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HEALTH CARE REFORM STUDIES

II

THE WHITE HOUSE

WASHINGTON

April 2, 1990

MEMORANDUM FOR DAVID Q. BATES

FROM: KEN YALE *KY*
SUBJECT: Health Care Reform Studies

The President gave the DPC a mandate to review studies and recommendations for health care delivery system reform.

Due to the growing interest in the health care reform debate, there are many such studies currently underway or recently completed. Some are major government initiatives: ie., the "Pepper Commission", Social Security Quadrennial Commission, and Treasury Department Health Care Financing. Others are major private sector reports and recommendations: ie., the American Medical Association and Health Insurance Association of America reports. In addition, there are several major legislative proposals introduced or in the formative stages on the Hill.

We are working with HHS to develop a system to compile these reports and recommendations. You will recall that Governor Sununu had asked about the different reports at an earlier meeting. At some point it may be appropriate to develop a side-by-side comparison, to address questions such as those raised by the Governor. In addition, we can produce a summary of any report for your use, should it be necessary.

cc: Stephen Danzansky
Dan Heimbach
John Schall
Justine D'Andrea
Sara Sumner

HEALTH CARE REFORM STUDIES

1. A National Health System for America, The Heritage Foundation (1989)
2. A National Health Program for the United States: A Physician's Proposal, The New England Journal of Medicine (January 12, 1989)
3. National Governors' Association Study on Medicaid Eligibility and Coverage for Pregnant Women, Children and Families (July 1989)
4. Insurance Association of Connecticut Proposal on Medically Uninsured (January 9, 1990)
5. S.2032, Health Care Insurance Credit Legislation (Cohen, introduced January 30, 1990)
6. S.2050, Medigap Fraud and Abuse Prevention Act (Kohl, introduced February 1, 1990)
7. H.R. 3931-3, Medicaid Expansions (Waxman, reintroduced February 1, 1990)
8. Health Insurance Association of America (HIAA) Proposal to Expand Access to Health Care (February 19, 1990)
9. AFL-CIO Principles For National Health Care Reform (February 20, 1990)
10. S.2163, Universal Health Insurance for Seniors (Kennedy, introduced February 22, 1990)
11. H.R.4070, The Health Care Empowerment and Access Legislation (Grandy, introduced February 22, 1990)
12. S.2199, The Health and Long-Term Security Act of 1990 (Packwood, introduced February 28, 1990)
13. Department of the Treasury Report: Financing Health and Long-Term Care (March 1990)
14. A Report to the Governor and Members of the California Legislature on Health Insurance Coverage (March 1, 1990)
15. Pepper Commission Report on Access to Health Care and Long-Term Care (March 2, 1990)
16. American Medical Association (AMA) Health Care Reform Proposal (March 5, 1990)

17. S.2246, Medicare Home Benefits Improvement Act (Bradley, introduced March 7, 1990)
18. H.R. 4253, Universal Health Program for All Americans (Oaker, introduced March 13, 1990)
19. H.R. 4280, Health Insurance for Children and Mothers Act of 1990 (Stark, introduced March 15, 1990)
20. Steelman Report

FINANCING HEALTH AND LONG-TERM CARE

Report to the President and to the Congress



March 1990

FINANCING HEALTH AND LONG-TERM CARE

Report to the President and to the Congress



March 1990



DEPARTMENT OF THE TREASURY

WASHINGTON

March 1990

ASSISTANT SECRETARY

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

I am pleased to submit to you our report, Financing Health and Long-Term Care. President Reagan mandated this report when he sent to Congress proposals to provide catastrophic health care coverage for the elderly. In his directive, he required specifically that the Department of the Treasury present to the President a study of various tax incentives related to catastrophic illness for the nonelderly, personal savings for long-term care, and development of the private long-term care insurance market for the elderly.

Section 113 of Public Law 100-360, the Medicare Catastrophic Coverage Act of 1988, also provided that the Secretary of the Treasury conduct a study of Federal tax policies to promote the private financing of long-term care. The law required the study to consider the cost to the United States Treasury and the potential benefits to consumers, including whether the incentives would benefit all or most of the population requiring protection. The legislation repealing the Medicare Catastrophic Coverage Act of 1988, Public Law 101-234, specifically retained the mandate for this study (section 102).

Pursuant to both these directives, I hereby submit Financing Health and Long-Term Care: Report to the President and to the Congress. This Report will be submitted concurrently to the Domestic Policy Council, consistent with your mandate to the Council that it conduct an overall assessment of the quality, accessibility, and cost of our nation's health care system.

The Report contains no specific recommendations, but instead presents for further consideration and analysis data bearing on these issues and tax options for financing long-term care for the elderly and health insurance for the nonelderly.

Respectfully,

Kenneth W. Gideon
Assistant Secretary
(Tax Policy)



DEPARTMENT OF THE TREASURY

WASHINGTON

March 1990

ASSISTANT SECRETARY

The Honorable Thomas S. Foley
Speaker of the House
House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Section 113 of Public Law 100-360, the Medicare Catastrophic Coverage Act of 1988, provided that the Secretary of the Treasury conduct a study of Federal tax policies to promote the private financing of long-term care. The law required the study to consider the cost to the United States Treasury and the potential benefits to consumers, including whether the incentives would benefit all or most of the population requiring protection. The legislation repealing the Medicare Catastrophic Coverage Act of 1988, Public Law 101-234, specifically retained the mandate for this study (section 102).

In proposing catastrophic health care for the elderly, President Reagan also directed the Department of the Treasury to present to the President a study of various tax incentives related to catastrophic illness for the nonelderly, personal savings for long-term care, and development of the private long-term care insurance market for the elderly.

Pursuant to both these directives, I hereby submit Financing Health and Long-Term Care: Report to the President and to the Congress. This Report will be submitted concurrently to the President's Domestic Policy Council, consistent with President Bush's mandate to the Council that it conduct an overall assessment of the quality, accessibility, and cost of our nation's health care system.

The Report contains no specific recommendations, but instead presents for further consideration and analysis data bearing on these issues and tax options for financing long-term care for the elderly and health insurance for the nonelderly.

I am sending a similar letter to Representative Robert H. Michel.

Sincerely,

Kenneth W. Gideon
Assistant Secretary
(Tax Policy)



DEPARTMENT OF THE TREASURY

WASHINGTON

March 1990

ASSISTANT SECRETARY

The Honorable J. Danforth Quayle
President of the Senate
United States Senate
Washington, D.C. 20510

Dear Mr. President:

Section 113 of Public Law 100-360, the Medicare Catastrophic Coverage Act of 1988, provided that the Secretary of the Treasury conduct a study of Federal tax policies to promote the private financing of long-term care. The law required the study to consider the cost to the United States Treasury and the potential benefits to consumers, including whether the incentives would benefit all or most of the population requiring protection. The legislation repealing the Medicare Catastrophic Coverage Act of 1988, Public Law 101-234, specifically retained the mandate for this study (section 102).

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The Report contains no specific recommendations, but instead presents for further consideration and analysis data bearing on these issues and tax options for financing long-term care for the elderly and health insurance for the nonelderly.

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Kenneth W. Gideon
Assistant Secretary
(Tax Policy)

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PART ONE
EXECUTIVE SUMMARY

CHAPTER 1: EXECUTIVE SUMMARY

I. BACKGROUND OF THE REPORT

The report was prepared in response to both a Presidential directive and a congressional mandate. When President Reagan sent Congress his proposals for catastrophic health care coverage for the elderly in February 1987, he directed the Department of the Treasury to study and report back to him on a variety of tax measures to help finance catastrophic illnesses for the nonelderly and long-term care for the elderly. The Medicare Catastrophic Coverage Act of 1988 added a legal requirement that Treasury study Federal tax policies to help finance long-term care, a requirement that was specifically retained when the Act was repealed in 1989.

II. FINANCING LONG-TERM CARE FOR THE ELDERLY

A. Definition of Long-Term Care

Long-term care covers the support of individuals with chronic physical or mental disabilities that make it difficult for them to care for themselves over an extended period of time. Long-term care often involves custodial skills that many adults are able to provide, such as bathing, cooking, and shopping, rather than medical skills. Although nonelderly individuals also have long-term care needs, this Report focuses on financing long-term care for the elderly.

B. Current Financing of Long-Term Care

Over three-quarters of the elderly who require long-term care receive that care in the community. Of those cared for in the community, more than three-quarters are cared for informally by family and friends. Formal care in the community, about half of which is paid for by the elderly and their families and the other half by government, is provided to the rest. The remaining quarter of the elderly needing long-term care receive it in nursing homes, with slightly more than half of the cost borne by the elderly and their families, and most of the remainder paid by Medicaid; only 1 percent is currently paid by private insurance.

C. Projected Needs and Financing

Needs for long-term care are expected to grow in the future due to longer life expectancies, aging of the population generally, and economic factors such as rising incomes. Financing of these needs must come from one of the following sources: the income and wealth of the elderly and their families, time contributed by members of their families and communities, private long-term care insurance, Federal and state tax subsidies, or other Federal, state, and local programs. This Report examines each financing source, with the following findings:

- The income and wealth of the elderly have grown rapidly over the past two decades, both in absolute terms and relative to the income and wealth of the nonelderly. Further, there

should be a continued improvement in the economic well-being of the elderly. However, most pensions pay the same amount in early retirement years as in later retirement years, when the need for long-term care is greatest.

- The private long-term care insurance market is still developing. Clarification of the Federal tax treatment of employers' contributions to prefund this insurance and of distributions from policies might be helpful.
- Federal tax law already provides very generous treatment for employer pension contributions and reserve earnings, which are not taxed to employees until received as pension benefits. This tax treatment appears to be the appropriate model for long-term care, because a significant portion of long-term care expenses are for ordinary living costs and custodial care rather than medical care. (Expenses for medical care, over an income floor, are effectively untaxed because they are deductible.)

III. FINANCING HEALTH INSURANCE FOR THE NONELDERLY

A. Expenditures on Health Care

In 1987 total expenditures on health care in the United States were estimated to be \$500 billion, or 11.1 percent of GNP, compared to less than 6 percent of GNP in 1965, just over two decades ago. Federal outlays related to health were estimated to be about \$145 billion in 1987, or more than one out of every eight Federal outlay dollars. Tax subsidies related to health care also reduced Federal revenues by nearly \$50 billion annually. State and local governments in turn expended an estimated \$63 billion on health care in 1987, exclusive of tax expenditures. Counting all sources of funds, governments directly or indirectly cover almost half of all health care expenditures, spending about 1/4 of \$1 trillion on health care in 1987. For the future, increased demand for health care and continued inflation of prices for medial services are expected to cause expenditures on health care to rise at a much faster rate than the growth rate of gross national product.

B. Comparison with Other Countries

Private and public expenditures on health care comprise a larger percentage of gross national product in the United States than in any other major industrial country. Indeed, only France and Sweden approach the share of GNP allocated to health in the United States. Other nations, such as Canada, that were on a par with the United States 20 years ago allocate about 3 percentage points less than the United States to health care.

This is not to argue that the United States share of total resources spent for health care is "too high" or should equal what other countries distribute to their health systems. In some cases, lower spending levels in other countries reflect more restricted access to care. Moreover, if properly targeted, resources allocated to health care can lead to improved productivity and higher rates of economic growth. What is troubling is evidence that other countries may be equaling--or, in some cases, surpassing--our performance in health care, and achieving at least as good an outcome

with less resources. Measures of life expectancy and infant mortality, for example, do not seem to reflect the extra outlays for health care in the United States.

C. Health Insurance Coverage of the Nonelderly Population

The Federal government influences the availability of health insurance to the nonelderly in two ways. It directly provides insurance to 12 percent of the nonelderly population through Medicaid and other public programs. Two-thirds of the nonelderly receive an indirect government subsidy through the exclusion of employer-provided health insurance premiums from employees' income subject to income and Social Security taxes. For a typical employee, this tax subsidy reduces the cost of health insurance by over 30 percent.

