodial care such as room and board. Although this is true, there are good reasons to increase third-party coverage for nursing home care. The primary purpose of insurance is to protect individuals against catastrophic losses. Whether or not one considers nursing home care to be medical care, it can have catastrophic consequences. Although exact figures are not available, the cost of a month of care in a typical nursing facility now is in excess of $1,500.\textsuperscript{19} Average annual family incomes for those over sixty-five are approximately $15,000.\textsuperscript{20} A prolonged nursing home stay can quickly deplete resources, result in poverty, and lead to Medicaid taking over payment responsibilities.

Additional third-party coverage for nursing home care is the key to preventing financial catastrophe among the elderly, but there is still the question of how this coverage can best be achieved. Two possibilities are the development of private insurance policies, or extending Medicare to include a voluntary option for long-term care services.

In an article in this journal, Mark Meiners first proposed the possibility of private coverage for nursing home care.\textsuperscript{21} Since then there have been a number of developments. Meiners and Gorden Trapnell have made actuarial estimates indicating that insurers could provide prototype policies covering nursing home and home health services for a seventy-year-old individual at a premium under $50 per month.\textsuperscript{22} Kennell estimates that such a policy would cost half of the elderly population, age sixty-five to sixty-nine, less than 5 percent of their cash income. However, this would be true of only 9 percent of those over eighty years old.\textsuperscript{23}

Today, an estimated forty companies are marketing long-term care
products; most are indemnity policies. Subscribership for these poli-
cies, many of which are experimental, has grown from 90,000 to 150,000
during the past year.\textsuperscript{24} Representatives in three states have introduced
legislation mandating long-term care benefits. Over ten other states have
commissioned special committees to examine what actions states can
adopt to foster the development of these policies.\textsuperscript{25}

One of the most significant experiments in the development of long-
term care insurance is the joint venture by the American Association of
Retired Persons (AARP) and Prudential Insurance Company. In 1985,
AARP-Prudential sent marketing kits to 215,000 randomly selected eld-
erly and near-elderly households in six states. The insurance plan could
cover 50-70 percent of the average cost per day of nursing home ex-
penses and 60-80 percent of health care expenses for a monthly pre-
mium that ranged between $15 for individuals age fifty to fifty-nine,
and $95 for those seventy-five to seventy-nine. Only 1,500 of these house-
holds chose to purchase a policy.\textsuperscript{26} Those that did tended to be younger
households, with higher than average incomes and greater knowledge
about the lack of coverage by Medicare and Medigap policies for long
term services. One of the lessons of the experiment, according to Ron
Hagen, an AARP researcher, is that nearly all of the elderly deny the pos-
sibility that their last years of life will be lived in a debilitated, dependent
state. This denial is a greater impediment to the development of a private
long-term care market than setting premiums within the elderly’s house-
hold budget.\textsuperscript{27}

Another problem with long-term care is that insurance companies may
not wish to provide coverage due to the fear of adverse selection- that
those who are most likely to need long-term care will be the ones who
purchase it. Although the AARP survey does not support this, it is clear
that insurance companies are reluctant to quickly enter the long-term
care market. If this continues to be a problem, federal action might be
called for.

Karen Davis and Diane Rowland have proposed that Medicare enact
an optional long-term care plan that would cover skilled and custodial
nursing home care as well as home care services.\textsuperscript{28} In order to avoid
adverse selection, individuals would have to enroll between ages sixty
and seventy and benefits could not be used until the person had been
enrolled for five years. There would be a 10 percent coinsurance rate
subject to a maximum of $3,000 out-of-pocket. Premiums would be
assessed at 4 percent of income.

Whatever approach is taken, Congress must face that the fact that the
major cause of high-cost illness is long-term care expenses. Any approach
that does not explicitly cover these expenses will do little to help keep
the chronically ill out of poverty.
We would like to thank Greg de Lissovoy, Katherine Desmond, and Greg Samsa for creating the analysis file used in this study. We appreciate the comments on earlier drafts from a number of colleagues: Maxine Gomick, Korbin Liu, Nelda McCall, Mark Meiners, Lynn Paringer, Judith Sangl, and William Weissert. We would also like to thank Professor Weissert for providing funding for the programming tasks through the Program on Aging at the University of North Carolina School of Public Health. Furthermore, we appreciate the support provided by the National Center for Health Services Research and Health Care Technology Assessment.

NOTES

4. Ibid.
5. Ibid.
6. Ibid.
11. Ibid.
15. Waldo and Lazenby, “Demographic Characteristics and Health Care Use and Expenditures.”
16. A more detailed discussion of the study methodology is available from the authors. Thomas Rice, Department of Health Policy and Administration, School of Public Health, 263 Roseman Hall, 201-H, University of North Carolina, Chapel Hill, NC 27514
17. Waldo and Lazenby, “Demographic Characteristics and Health Care Use and Expenditures.”
18. Ibid.
19. Ibid. This was computed by taking the most recent data, from 1977, and inflating it by an annual rate of 8.4 percent.
24. L. Lane, American Health Care Association, personal communication.
27. R. Hagen, American Association of Retired Persons, personal communication.