In 1985, nearly 35 million individuals under age 65, or over 17 percent of the nonelderly population, did not have health insurance coverage. Of the nonelderly uninsured, over half were employed, and an additional 32 percent were children. Among the insured nonelderly population, coverage of the insurance varied.

D. The Exclusion for Employer-Provided Health Insurance

This Report examines the tax exclusion for employer-provided health insurance, and finds the following:

- The current exclusion is unlimited and untargeted, providing a subsidy to purchase large amounts of health insurance coverage, such as first-dollar coverage and coverage of routine care.
- The exclusion increases demand for health care services, putting upward pressure on prices for the services.
- The exclusion benefits most those who work for employers that provide large amounts of health insurance for employees, but provides no benefit to employees whose employers provide no health insurance.
- The exclusion provides a larger benefit to those in higher tax brackets.

VI. SUMMARY OF OPTIONS

The following options are presented for further consideration and analysis. The more detailed discussion of these options in Chapters 6 and 10 include a number of important design considerations that are not summarized here.

A. Options for Financing Long-Term Care for the Elderly

- **Adjust Pension, Annuity, and Individual Retirement Account Payments for Long-Term Care.** This option would allow payments from pensions, annuities, and IRAs to be adjusted for certain contingencies associated with the need for long-term care, such as the

inability to perform certain Activities of Daily Living (ADLs). Payments could also be adjusted to pay for private long-term care insurance. The tax law would be clarified to cover these adjustments.

- **Clarify the Tax Law.** The tax treatment of employers' contributions to prefund long-term care insurance, and of the distributions from these policies, could be clarified. In particular, to avoid large future revenue losses, distributions from long-term care policies would continue to be subject to tax, but with a continued allowance of a deduction for medical expenses.

B. Options for Financing Health Insurance for the Nonelderly

Some of the options presented below would increase Federal revenues while other options would reduce them, making it possible to form a revenue-neutral proposal for financing health insurance for the nonelderly.

- **Limit the Employee Exclusion.** The exclusion could be capped at a specified dollar amount per month. The cap could be set sufficiently high that it would apply to relatively few employees.
- **Allow Exclusion Only for Policies with Specified Provisions.** The employee exclusion could be limited to employer-provided health insurance policies that contained specific provisions, such as a minimum deductible and coinsurance rate.
- **Limit Employer Deduction for Health Insurance.** Rather than limit the employee exclusion, the amount deductible by employers could be limited to a specified amount per employee.
- **Tax Credit for Health Insurance.** A tax credit could be provided to families who do not have employer-provided or public health insurance. If the credit were refundable, it could be paid through insurance companies for families who do not file income tax returns.
- **Deduction for the Self-Employed.** The current 25 percent deduction for health insurance purchased by the self-employed, which expires October 1, 1990, could be made permanent, and could be expanded.

PART TWO

FINANCING LONG-TERM CARE FOR THE ELDERLY

CHAPTER 2: INTRODUCTION AND SUMMARY

I. INTRODUCTION

A. Long-Term Care Defined

Long-term care is support for persons whose chronic physical or mental disabilities make it difficult for them to care for themselves over an extended period of time. Many elderly people, but also many nonelderly, require long-term care. This Report, in accordance with its mandate, focuses on financing long-term care for the elderly.

Long-term care often involves custodial skills that many adults are able to provide, such as bathing, cooking, and shopping, rather than medical skills. Most individuals needing long-term care therefore receive it in their own home or that of a family member and are cared for informally by family and friends. Although concern about access to long-term care often focuses on whether those who need care can afford nursing home costs, current estimates suggest that for each elderly nursing home resident, there are two persons with long-term care needs who are cared for within the community.¹ Most of the elderly who both require long-term care and live in the community (76 percent) receive all their care informally.² Thus, for nearly two-thirds of the elderly who receive long-term care, the direct costs are borne as much or more by family and friends as by the elderly themselves.

For the elderly in nursing homes and those in the community who pay for care, however, long-term care expenses are large. With a year of nursing home care costing approximately \$22,000 in 1985,³ uninsured persons of moderate means may be unable to pay for more than a short stay. As a result, Medicaid is a major provider of funds for nursing home care. For the future, the number of elderly persons requiring long-term care and the amount of care they will need are expected to increase as life expectancies lengthen and economic and social factors, such as support from extended families, change.

B. Current and Future Needs for Long-Term Care

Nearly a quarter of persons now over 65 require long-term care. Most receive care outside of nursing homes. In 1980, 4.6 percent of the elderly received long-term care in nursing homes, while 18.1 percent of the elderly received long-term care while living in the community (see Table 2.1).

The elderly themselves will become a larger proportion of the U.S. population in the future. Defining the "elderly" as those aged 65 and older, Table 2.1 shows that the proportion of the U.S. population that is elderly is expected to grow from 11.3 to 21.7 percent between 1980 and 2040. A significant part of this increase is due to demographic changes such as the aging of the post-World War II baby boom generation and the decline in the birth rate. Another part, however, is directly related to the longer life spans of individuals.

Life expectancy for females at age 65, for instance, has risen over 40 percent since 1935 and is now close to 19 years. At the same time, longer life spans, along with other changes in

Table 2.1 Current and Projected Long-Term Care Needs of the U.S. Population Age 65 and Over

Year	U.S. Population ¹		Persons Age 65 and Over Needing Long-Term Care				
	Total	Age 65 and Over	Total	In Nursing Homes	In the Community		
					Total	Limited Needs ²	Severe Needs ³
A. Total Population (Thousands)							
1980	226,053	25,544	5,813	1,187	4,626	1,465	3,161
2000	268,623	34,921	9,343	2,081	7,262	2,198	5,064
2020	297,236	51,422	12,923	2,805	10,118	3,085	7,033
2040	308,558	66,988	18,769	4,354	14,415	4,241	10,174
B. Percent of Total Population Age 65 and Over							
1980	--	100.0%	22.8%	4.6%	18.1%	5.7%	12.4%
2000	--	100.0	26.8	6.0	20.8	6.3	14.5
2020	--	100.0	25.1	5.5	19.7	6.0	13.7
2040	--	100.0	28.0	6.5	21.5	6.3	15.2
C. Percent of Total U.S. Population							
1980	100.0%	11.3%	2.6%	0.5%	2.0%	0.6%	1.4%
2000	100.0	13.0	3.5	0.8	2.7	0.8	1.9
2020	100.0	17.3	4.3	0.9	3.4	1.0	2.4
2040	100.0	21.7	6.1	1.4	4.7	1.4	3.3

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Notes: ¹Bureau of the Census projections, medium series.

²Limited needs include persons who cannot perform "Instrumental Activities Necessary to Daily Living," such as shopping, cooking, and performing chores.

³Severe needs include persons who cannot perform at least one of six "Activities Necessary for Daily Living," eating, using the bathroom, mobility, bathing, continence, and dressing.

Sources: Population data for 1980: U.S. Bureau of the Census, *Decennial Census of the Population*; projections for 2000 to 2040: U.S. Bureau of the Census, *Projections of the Population of the United States by Age, Sex, and Race: 1983 to 2080. Current Population Reports, Series P-25, No. 952, Table 6.*

Long-term care estimates reported in the Department of Health and Human Services, *Report to the Secretary on Private Financing of Long-Term Care for the Elderly*, November 1986, Tables 2-1 to 2-3.

well-being, require further adjustments in society. Private suppliers of goods will produce fewer toys and more travel services, for example, as the population ages. The public provision of goods also will change, such as by increasing Social Security payments to an increasing number of aged persons.

While the elderly are increasingly better off in terms of health, as well as income and wealth, the increase in the number of the elderly over age 85--the age group most likely to need long-term care--may lead to a significant increase in the demand for long-term care. Thus, as shown in Table 2.1, the Department of Health and Human Services estimates that the proportion of the elderly requiring long-term care will increase by 23 percent (from 22.8 percent of the elderly to 28.0 percent of the elderly) between 1980 and 2040.

Total expenditures on one component of long-term care, nursing home care, have grown steadily over the last 25 years in the aggregate, on a per capita basis, and as a share of GNP. Table 2.2 shows the growth of expenditures over this period and the projections of the Health Care Financing Administration on future growth to the year 2000. Nursing home expenditures increased as a percentage of GNP, from 0.3 in 1965 to just under 1 percent in the mid-1980's.⁴ These expenses include nursing home care for the nonelderly, as well as the elderly. The increase in nursing home expenditures reflects growing numbers of elderly who require care as well as changes in the nature of that care. Such shifts in spending patterns are common as the income of a society increases over time, the relative prices of goods change, and the society ages. In addition, government subsidies for long-term care are tied rather closely to institutional care, fostering use of nursing homes. Expenditures for nursing home care are currently paid about one-half by private parties and one-half by government, primarily through Medicaid (although the percentage paid by Medicaid has declined somewhat since 1980). Long-term care insurance covers only a tiny fraction of persons. Medicare, which is believed by many to cover long-term care, was not meant to provide long-term care. Medicare coverage is a small fraction of total long-term care costs.

Although future projections such as those in Tables 2.1 and 2.2 are quite tentative, it is likely that long-term care needs of the elderly and expenditures on their care will continue to grow over the coming decades for the following reasons: changes in birth rates and the aging of the baby-boom population mean an increase in the proportion of the population in more advanced years; the increased economic well-being of the elderly and their children appears to be accompanied by an increase in demand for a variety of forms of care; changes in family and social structures imply an increase in demand for formal caretaking, e.g. because of a possible decline in the number of informal caretakers; and the increased life spans of individuals, while implying increased well-being, have not yet been accompanied by a decrease in health care expenditures by persons at each age.⁵ It is unlikely that nursing homes will be the most efficient form of formal provision in all cases. Increased needs for caretaking, therefore, should be met in a variety of ways.

C. The Financial Well-Being of the Elderly

There have been many recent improvements in the financial well-being of the elderly. The income of the elderly is now approximately the same as that of the nonelderly. Moreover, the youngest elderly--those between the ages of 65 and 70--on average have higher after-tax incomes, lower

Table 2.2 Actual and Projected Nursing Home Care Expenditures, All Ages, 1965-2000¹

<u>Year</u>	<u>Current Dollars</u>		<u>1982 Dollars</u>		<u>Percent of GNP</u>
	<u>Amount (\$billions)</u>	<u>Per Capita</u>	<u>Amount (\$billions)</u>	<u>Per Capita</u>	
1965	\$ 2.1	\$ 10	\$6.8	\$30	0.3
1970	4.7	22	13.9	52	0.5
1975	8.0	36	19.1	61	0.6
1980	20.4	87	23.8	102	0.7
1985	35.0	141	31.4	127	0.8
1990	54.5	211	41.4	160	0.9
1995	84.7	317	52.7	197	1.0
2000	129.0	468	65.9	239	1.2

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Source: *Health Care Financing Review*, 8(4) (Summer 1987). Tables 9, 10, and 18, and calculations based on them.

¹ In 1987, 81 percent of nursing home expenditures were for the elderly. See Waldo, *et al.*, Health Expenditures by age group, 1977 and 1987, *Health Care Financing Review*, Summer 1989.

poverty rates, and greater net worth than both the older elderly and the nonelderly. While there is little evidence that the elderly dissave rapidly, some of the elderly face declining incomes because most private pensions pay the same amount in early retirement years as in later retirement years, when the need for long-term care is greatest.

Each generation of the elderly has generally fared better financially than the previous generation. Thus, it should not be surprising that the youngest elderly have greater resources than the older elderly. Moreover, this trend is expected to continue: private pensions and Social Security are expected to grow in real terms, reflecting the higher real earnings of today's workers over workers a generation ago, providing tomorrow's elderly greater resources than today's elderly. Any change in the public provision or tax subsidization of long-term care must take these factors into account.

D. Financing Long-Term Care of the Elderly

Responsibility for long-term care of the elderly is shared by their families and friends, their community, state, local, and Federal governments, and the elderly themselves. The United States' long-term care system is an aggregation of diverse arrangements rather than a single, coordinated national program. Reviews of the effectiveness of our current long-term care system, as well as of proposals to change Federal financing programs and policies, must take into account both the diversity of these arrangements and the diversity of the elderly themselves.

The current long-term care system depends on informal family and community resources to meet the long-term care needs of most of the elderly. The proportion of the population that is elderly and needs long-term care is increasing. Those elderly who have few family or friends to care for them, and those who need but cannot afford skilled or constant care, may find informal care difficult to secure. Services available to the elderly may depend more on where they live than on what they need.

It is important to recognize that individuals requiring long-term care have expenses for health and custodial care, but also expenses of ordinary living such as food and shelter. Similarly, long-term care financing involves the issue of retirement income as much as it does insurance. A person with \$25,000 of retirement income and no spouse or other dependents could spend almost all of that income on nursing home care if the nursing home provided for all needs including shelter and food. One with \$15,000 of retirement income, on the other hand, would probably have a shortfall of income by which to afford a nursing home. A couple with \$15,000 would have an even greater shortfall. Government policy relating to retirement plans, Social Security, and Medicare, affect the resources individuals have available to finance their long-term care needs.

Long-term care financing is also an issue of insurance. Disability requiring custodial care is an uncommon event of potentially very high cost. For example, the likelihood of using a nursing home in one's lifetime is approximately one in eight, with the cost for a year of nursing home care approximately \$22,000 in 1985. A significant fraction of the elderly in nursing homes have quite short stays--52 percent of persons admitted to nursing homes in 1977 stayed 90 days or less, and 14 percent incurred costs below \$1,000 in 1980. But for those who remain for extended periods, costs are quite high.⁶

The need for long-term care is a risk that is at least partially insurable in the private market. A well-developed private long-term care insurance market hinges on getting people to buy some insurance before they approach the very high-risk years. Group coverage would enhance access and provide coverage with lower premium payments. If group insurance for long-term care, for example, can be marketed to older workers or early retirees--or to their children whose policy covers their parents--there is a good chance of avoiding the serious problems of adverse risk selection. By contrast, trying to market individual policies to 75-year old people runs the risk of loading up the insurance pool with people who already know they are at high risk of needing long-term care.

The risk-pooling aspects of insurance eliminate the need for each individual to save enough to cover the costs of long-term care that relatively few will bear. The market for long-term care insurance is small but growing. Nonetheless, this Report finds that there are a number of characteristics of current long-term care insurance and of current tax rules that may inhibit the market's development. While the tax rules should be clarified, any public action in this area should still proceed cautiously. Many elderly clearly would not find certain types of long-term care insurance worth the cost, such as insurance that covers only institutional care. Institutional arrangements might vary widely in the future, and public policy should not foreclose future options to provide long-term care in the most efficient fashion.

II. SUMMARY

The following four chapters provide a detailed description and analysis of current and possible future financing sources for long-term care. Chapter 3 provides an overview of current long-term care needs, provision, and financing. Chapter 4 covers the private financing of long-term care, including trends in the income and wealth of the elderly and development of the private long-term care insurance market. Government financing of long-term care is discussed in Chapter 5. The discussion includes a review of Federal tax policy and long-term care financing, and analysis of options for a new Federal tax incentive for long-term care financing, Individual Medical Accounts. Chapter 6 describes options for further consideration and analysis for meeting the changing needs of the elderly population.

CHAPTER 3: CURRENT LONG-TERM CARE NEEDS, PROVISION, AND FINANCING

I. FACTORS INFLUENCING LONG-TERM CARE NEEDS

This section examines the demographic, economic, and other factors that influence the need for long-term care.

A. Longer Life Expectancies

Individuals are living longer today than at any time in the past. Table 3.1 shows actual and projected life expectancies at birth and at age 65 from 1935 through 2040. For males, life expectancy at birth increased by 12 years, to 71.5, between 1935 and 1987. Life expectancy at birth for females increased even more, by over 15 years to 78.5 years in 1987. Life expectancies at age 65 for both males and females also have shown significant increases. Males aged 65 had a life expectancy of 11.9 years in 1935; in 1987, that expectancy increased to 14.9; for females, the corresponding increase was from 13.2 years to 18.8 years--an increase of over 40 percent.

These trends are expected to continue, and the projections in Table 3.1 show that those aged 65 are expected to continue to have increased years of life. Male and female life spans are expected to increase by about 4 and 5 years by 2040, while life expectancy at age 65 will increase by an average of close to 2-1/2 years.

People are also retiring earlier. The average age at retirement for both men and women fell dramatically between 1940 and 1985 (Table 3.2). The combined effect of these two trends--longer lives and earlier retirement--is that the elderly today are spending many more years in retirement than they did in the past. Table 3.2 indicates that life expectancy at retirement has increased by over 5 years for men and 8 years for women since 1940. In addition to more years of retirement for those who retire, earlier retirement means that a larger portion of the population spends some portion of its life in retirement.

B. An Aging Population and Changes in Disability Status

One result of longer expected life spans is that the average age of the population will increase. Figure 3.1 indicates the expected changes in the age distribution of the population as a percent of total population. Increasing average age, however, results not simply from increasing longevity in the population as a whole, but also from the entry of the large "baby boom" cohort into old age, and the lower birth rates of recent years. The proportion of elderly in the population will continue to grow. Among the elderly, the proportion over 85 will grow more rapidly than the population of the "young elderly," those between 65 and 85.

Aging of the population alone, however, does not necessarily imply that the population is becoming more disabled, or that the demand for health and long-term care will increase. Imagine, for instance, a society with no change in birth rates, but a pattern of improving health due to control or elimination of conditions and illnesses particularly affecting the elderly. Growth in the proportion of the population over 85 in this society might not lead to any increase in disability, health care needs, or long-term care needs; in fact, there might be a decline. On the

Table 3.1 Life Expectancy at Birth and at Age 65, for Males and Females, 1935-2040

<u>Year</u>	<u>At Birth</u>		<u>At Age 65</u>	
	<u>Male</u>	<u>Female</u>	<u>Male</u>	<u>Female</u>
1935	59.5	63.4	11.9	13.2
1945	62.5	68.2	12.6	14.4
1955	66.6	72.7	13.1	15.6
1965	66.8	73.8	12.9	16.3
1975	68.8	76.6	13.7	18.0
1985	71.1	78.3	14.4	18.6
1987	71.5	78.5	14.9	18.8
1995	71.8	79.6	15.4	19.5
2000	72.2	80.2	15.7	19.8
2010	74.7	81.1	16.1	20.2
2020	75.3	81.7	16.4	20.6
2030	75.8	82.3	16.7	21.1
2040	76.3	82.8	17.1	21.5

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¹ Estimates are based on Alternative II-A and II-B assumptions about trends in life expectancy that are used in projecting the number of persons who will be eligible for Social Security benefits.

Source: 1988 *Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds*, Table 11, p. 37.

Table 3.2 Life Expectancy at Age of Retirement by Sex, 1940-1985

<u>Year</u>	<u>Average Retirement Age</u>		<u>Life Expectancy at Retirement Age</u>	
	<u>Male</u>	<u>Female</u>	<u>Male</u>	<u>Female</u>
1940	68.8	68.1	10.1	11.8
1950	68.7	68.0	10.8	13.0
1960	66.8	65.2	12.0	15.7
1970	64.4	63.9	13.4	17.7
1980	63.9	63.5	14.9	19.6
1985	63.7	63.4	15.4	19.8

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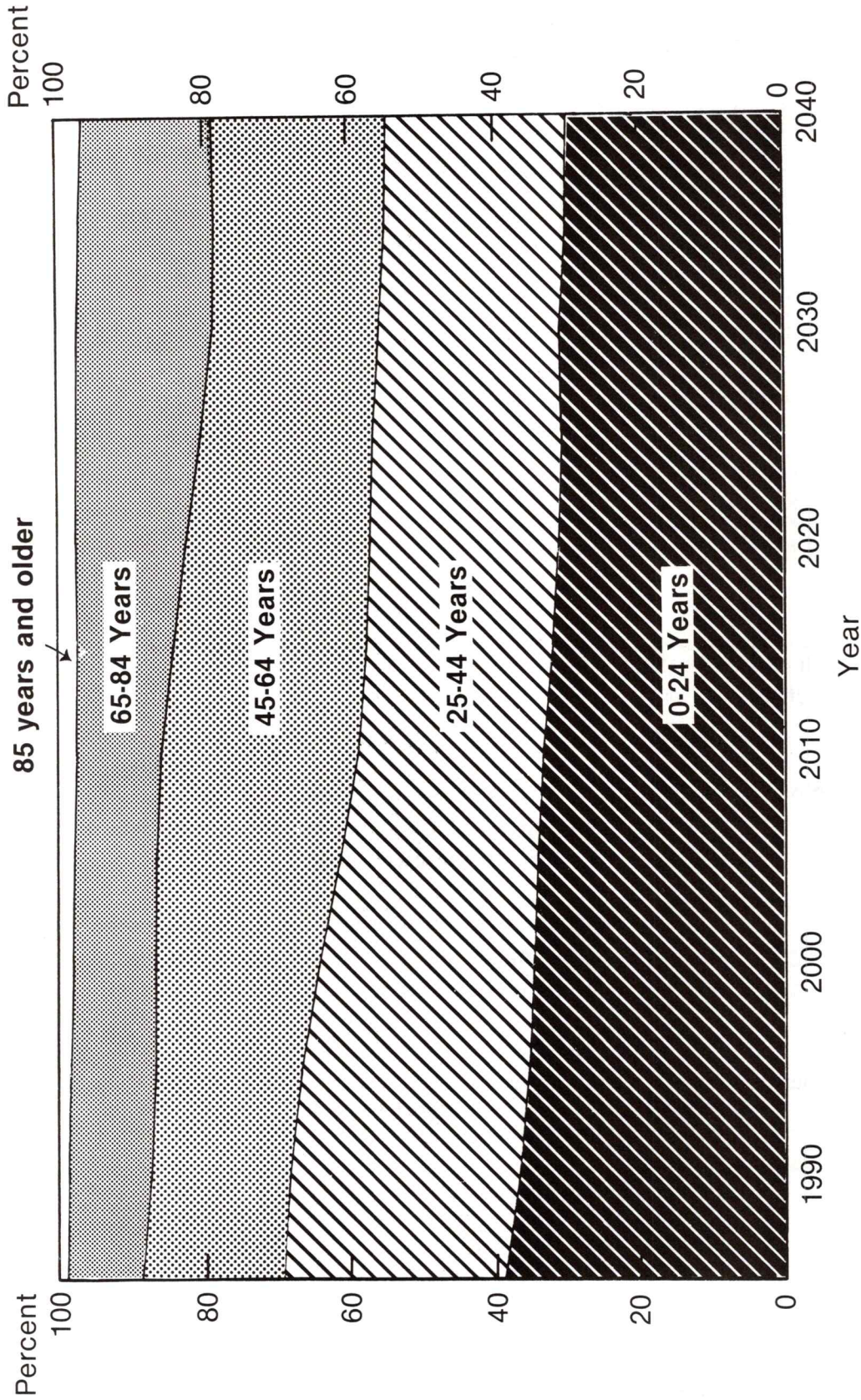
Notes: The average retirement age represents the average age at which men and women began receiving Social Security retirement benefits in the given year.

The life expectancy at retirement is a weighted average of the life expectancies at ages 60, 65, and 70 for white and nonwhite men and women.

Sources: Data on retirement age are from Department of Health and Human Services, Social Security Administration, *Social Security Bulletin, Annual Statistical Supplement*, 1987, Table 53.

Data on life expectancies are from Department of Health and Human Services, National Center for Health Statistics, *Vital Statistics of the United States*, 1985, Vol. II, Sec. 6, Table 6-4, and Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States*, 1988, Table 17.

Figure 3.1
Percent of U.S. Population by Age Group
1985-2040



Source: U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Projections of the Population of the United States, by age, race, and sex: 1983 to 2080, Series P-25, No. 952, Table 6.

other hand, certain types of health improvements lead to increases in health and long-term care expenses. One result of improved health care is that some individuals who in the past would have died at earlier ages now live to 65 and beyond. Some of these individuals are more likely to need long-term care than the average elderly individual.

There is little consensus in the literature on whether past improvements in health have increased or decreased the total demand for long-term care. In recent years, expenditures on long-term care have increased faster than the elderly population. Such data might be thought to be proof that age-specific needs have not declined with increased longevity. However, too many other factors are at play to draw such a conclusion.

C. Economic and Other Factors

Increased income and wealth of the elderly are likely to be associated with increases in demand for a variety of goods. Spending for long-term care may rise with increased well-being, just as spending for higher quality housing or additional travel rises. Moreover, the availability of Medicaid and Medicare may increase the demand for care both directly and indirectly. First, individuals can avail themselves of public services with less cost to themselves. Second, the presence of public insurance may increase the amount of residual long-term care services that individuals are willing to pay for or to insure privately.

In addition, the demand for formal long-term care may be driven by economic and demographic changes in the nonelderly population. The increased financial well-being of the nonelderly implies a change in demand for a variety of goods and services, and one change may be an increase in the demand for formal provision of long-term care for parents. The decline in the birth rate and the decline in the proportion of adults who work in the home are also associated with an increased demand for paid caretaking. In that sense, it is not surprising an increased demand for non-parental child care and for formal long-term care have occurred over the same period.

The pattern of demand will also depend not only on the number of elderly and the incidence of disability, but also on the availability of support services in the community, as well as of insurance coverage. It seems likely, for example, that the widespread availability of insurance would lead to "induced demand" for long-term care. The increased demand for personal long-term care services would substitute for some of the considerable care now provided by family members. The phenomenon of induced demand has been demonstrated in the response of demand for acute medical care to the spread of insurance, and there is even more reason to expect it in long-term care where services have substantial social and custodial aspects. The extent of such extra demand, however, may depend on the extent to which third-party payors exercise cost discipline over the providers of services.

In summary, if past trends continue it is likely that the demand for long-term care will continue to increase in the future. This may occur both because society has a changing expectation of what constitutes appropriate care and because improvements in health and longevity are not accompanied by offsetting declines in age-specific needs.

II. CURRENT PROVISION AND FINANCING OF LONG-TERM CARE

A. Provision of Long-Term Care

Most long-term care that the elderly receive is provided in the community and not in institutions (see Figure 3.2). Over three-quarters of the elderly who require long-term care receive that care in the community. Of those cared for in the community, over three-quarters are cared for by family and friends, with the remaining quarter receiving formal care. The number of elderly receiving formal care in the community (care other than that from family and friends) thus is about equal to the number receiving formal care in institutions. About half of those receiving formal care in the community pay for such care.

While long-term care by friends and family may involve no direct expenditures by the elderly or even their care givers, this care is not costless. Family caregivers may give up the opportunity to earn greater wages or enjoy leisure hours, and, of course, there may be varying degrees of stress associated with caring for a disabled relative.

By the same token, the needs of the elderly, like those of persons of all ages, cannot be defined solely by their needs for physical goods and services. Many elderly are cared for in the community because of the importance of the social relationships established there. Psychological and emotional needs to belong, to be comfortable with one's environment, to avoid disruptive change, to see and care for loved ones, and to live with one's spouse, are extraordinarily strong. The desire for community care, as opposed to institutional care, is influenced by these factors as well as by cost and other considerations.

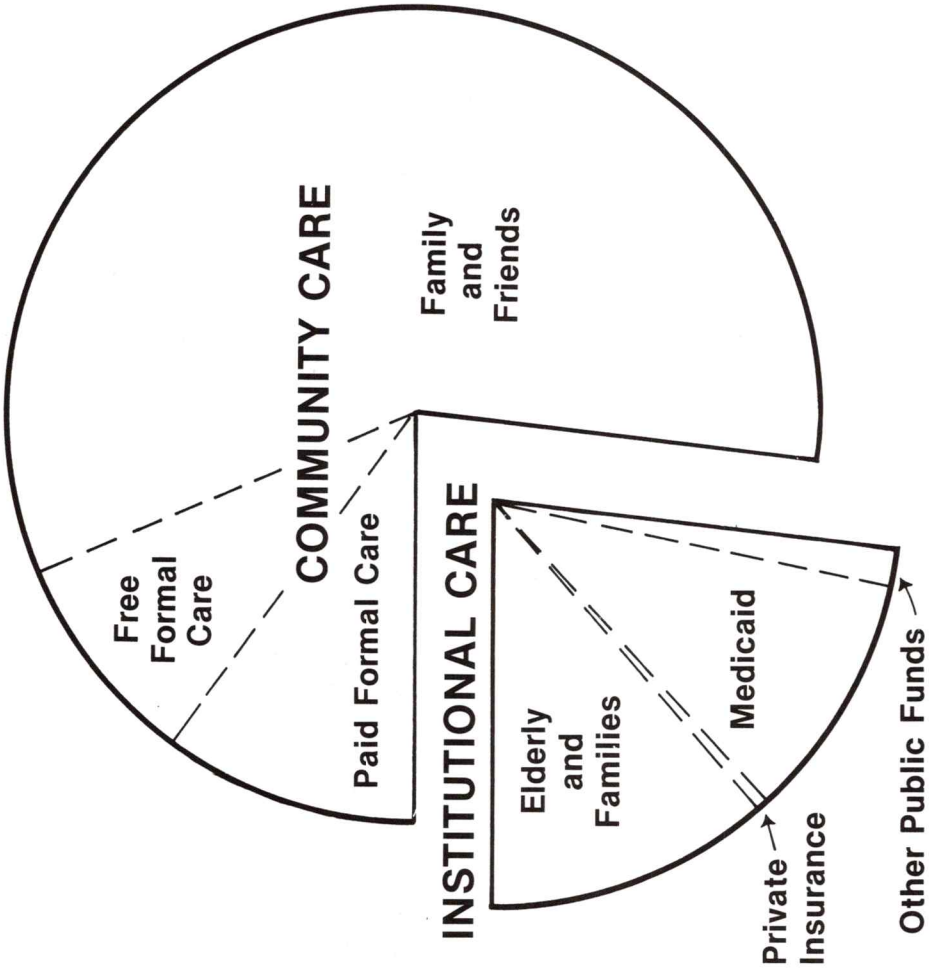
B. Financing Long-Term Care

In 1987, approximately \$41 billion was spent on nursing home care for individuals of all ages. There are three basic sources of financing formal long-term care (including that provided in nursing homes) for the elderly: the income and assets of the elderly themselves, including financial and other support from family and friends; private insurance coverage; and government programs.

Income and Assets. Out-of-pocket expenditures on nursing homes constitute the greatest portion of long-term care expenditures, accounting for half of such spending in 1987. Again, however, counting only out-of-pocket expenditures understates total costs. The foregone earnings and leisure of informal caregivers represent a cost. If caregivers were to exchange their services with each other rather than provide them within their own households, income and financial accounts would reflect significantly greater amounts spent on long-term care.

Private Insurance. Private insurance is extremely limited at present, accounting for only 1 percent of nursing home expenditures.⁷ Insurance covers such a small proportion of costs in part because until recently there was only a limited amount of private long-term care insurance offered. There is considerable evidence, however, that the private market for long-term care insurance is growing. Over 100 companies currently offer long-term care policies, and the number of policyholders is estimated to have grown from 200,000 in mid-1986 to over 1 million by the end of 1988.

Figure 3.2
Current Provision and Financing of
Long-Term Care for the Elderly



Of Those Requiring Care in 1982

77% received care in the community of these:

- 76% were cared for by family and friends
- 11% received free formal care in the community
- 13% paid for their care in the community

23% received care in nursing homes of these costs:

- 49% were paid for by the elderly and their families
- 1% were paid by private insurance
- 44% were paid by Medicaid
- 6% were paid by other public funds

Source: Distribution of those needing long-term care from HHS November 1986, page v.
 Sources of funds for institutional care from HCFA, Health Care Financing Review, Summer 1987, Tables 14 and 18.

Government Programs: Medicaid. In 1984, almost 90 percent of Medicaid long-term care expenditures were for nursing home care. In-home services accounted for slightly less than five percent and psychiatric hospitals accounted for the remainder. Medicaid expenditures for the mentally retarded and for other disabled among the nonelderly account for a significant fraction of Medicaid nursing home expenditures. Only about 60 percent of Medicaid nursing home expenditures are for the elderly.

Medicaid benefits are available to those who qualify by meeting categories of eligibility, for example, income and asset tests. Individuals may become eligible for Medicaid even though income is too high if they would be eligible for Medicaid but for failure to meet the income test and if medical spending reduces available income sufficiently (referred to as "spending down"). Thus, many of the individuals who receive Medicaid nursing home benefits do so after a period as a private pay patient. Medicaid reimbursement rates in many states are below the rates for private patients. This may act as an inhibiting factor to nursing home placement if facilities are not accessible at the Medicaid reimbursement rate.

The rules for determining the eligibility of married couples take into account the support needs for the noninstitutionalized spouse (referred to as the "community spouse"). Single individuals could retain assets of \$1,900 in 1988, and had to apply their income, except for a small personal needs allowance, to nursing home care. Married couples with a community spouse were allowed to retain income for the community spouse up to the Supplemental Security Income (SSI) needs level (\$350 per month in 1988). Assets were limited to \$1,900 for the community spouse, but the value of the couples' home was excluded from the asset computation. The rate at which individuals and couples spend down their assets is not clear and probably depends on state policy and other factors. The 1985 National Nursing Home Discharge Survey indicates that about 44 percent of discharged persons had received Medicaid while in the nursing home.

The Medicare Catastrophic Coverage Act of 1988 made important changes to the determination of eligibility for married couples in which one spouse lives in the community. Although most provisions of this Act have been repealed, the community spouse changes were retained. Under the new law, the community spouse is allowed to retain liquid assets of at least \$12,000 and as much as \$60,000 depending on the circumstances and the state. The community spouse may also retain an allowable income of between \$800 and \$1,500 per month. Thus, these new provisions appear to make Medicaid available to most institutionalized individuals with a community spouse. However, the majority of current nursing home residents do not have a community spouse.

Other Government Programs. Long-term care is also financed by Federal and local programs. Some of the Federal programs and provisions supporting long-term care are listed below.

Medicare. Medicare generally does not cover long-term care expenses, nor was it designed to do so. Medicare Part A does provide for reimbursement for up to 100 days of post-hospital skilled nursing care and unlimited visits of primary skilled home health care. However, the care requirement provisions do not include reimbursement for custodial or intermediate long-term care facilities, and so Medicare currently pays for about 2 percent of nursing home expenditures. The medically-related skilled nursing facility provisions of the Medicare Catastrophic Coverage Act of 1988 were repealed in 1989.

Older Americans Act Programs. The Administration on Aging provides financial assistance to states to provide services to the elderly. Allocations are made for supportive services, including transportation, housekeeping, senior centers and services to individuals in long-term care institutions, and for group nutrition services and home-delivered meals. States are required to match these funds by at least 15 percent.

Social Services Block Grants. The Social Services Block Grant program provides grants to states to use at their discretion, and funding under this program provides some home-based services.

Veterans Administration Programs. VA programs finance both nursing home and home health care. Nursing home benefits to elderly veterans who do not have service-related disabilities are limited to 6 months of care. In Fiscal Year 1985, VA nursing homes served 20,442 veterans (elderly and non-elderly) at a total cost of \$395 million, while the VA contracted with private nursing homes to serve an additional 38,907 veterans at a cost of \$265 million and with state-run homes to serve an additional 13,540 veterans at a cost of \$48 million.⁹ This figure is expected to grow in the future as World War II veterans age.

Income Tax Provisions. The Internal Revenue Code contains a wide variety of provisions that affect the ability of households to cover long-term expenses. The most important of these provisions relate to health and pension benefits and are discussed more thoroughly in Chapter 5, Section I, below. Two other tax provisions that may be available in certain cases of long-term care are the child and dependent care credit and the exclusion for employer-provided dependent care.

A child and dependent care credit for the care of an elderly person may be claimed if certain conditions are met. The credit is for expenses incurred to permit the taxpayer or, if married, taxpayer and spouse, to obtain earned income. In general, a child and dependent care credit may be claimed against such earnings if: (1) the elderly person is physically or mentally unable to care for himself or herself; (2) the elderly person is the dependent of the taxpayer or meets all of the requirements for being a dependent except that the elderly person has gross income of at least \$2,050 (for 1990); (3) the person resides in the taxpayer's household (that is, regularly spends at least eight hours per day in the taxpayer's home); and (4) the taxpayer or, if married, both the taxpayer and spouse, are employed or are actively seeking work. (For purposes of this credit, a spouse who is a student or who is disabled is deemed to be employed.) If these conditions are fulfilled, dependent care expenses of up to \$2,400 for one person or up to \$4,800 for two or more persons are eligible for the credit. The credit rate ranges from 30 percent for taxpayers with incomes up to \$10,000 to 20 percent for those with incomes exceeding \$28,000. Thus, the maximum credit ranges from \$480 to \$720 for one person and \$960 to \$1,440 for two or more persons.

Employees may exclude from income subject to tax certain employer-provided dependent care. The exclusion is limited to \$5,000 a year (\$2,500 in the case of a separate return by a married individual). The amount of expenses eligible for the dependent care credit is reduced, dollar for dollar, by the amount excluded from income under an employer-dependent care assistance program. The definition of dependent care eligible for the exclusion is the same as the definition of expenses eligible for the dependent care credit.

CHAPTER 4: PRIVATE FINANCING OF LONG-TERM CARE

I. TRENDS IN THE INCOME AND WEALTH OF THE ELDERLY

The economic well-being of the elderly has improved in recent years, both in absolute terms and relative to that of the nonelderly. In addition, it appears likely that those who will become elderly in the near future will have higher standards of living than those who are elderly now. These increases in present and future well-being are due to a variety of factors, in particular increases in government transfers to the elderly and increases in lifetime earnings and private pensions. Despite improvements in the well-being of the elderly in general, some have below average incomes, and some of those with the lowest incomes, particularly single elderly women, are at greatest risk of needing nursing home care. A small proportion of the elderly, as with the general population, are likely to be poor in the future.

A. Measures of Financial Well-Being

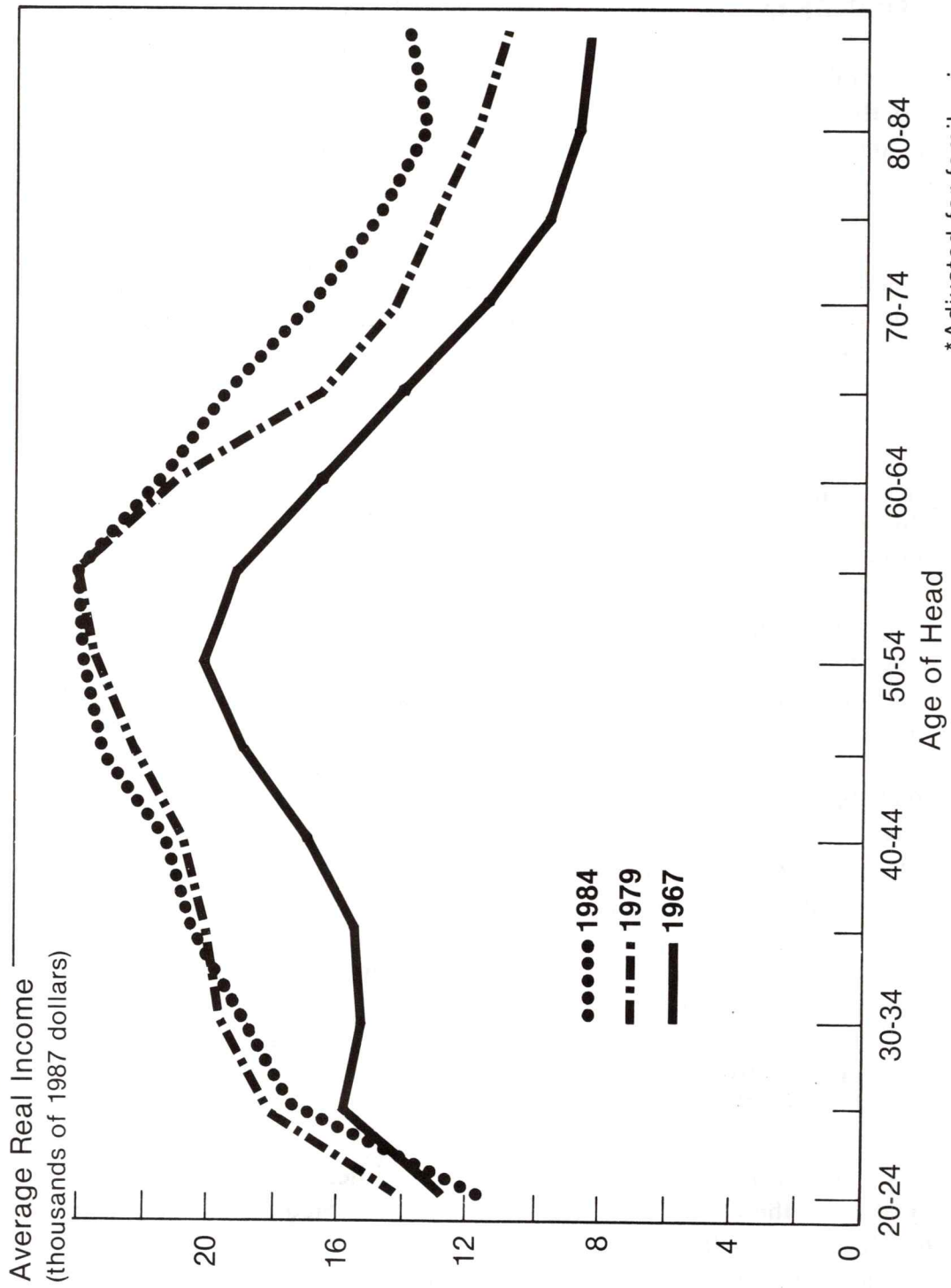
Income. The relative well-being of the elderly can be assessed in part by comparing their average income with that of other groups. Figure 4.1 presents a comparison of the average real income of family units by the age of the head for 1967, 1979, and 1984, adjusted for size of family unit.¹⁰ In all three years, average income rises with age until age 50-54 or 55-59 (depending on the year examined) and then falls. The decline as age 60 is approached is due partly to an increase in the proportion of the population that has moved into permanent or semi-retirement. Median income follows a similar pattern, although the ratio of median to average income is greater at younger ages, implying a more even distribution of income in younger years.¹¹

By 1984 the average income of families with heads aged 65-69, adjusted for family size, was higher than the average income of all families taken together. Families with heads over 65 typically have lower incomes than those headed by persons between the ages of 35 and 65, but they typically have higher incomes than young families, those with heads less than 35 years old.

Available data on the incidence of poverty over approximately the same period show a similar improvement in the relative well-being of the elderly. In 1966, the poverty rate for the elderly was 28.5 percent, nearly double the rate for the population as a whole of 14.7 percent. By 1987, the poverty rate for the elderly had fallen by over half, to 12.2 percent, a lower rate than the 13.5 percent experienced by the population as a whole.¹²

There are several reasons why the data presented here underestimate the income of the elderly relative to that of the nonelderly. First, the data presented are for before-tax income. However, since the elderly typically face lower average income tax rates than the nonelderly, net-of-tax income data would indicate that the economic position of older Americans, relative to the nonelderly, is better than suggested by the figures above. Table 4.1 shows that the elderly are far less likely than the nonelderly to have sufficient income subject to Federal income tax to be required to file a Federal income tax return. Over 38 percent of those over 65 are not tax filers, and so pay no Federal income tax, whereas only 5 percent of the nonelderly are nonfilers.

Figure 4.1
Average Real Income of Families
by Age of Head, 1967, 1979, and 1984*



* Adjusted for family size

Source: Table B-1

Table 4.1 Estimated Number of Federal Individual Income Tax Return Filers and Nonfilers in 1990 by Age of Primary Filer

(1990 Levels of Income)

Age	Number (000)			Percent Nonfilers
	Filers	Nonfilers	Total	
Under 65	88,405	4,723	93,128	5.1
65 and Over	13,391	8,236	21,627	38.1

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Note: Figures exclude dependents whether or not they are filers.

Source: Treasury Individual Tax Model runs.

Because of the partial tax exemption of Social Security income, as well as other tax provisions that favor those over age 65, the average tax rate of the nonelderly is significantly higher than the average tax rate on the elderly. Wage and salary income, moreover, is subject to Social Security payroll tax, while most forms of retirement income are not subject to Social Security tax. This differential income and Social Security tax treatment is illustrated in the examples in Table 4.2.

In addition, other noncash components of income, such as Medicare, veterans' benefits, and public housing, are not included in these income comparisons. There is evidence both that the elderly receive a larger share of their total income in noncash forms than the nonelderly, and that noncash income has grown in relative importance over time.¹³ Thus, after taking into account tax payments and noncash sources of income, the position of the elderly is further improved relative to that of the nonelderly.

Finally, the results are based on survey data in which the elderly may underreport to a far greater extent than do the nonelderly. Wages are reported much more accurately than other sources of income, but make up a much smaller proportion of the income of the elderly.¹⁴

The best evidence suggests that after adjusting for all these factors, elderly households--in particular, the younger elderly--have greater financial resources than nonelderly households.¹⁵

Wealth. In addition to income, the accumulated wealth of individuals, which is ultimately available to purchase long-term care or other goods, is an important measure of economic well-being.

Individuals' wealth is the result of some combination of inheritances, gifts, saving over time, and the rate of return earned on investments. While individuals' incomes fluctuate over their lifetimes--typically starting low, peaking at middle age and then declining slightly toward retirement years--individuals may prefer consumption to be relatively stable over time. So, one might expect to see individuals borrow in their early years of low earnings, save in the middle, high-earning years, and draw down wealth in their later years. However, the elderly do not appear to reduce their wealth holdings significantly as they age.

Figure 4.2 presents the distribution of median real wealth of households by age of head for the years 1962 and 1983.¹⁶ Wealth is defined here as the difference between total household assets and liabilities.¹⁷ The typical household with a head aged 65 or over has greater wealth than the typical household with a nonelderly head. In terms of age distribution, the typical elderly household has less wealth, on average, than those with a head aged between 45 and 64, but is wealthier than households with a head aged under 45. Further, the 1983 data indicate that households with heads aged 65-69 have the highest median wealth of any age group. These data do not indicate that individuals rapidly draw down their savings in old age.

The economic well-being of the elderly may be understated. The wealth data are not adjusted for the size of the household. Since households headed by the elderly tend to be small, such households may be even better off, relative to the nonelderly, than indicated in Figure 4.2. In 1980, for example, the average elderly household size was 1.7 persons, while the average nonelderly household consisted of 3.0 persons.¹⁸

Table 4.2 Illustration of Federal Income and Social Security Payroll Taxes in 1990 for Taxpayers Under and Over Age 65

	<u>Married Couple With No Dependents Filing Jointly</u>			
	<u>Couple Both Under 65 with Total Income of:</u>		<u>Couple Both 65 or Over with Total Income of:</u>	
	<u>\$15,000¹</u>	<u>\$30,000¹</u>	<u>\$15,000²</u>	<u>\$30,000²</u>
Adjusted Gross Income	\$15,000	\$30,000	\$ 5,000	\$20,000
Less: Standard Deduction	-5,450	-5,450	-6,750	-6,750
Less: Personal Exemptions	-4,100	-4,100	-4,100	-4,100
Taxable Income	\$ 5,450	\$20,450	\$ 0	\$ 9,150
Federal Income Tax	\$ 817	\$ 3,067	\$ 0	\$ 1,372
Employee Share of Social Security Payroll Tax	1,147	2,295	0	0
Total Tax	\$ 1,965	\$ 5,362	\$ 0	\$ 1,372
Total Tax as a Percent of Total Income	13.1%	17.9%	0%	4.6%
	<u>Single Individual With No Dependents</u>			
	<u>Under 65 with Total Income of:</u>		<u>65 or Over with Total Income of:</u>	
	<u>\$10,000¹</u>	<u>\$20,000¹</u>	<u>\$10,000³</u>	<u>\$20,000³</u>
Adjusted Gross Income	\$10,000	\$20,000	\$ 4,000	\$14,000
Less: Standard Deduction	-3,250	-3,250	-4,050	-4,050
Less: Personal Exemption	-2,050	-2,050	-2,050	-2,050
Taxable Income	\$ 4,700	\$14,700	\$ 0	\$ 7,900
Federal Income Tax	\$ 705	\$ 2,205	\$ 0	\$ 1,223
Employee Share of Social Security Payroll Tax	765	1,530	0	0
Total Tax	\$ 1,470	\$ 3,735	\$ 0	\$ 1,185
Total Tax as a Percent of Total Income	14.7%	18.7%	0%	5.9%

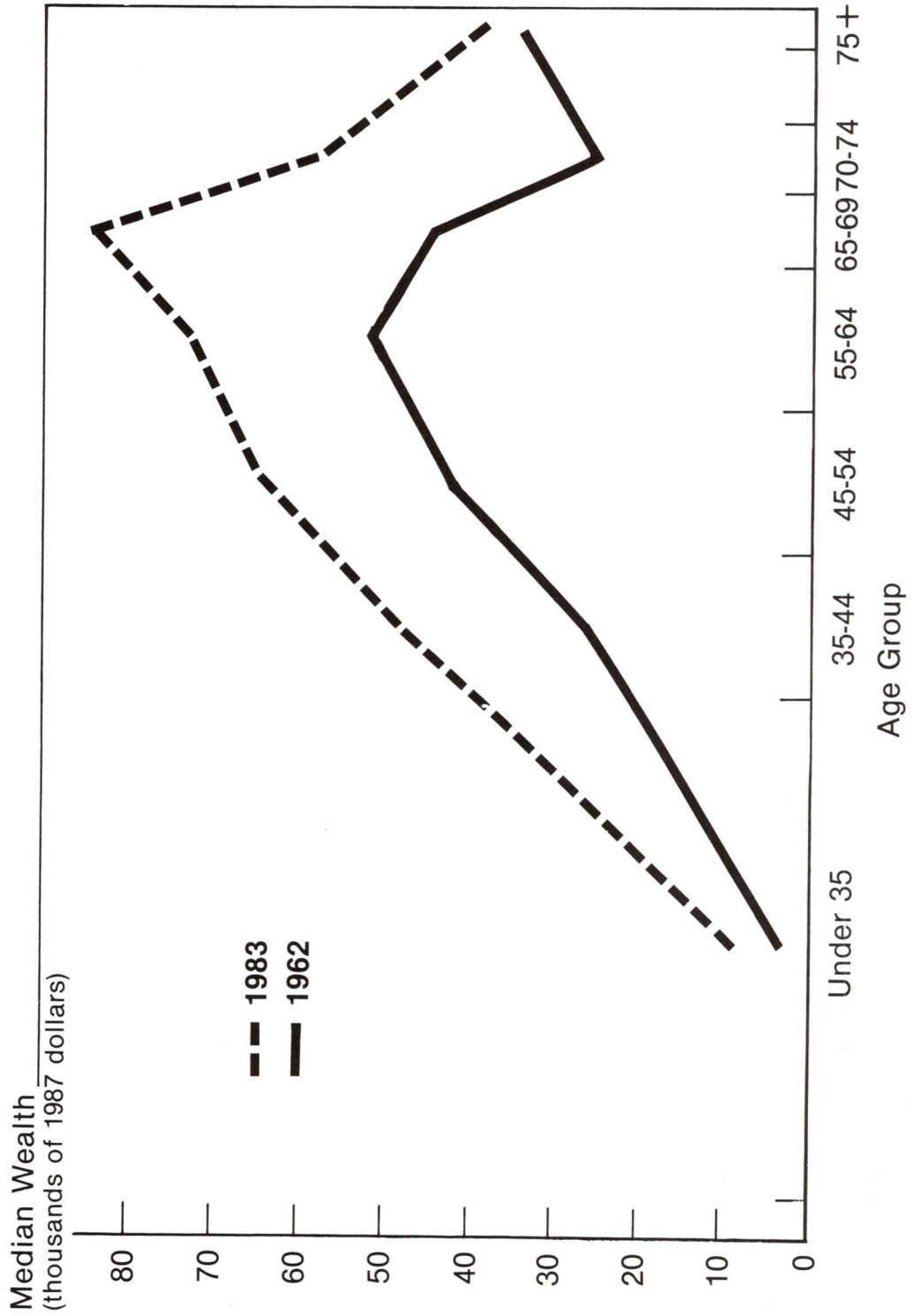
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¹Income assumed to be entirely subject to both income and Social Security payroll tax.

²Income assumed to consist of \$10,000 of Social Security benefits with remaining income subject to income tax, but not Social Security payroll tax.

³Income assumed to consist of \$6,000 of Social Security benefits with remaining income subject to income tax, but not Social Security payroll tax.

Figure 4.2
Median Real Wealth of Households
by Age of Head, 1962 and 1983



Source: Table B-5

B. Present Sources of Income

The proportion of the elderly who receive income from different sources has changed over time, reflecting changes in demographic characteristics of the elderly, age at retirement, eligibility for benefits and transfers, the characteristics of benefit and transfer programs, and macroeconomic circumstances during working lives and retirement. Fewer of the elderly receive income from earnings now than previously, reflecting, in part, the earlier retirement age of the average worker. On the other hand, more elderly receive some income from pensions, Social Security, and public assistance. Income from assets is also received by more elderly now than in the 1960s or 1970s.

Pensions. Pension income is received by a minority of existing retired households, although the proportion of households receiving pensions has been increasing rapidly. Between 1967 and 1984, the proportion of households receiving private pensions increased from 12 percent to 24 percent, while the proportion of households receiving public pensions also grew, from 10 percent to 16 percent. Table 4.3 shows the percent of elderly households that report receiving income from various sources, including pensions, in 1967, 1976, and 1984. Table 4.4 shows the percent of income received by households with heads aged 65 or over from various sources, including pensions, in 1967, 1976, and 1984. Private pensions contributed 5 percent of the total income of households with heads aged 65 or over in 1967, and 7 percent of this group's total income in 1984. Public pensions constituted 7 percent of the income of these households in both years.

The importance of public and private pensions as sources of income to the elderly varies among income groups. Table 4.5 shows that for households with income under \$5,000, pensions accounted for 3 percent of income in 1984, compared to 15 percent for households with income over \$20,000. The proportion of income of the elderly accounted for by pensions varies by age as well as by income class. For individuals in the lowest income quartile in 1984, the relative contribution of pensions was greatest, 6.5 percent, for the youngest elderly, those aged 65 to 69 (Table 4.6). This relative contribution declined with age, reaching 1 percent of income for those over 85 years of age. By contrast, pension income accounted for 12.9 percent to 20.8 percent of income for elderly individuals in the highest income quartile.

Social Security. Social Security income is received by most households with heads over age 65, and is the single largest source of income for these households. Reciprocity grew slightly, from 86 percent of elderly households in 1967 to 91 percent in 1984 (Table 4.3), and the Social Security share of income also grew from 34 percent to 38 percent (Table 4.4).

Most workers currently become eligible for full Social Security benefits at age 65, and for reduced benefits at age 62. The average age at which workers begin receiving Social Security benefits is now between 63 and 64 years old, as Table 3.2 shows. The age of eligibility for full benefits is scheduled to increase gradually from age 65 to age 67 over a period of over two decades, beginning with those who turn 62 in the year 2000. For persons under 70 who are eligible for benefits, prior to 1990 the Social Security benefit was reduced by \$1 for every \$2 of earnings if the earnings exceeded a statutory amount (\$8,880 in 1989). The rate of offset was reduced to \$1 for every \$3 of earnings in 1990 and the earnings limit increased to \$9,360.¹⁹

The importance of Social Security income varies among income groups, with the poor relying on it most heavily. In 1984, Social Security benefits accounted for 77 percent of income in households

Table 4.3 Percent of Households With Heads Age 65 and Over Receiving Income From Various Sources in 1967, 1976, and 1984

Income Source	1967	1976	1984
	(Percent)		
Pensions:			
Private	12	20	24
Public	10	13	16
Social Security	86	89	91
Savings and Investments	50	56	68
Earnings	27	25	21
Other:			
Veterans' Benefits	10	6	5
Unemployment Insurance	1	2	1
Public Assistance	12	11	16
Personal Contributions	3	1	1

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Note: Private pensions include railroad retirement in 1976 and 1984. "Other" income includes veterans' benefits, public assistance, personal contributions, unemployment compensation, and miscellaneous income.

Sources: Department of Health and Human Services, Office of Research and Statistics, *Income of the Population 55 and Over (1976-1984)*, and *Demographic and Economic Characteristics of the Aged: 1968 Social Security Survey*.

Table 4.4 Percent of Total Income from Various Sources for Households With Heads Age 65 and Over in 1967, 1976, and 1984

Income Source	1967	1976	1984
	(Percent)		
Pensions:	12	14	14
Private	5	8	7
Public	7	6	7
Social Security	34	39	38
Savings and Investments	15	18	28
Earnings	29	23	16
Other	10	6	4
Total	100	100	100

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Note: Private pensions include railroad retirement in 1976 and 1984. "Other" income includes veterans' benefits, public assistance, personal contributions, unemployment compensation, and miscellaneous income.

Sources: Department of Health and Human Services, Office of Research and Statistics, *Income of the Population 55 and Over (1976-1984)*, and *Demographic and Economic Characteristics of the Aged: 1968 Social Security Survey*.

with less than \$5,000 in income, but only 20 percent of income for households with income over \$20,000 (Table 4.5). This difference in importance reflects both the design of the Social Security program, with higher income replacement rates for lower income workers, and the greater amount of income from other sources for higher income households.

The share of income contributed by Social Security also varies by age group. For instance, Social Security accounted for 67.8 percent of the income of individuals aged 65 to 69 in the lowest income quartile, but between 76.2 percent and 81.9 percent of income for older groups in the same quartile (Table 4.6).

Income from Savings and Investments. Income from savings and investments was received by over two-thirds of households with heads over age 65 in 1984, and was their second largest income source. The proportion of these households receiving income from savings and investments grew from 50 percent in 1967 to 68 percent in 1984. Savings and investments income became increasingly important to the elderly, rising from 15 percent of income in 1967 to 28 percent of income in 1984.

Again, there is a great deal of variation among the elderly. Income from savings and investments was a minor source of income (4 percent) for households with under \$5,000 of income in 1984, but was a major source of income (39 percent) for households with incomes over \$20,000. Among individuals over age 65 who were in the lowest income quartile in 1984, the share of income that came from investments and savings showed no clear pattern. For individuals in the highest income quartile, however, the share of income from savings and investments rose with age.

Earnings. Earnings continue to play a less important role for the elderly over time. Fewer households with heads over age 65 reported earnings income in 1984 than in 1967, and the share of earnings in total income for this group fell as well. These data are closely related to the tendency toward earlier retirement reported earlier. In 1967, 27 percent of these households received income from earnings, and earnings were 29 percent of their income. By 1984, only 21 percent of them received earnings income, and earnings accounted for just 16 percent of their income.

The importance of earnings to elderly households depends on both income and age. Earnings were too small a component of income to measure for elderly households with total income under \$5,000, and only 10 percent of income for households with incomes between \$5,000 and \$10,000. However, earnings are an important component of income for these individuals in the upper-income quartile, accounting for 23 percent of their income in 1984. Among individuals age 65 and over in both the lowest and highest income quartiles, earnings are a larger proportion of income for younger individuals (those between 65 and 69) than for older individuals. However, some of the oldest individuals in both quartiles (those over 85) report earnings.

Other Income Sources. Pensions, Social Security, savings and investments, and earnings are the primary sources of retirement income. They accounted for nearly all (96 percent) money income of households headed by persons age 65 and over in 1984. The distribution of the remaining sources of income, primarily Social Security disability and welfare payments, varies with income level. These income sources are more important for lower-income households and constitute approximately 15 percent of their income. The importance of these income sources rises with age.

**Table 4.5 Percent of Total Income from Various Sources
for Households With Heads Age 65 and Over
by Income Group, 1984**

Income Source	Total	Under \$5,000	\$5,000	\$10,000	\$20,000
			to \$9,999	to \$19,999	and Over
(Percent)					
Pensions	14	3	8	17	15
Social Security	38	77	71	48	20
Savings and Investments	28	4	4	21	39
Earnings	16	0	10	10	23
Other	4	16	7	4	3
Total	100	100	100	100	100

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Note: Pensions include both public and private pensions.
Private pensions include railroad retirement.
"Other" income includes veterans' benefits, public
assistance, personal contributions, unemployment
compensation, and miscellaneous income.

Source: Department of Health and Human Services, Social Security Administration,
1985. *Income of the Population 55 and Over, 1984.*

Table 4.6 Percent of Total Income by Source, Age, and Income Quartile, 1984

Age	Public and Private Pensions	Social Security	Savings and Investments	Earnings	Cash Welfare	Other ¹	Total
Lowest Income Quartile ²							
65 to 69	6.5	67.8	4.2	9.8	8.1	3.6	100.0
70 to 74	3.4	76.6	3.6	5.0	8.2	3.2	100.0
75 to 79	2.3	81.9	1.0	1.9	9.5	3.3	100.0
80 to 84	1.4	76.2	6.6	3.2	8.9	3.6	100.0
Over 85	1.0	80.5	3.4	.8	10.8	3.6	100.0
Highest Income Quartile ²							
65 to 69	19.8	20.0	26.2	32.2	.1	1.8	100.0
70 to 74	18.7	26.3	30.2	22.6	.1	2.2	100.0
75 to 79	20.8	28.9	34.4	14.2	.1	1.7	100.0
80 to 84	15.7	27.9	34.4	20.0	0	2.0	100.0
Over 85	12.9	24.5	41.0	20.6	.2	.8	100.0

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¹ Other income includes: interfamily transfers, unemployment compensation, veterans payments, disability payments, and miscellaneous income.

² Quartiles refer to income shares of the population of all ages. The composition of income for all age groups in the lowest and highest quartiles is given in Appendix Table C-3.

C. Future Income Sources

The composition of retirement income is likely to continue to change in the future in response to economic, institutional, and demographic changes. Concerns about income adequacy for those who will retire in the early decades of the next century need to take account of these changes. While it is not possible to predict precisely the magnitudes of most changes, the general directions often are clear. For some income sources, such as Social Security, where program rules are embedded in legislation, somewhat firmer predictions can be made, if the legislation is assumed to remain unchanged.

Pensions. As noted above, pensions currently provide 14 percent of total retirement income, and are a significant share of income for upper-income retiree households but only a small share for lower-income households. The proportion of households receiving pension income is likely to continue to grow, for several reasons. First, the proportion of workers covered by a private pension plan increased dramatically from 22.5 percent in 1950 to 47.2 percent in 1980.²⁰ Employment by state, local, and Federal governments has also grown over this period, and public employers typically offer pension plans. Thus, future retirees are more likely to be covered by pensions.

In addition, provisions of the Employee Retirement Income Security Act of 1974 (ERISA) increase the probability that workers covered by employer pension plans will actually receive retirement benefits. Important provisions include shorter vesting requirements for pension rights and establishment of Individual Retirement Accounts (IRAs) for workers whose employers do not provide pension plans. It is therefore increasingly likely that workers who reach retirement age will be eligible for an employer-provided pension. ERISA also established the Pension Benefit Guarantee Corporation (PBGC) to insure the retirement benefits of employees in defined benefit plans, and subsequent legislation has strengthened PBGC's financial status.²¹

Provisions of the Retirement Equity Act (REA) of 1984 make it more likely that spouses of retired workers will receive pension benefits through joint and survivor annuities. REA also lowered the latest age of participation to 21 years and permitted longer breaks in service. In fact, most of the major tax acts of the last decade contained provisions that broadened pension coverage and vesting and strengthened funding.²²

Changing labor force participation patterns also are likely to increase pension reciprocity by households. Since the 1950s, the proportion of women who participate in the labor force has been growing, primarily because women are remaining in the labor force as they age, rather than working only in their early years. Thus, women are accumulating both labor force experience and pension rights. Future retiree households are therefore more likely to receive pension income from both spouses.

Employer-provided retiree health benefits can be an important component of noncash income for retirees who receive them, and receipt often is tied to pension reciprocity. A study in 1986 by the Department of Labor found that employer-provided retiree health benefits paid 23 percent of the 1977 total health care costs of retirees over age 65 who were covered. By comparison, retirees over age 65 who purchased individual health insurance had only 12 percent of their health costs paid for by the insurance.²³ In 1986, 72 percent of employees in medium and large firms were covered by health

insurance plans that provide retiree coverage. Over three-quarters of employees whose firms offer retiree health benefits work for firms that offer their retirees the same coverage as when employed (although benefits may be reduced to the extent that expenses are reimbursed by Medicare). Half of the employees whose firms offer retiree benefits work for firms that offer the benefits at no cost.²⁴ The financial liability associated with these benefits has been highlighted recently by the Financial Accounting Standards Board proposal to include the unfunded liabilities on corporate balance sheets. Whether this component of retirement income will grow in the future is unclear.

Social Security. Social Security will continue to remain an important component of retirement income well into the next century. The 1983 amendments to the Social Security Act are expected to place the system on sound financial footing, with revenues exceeding outlays until about 2030. Technical insolvency of the system would be reached about 2050. Real Social Security benefits will continue to grow over time under relatively modest assumptions about economic growth over the period.²⁵ As with pension income, increases in female labor force participation and in total years worked should provide a greater number of future retirees with Social Security benefits.

Income from Savings and Investments. The marked increase of savings and investments income as a source of retirement income is generally attributed to the relatively robust real growth in the economy during the time when current retirees were in their prime earning years, together with relatively high real interest rates earned by those assets in recent years. Whether the growth in savings and investments income reflects a continuing trend or simply the particular macroeconomic circumstances of the last 20 years is unclear. The future of the aggregate savings rate and the degree of offsets caused by pension and Social Security savings are themselves the subjects of debate.

Earnings. The future role of earnings in the income of persons over 65 is also unclear. The labor force participation rate of both men and women in this age group has been dropping over time. In addition, the participation rates of somewhat younger persons aged 55 to 64 also have been falling, in part because of early retirement incentives in private pensions. Obviously, if these two trends continue, the share of earnings in income would continue to drop.

Two provisions in current Social Security law could, however, counteract this trend. First, Social Security benefits received by persons between the ages of 65 and 70 were offset at a rate of \$1 for every \$2 of annual earnings above \$8,880 prior to 1990. In 1990, the offset rate dropped to \$1 for every \$3 of earnings above \$9,360, making income from earnings more attractive to this age group of Social Security beneficiaries. Second, the minimum age at which unreduced Social Security benefits will be paid will slowly rise from the current age 65 to age 67 over a period of about two decades beginning with persons aged 62 in the year 2000. Persons between the ages of 65 and 67 will have less incentive to retire and, accordingly, a greater incentive to continue to earn than under current rules. The net effect of labor force participation trends and changes in Social Security rules on the proportion of income from earnings is unclear.

D. Conclusions: The Financial Well-Being of the Elderly and Long-Term Care Financing

Exact and unambiguous measures of the economic well-being of the elderly are impossible to construct. Nevertheless, the data presented here support several conclusions. First, the after-tax income of the elderly is approximately the same as that of the nonelderly, while the elderly have

greater wealth and a lower poverty rate. In addition, the elderly between the ages of 65 and 70 are better off than both the older elderly and the nonelderly in terms of income, poverty rates, and wealth. Moreover, they have more leisure time, in terms of years of retirement, as the typical age of retirement has fallen. There is little evidence that the elderly dissave rapidly. Further, it appears likely that future retirees will be better off than the current elderly. In particular, private pensions and Social Security should continue to grow in real terms.

The problem of financing long-term care is not so much a problem of the financial resources of the elderly relative to the financial resources of other age groups, but a problem of long-term care costs relative to the financial resources of the elderly and the match between an individual elderly person's financial resources and long-term care requirements. Retirement income of various types provides one of the sources of paying for long-term care even for those who cannot pay all costs. But the cost of an extended period of formal long-term care is significant. Therefore, risk-pooling or insurance represents one alternative to financing long-term care. Several of the options presented in this Report attempt to incorporate a risk-pooling element into the current system of retirement income as a means of increasing resources available should an individual require long-term care.

The level of resources of the elderly and the virtual absence of long-term care insurance within the broad public and private retirement system raise the issue of whether existing private pensions and public programs are well adapted to current and future needs. The existing retirement system is not well-designed to deal with increased longevity, the improved well-being of the younger elderly, the greater likelihood of need for long-term care by the older elderly, or the lower income of the older elderly than of generations that succeed them.

Finally, the analysis suggests that there are large numbers of elderly that could afford long-term insurance, in the sense that premiums would not constitute a prohibitively large portion of their resources. Younger elderly, in particular, may be able to afford to finance their own long-term care over their entire retirement period, but not necessarily if they wait until later years of retirement to begin insurance premium payments.

II. DEVELOPMENT OF THE PRIVATE LONG-TERM CARE INSURANCE MARKET

The scarcity of private insurance for long-term care is frequently said to be the primary problem with the current long-term care system. There may be identifiable and correctable reasons why the private market for long-term care insurance has only come into existence recently and remains small. The presence of certain market conditions that limit a market is termed market failure. If there is market failure in the long-term care insurance market, it is important to identify its sources and to consider whether failure of the market to provide long-term care insurance should be corrected.

The lack of a significant market is not necessarily an indication of market failure in itself, however. There are many products that conceivably could be produced, but are not simply because there is insufficient demand for them at a price that would cover producers' costs.

Before proceeding, it is useful to recall that under current law nursing home care is financed about equally by private citizens and by governments. Further, most of the long-term care the elderly receive is provided in the homes of the elderly or their relatives, not in nursing homes. The costs of long-term care, therefore, are borne in large part not by taxpayers generally through government programs, nor even by those in need of the assistance, but rather by those who currently provide for such care in the home. Nursing home care, which is generally the only type of long-term care covered by current insurance policies, is most likely to be required when one or more of the following events occur: there are no spouses or children who can help the person in need of assistance; for a variety of reasons, the person in need of care and the potential caregivers in the family prefer alternative arrangements to care in the home; or the need for assistance has reached the point where it can no longer be handled adequately outside of an institutional setting. Thus, even for those with equal risk of functional impairment or disability, the value of long-term care insurance may vary widely depending upon the relative desire for the particular type of care that may be made available under the insurance package.

This section concludes that the problems facing long-term care insurers are similar to those facing providers of other types of insurance, although several problems may be somewhat more severe for long-term care insurance. Characteristics specific to long-term care also make current insurance products relatively unattractive to consumers. Thus, the lack of a substantial market for long-term care insurance--at least as currently marketed--may be rational. The analysis suggests that any policy changes should proceed on a modest basis. There is much to be learned about long-term care insurance as a product--its potential utilization, its value to individuals, the ability to measure eligibility and needs accurately and fairly, and the ways in which the product might optimally be designed. To assume the answers to all these questions could result in the development of a product with high cost relative to value to the consumer.

A. Possible Market Failure?

Consumer Misinformation. One reason given for consumers' failure to purchase private long-term care insurance is that they have incomplete or incorrect information about the product and their need for it. Individuals are said to systematically underestimate the probability of requiring long-term care in the future and the cost of such care should they require it. There is also evidence that many people mistakenly believe that Medicare or their Medigap policies will cover their long-term care costs.

Consumers clearly need correct information about their probable long-term care needs and the noninsurance alternatives available to pay for it. Private insurance companies have an incentive to provide such information in order to stimulate demand for their policies. In fact, a comparison of two recent surveys by AARP shows a sharp rise in the awareness of consumers regarding long-term care insurance and needs.²⁶

Adverse Selection. Insurance markets often suffer when providers lack information on the riskiness of individuals they insure. When the purchasers of insurance policies know more about their own riskiness than do the insurance providers, adverse selection may result. Adverse selection implies that when insurance is offered against some event, individuals who know they are likely to experience that event find insurance more attractive than individuals who know they are

unlikely to experience that event. Adverse selection may prevent a private insurance market from developing because premium levels must rise high enough to allow insurers to earn a market rate of return, but thereby may become too high to make policies attractive to low-risk individuals. Thus, an insurance market that includes low-risk individuals may fail to develop even though these individuals would be willing to pay a premium that the insurance company would set if the insurer could be certain that the individual was a good risk.

The problem of adverse selection can be somewhat offset by underwriting procedures that take account of some, but not all, risk factors. Adverse selection provides a rationale for group insurance or mandatory insurance since, in either case, the low-risk individuals cannot opt out because the premium is too high. Why adverse selection would be a greater problem for long-term care insurance than for acute health care or life insurance is not clear. Both of these insurance markets have become well-developed over the years despite potential adverse selection. Long-term care insurance would face greater barriers only if consumers have a larger informational advantage regarding their probability of requiring long-term care in the future than of their probabilities of needing acute health care or of dying.

Induced Demand. All insurance shares the problem of induced demand. The act of insuring against an event that is, at least to some extent, under the control of the insured, such as long-term care, makes that event more likely because its costs are then covered by insurance. Insurance coverage effectively lowers the cost of the event, and makes preventive actions less valuable. Lower costs generally raise the demand for a product. This induced demand raises the cost of insurance because more claims are paid, and it generally leads to insurance coverage that is limited by deductibles and copayments.

Induced demand may pose a significant problem for long-term care. Most long-term care is provided informally, in the home, and a significant portion of such care is custodial, rather than medical. The site of long-term care is under the control of the insured to a greater extent than is acute medical care. Moreover, those with equal needs or equal risks of needing care in the home may nonetheless have very different demands for institutional care depending upon the adequacy of current arrangements. Current long-term care insurance policies generally only insure against care in nursing homes, although a growing proportion cover adult day-care services. Significant amounts of ordinary living expenses, such as food and shelter, are often provided simultaneously with long-term care in nursing homes. Long-term care insurance is likely to create induced demand for nursing home care as covered individuals switch from receiving informal care at home to receiving formal care. Insurance for home care could also create induced demand for the covered services, were such insurance offered, because people generally prefer home care to nursing home care.

To take account of induced demand, long-term care insurance policies may need significant copayments, and perhaps deductibles. Such policies may also need to establish some clear eligibility criteria related to the degree of disability. Unlike acute care, disability is rarely a "yes" or "no" matter. It is more of a continuum of need, with the actual need dependent upon both the degree of disability--which is hard to define--and the support system a person has to fall back on. Under these circumstances, there may be a need to screen a very large population and limit coverage to some specified subgroup that is both clearly disabled and unable to cope without social support services. These features keep induced demand and price increases to a minimum, and prevent long-term care insurance from covering ordinary living expenses.

Institutions as "Tollgates". Since insurance is likely to induce increases in demand, such insurance may tend to provide institutional care rather than home care. Because most people view institutional care as less desirable than care in their own home, limiting coverage to nursing homes can create a "tollgate." Only those with serious disabilities will demand long-term institutional care. If there were low cost ways for insurers to determine an individual's true "need" for long-term care, tollgates would not be necessary.

Limiting coverage to institutional care does limit costs to the insurer, but at the cost of increased inefficiency in the long-term care market. The reason for this is that \$1 spent by the insurer on institutional long-term care may be worth less than \$1 to many elderly individuals receiving that care because they would prefer to be cared for at home. Despite the disparity between expenditures and the recipient's valuation of them, it may be a rational choice for that individual to enter a nursing home if all or part of the cost is borne by a third party.

Predictability. Related to the problems of adverse selection and induced demand are the difficulties that insurers may have predicting long-term care costs and determining premiums that will cover those costs. Insurers may be unwilling to take the risk that costs will be much higher than expected and may choose not to enter the long-term care insurance market. Insurers that do enter the market may charge premiums too high to stimulate consumer interest, or may initially write policies that offer flat dollar coverage rather than covering long-term care services.

The costs to insurers are always uncertain, whether the insurance covers long-term care, acute care or some other event unrelated to health. However, the problem may be somewhat more severe for long-term care coverage than for many other types of insurance. Less is known about the response of long-term care usage to third-party payments than is known about the response of acute care usage or other currently covered risks. In addition, because long-term care often is not used until many years after a policy is purchased, insurers may not have sufficient opportunity to adjust premiums.

Uncertainty regarding future costs leads to long-term care policies that limit insurer risk through characteristics such as providing a maximum benefit, high coinsurance rates, or multiple conditions for receipt of benefits. Some recent criticisms of existing long-term care insurance probably relate directly to clauses that insurance companies may have inserted to reduce risk, but which simultaneously decrease the extent to which policies will cover various types of needs. Reduced risk for the insurance company generally means increased risk for the insured.

Capital Market Imperfections. Much of the wealth of older individuals is in their homes. This wealth is illiquid, and so cannot typically be used to purchase long-term care insurance or other goods and services. This illiquidity would not, in and of itself, hold back the development of a market for long-term care insurance. Possible market solutions to this problem, such as home equity conversions, exist, although they have not been extensively employed. The U.S. Department of Housing and Urban Development has initiated a "Home Equity Conversion Mortgage Insurance Demonstration" program. In addition, purchase of long-term care insurance at an earlier age would avoid the necessity of large payments late in life.

B. An Unattractive Product?

Discussion in the preceding section suggests that the market for long-term care insurance faces the same problems faced by other sorts of insurance, although certain problems may be exacerbated for long-term care coverage, resulting in a small market for long-term care insurance. It may be features of the product itself that consumers find objectionable, rather than market failure. If this is the case, government policy should aim at providing or encouraging a type of financing for long-term care that avoids these features.

Many policies currently and recently offered or contemplated have significant limitations.²⁷ They generally pay only limited indemnity benefits of between \$10 and \$120 per day, only apply to care in a nursing home, and do not adjust benefits over time for inflation. Policies bought many years in advance of requiring long-term care, when premiums tend to be lower, will likely cover only a small portion of the actual cost of such care when needed.

These policies generally also have a number of important exclusions. Virtually all policies sold before 1989 required that the patient be admitted to a nursing home within 14 to 30 days of a hospital stay of at least 3 days and that the admission be for the same or related condition as the hospital stay. However, many elderly individuals with chronic debilitating conditions may require assistance with daily functions such as eating and bathing, rather than medical care, and those needs do not necessarily develop following a period of acute illness. Benefits also generally do not begin for between 20 and 100 days in the nursing home, and policies typically pay benefits for a maximum of 1 to 4 years. Premiums, which depend largely on age, vary from \$200 to \$1,500 per year, and insurance is generally unavailable for those over 80, although the need for long-term care rises with age.

A growing proportion of new policies do cover long-term care provided at home, such as convalescent care, homemaker or companion services, or skilled nursing care. The home care benefit, for those that offer it, is typically one-half the benefit paid for skilled nursing home care, although there is wide variation in eligibility.

Limits on Choice. The appeal of current long-term care insurance policies may be limited by the fact that individuals tend to view institutionalization as unattractive. Most people would prefer to be cared for at home and, so, may prefer insurance policies that covered care at home. Other consumers may well prefer to choose the form of long-term care they receive at the time the need arises, rather than at the time they purchase a long-term care insurance policy. One way to do this would be through policies that provide increased income, to be spent as the insured decides.

Private insurance could, in theory, cover long-term care at home in a much less restrictive manner than current policies. However, problems of defining covered services and induced demand would likely be greatly increased. The same problems would confront any public insurance that covered home care.

Another unattractive feature of long-term care insurance is that it meets only one of many possible needs of old age. Consumers prefer to buy acute health care policies that meet many needs, rather than policies for specific health needs such as cancer or cataracts. Similarly, long-term

care insurance offered as part of a package dealing with the broader retirement needs of the elderly would likely be more attractive than a long-term care policy alone.

Long-Term Care Insurance and Pensions. One way of overcoming many of these limits on choice would be to allow pension payments to be adjusted so that they have the same actuarial value, but would be adjusted for certain events requiring long-term care. Such adjustments would offer consumers greater choice, and would provide more individuals with access to funds for long-term care than would long-term care insurance alone. Consumers likely view the problem of saving for long-term care needs as part of a more general problem of saving for retirement. Therefore, long-term care insurance may be viewed more favorably if it is incorporated into a pension structure.

Medicaid as the Payor of Last Resort. The development of a broad private market for long-term care insurance may well be affected by the existence of Medicaid as the payor of last resort. The existence of Medicaid will, in addition, have important implications for the design of policies to encourage long-term care insurance.

Medicaid effectively covers each individual with a public long-term care policy. The policy deductible equals current income plus wealth not excluded from the "spend down" provisions, which for a community couple includes their home as well as up to \$60,000 of liquid assets under the 1988 Medicare Act. Thus, any additional insurance coverage--private or public--can be seen, at least in part, as asset or bequest protection rather than long-term care insurance.

Individuals with little wealth are not likely to demand much, if any, private long-term care insurance. Medicaid already provides fairly complete coverage, at low cost, for nursing home care. Even persons of moderate means may find their demand for private insurance significantly decreased by the existence of Medicaid, since it represents at least partial coverage. The revised asset and income levels that the Medicare Catastrophic Coverage Act permits may make Medicaid more appealing to moderate-income elderly married couples. Although the existence of Medicaid may affect the development of a broad market for long-term care insurance to some groups, some Medicaid features may make insurance attractive. Individuals, particularly single individuals, may be concerned with the possibility of spending down their assets. A significant number of nursing home entrants recover from their disability and leave the institution, often after making large out-of-pocket expenditures or spending down. The current system may provide an incentive for individuals to remain institutionalized even when that is no longer necessary or desired. The high costs of spending down to Medicaid eligibility under the current system may offset some of the disincentives facing those with moderate wealth in their decision to purchase long-term care insurance. The desire to leave bequests may also be a strong motivation for purchasing long-term care insurance, for those with sufficient wealth to contemplate bequests.

For individuals with somewhat higher levels of wealth the demand for long-term care insurance will decline the easier it is to divest oneself of assets, for instance, by distributing them to children or spouses, before requiring long-term care. As the law currently stands, Medicaid may include asset transfers made up to two years before entering a nursing home as part of the patient's wealth, although not all states check this far back. In any case, it is possible for many elderly to begin asset transfers more than two years before requiring long-term care, thus

avoiding significant costs. When such transfers occur, Medicaid becomes a system which protects bequests, by shifting the costs of long-term care to the government, hence taxpayers in general. Protecting bequests is not the role Medicaid was intended to play.

The existence of Medicaid as the payor of last resort has several potential implications for public policy toward long-term care. First, policies that liberalize Medicaid spend-down and asset rules will inhibit to some extent the development of the market for private long-term care insurance. Conversely, public programs that encourage purchasing private long-term care insurance will reduce Medicaid costs somewhat, offsetting in part costs of the programs themselves. Further, Medicaid cost reductions will be larger the greater the number of purchases of private insurance by lower-income taxpayers. It seems unlikely, however, that incentives to purchase insurance will be very effective for lower-income households in part because of the coverage Medicaid provides them. Lower-income households also are less likely to purchase insurance to the extent that incentives to purchase operate through the tax system and confer the greatest benefits on those facing high tax rates. Long-term care insurance may be more attractive to middle- and higher-income individuals who can afford to insure for care they regard as more attractive than Medicaid.

Individual and Group Insurance. Virtually all long-term care insurance policies have been offered on an individual, rather than group, basis until recently. Individual policies make long-term care insurance more expensive, both because the enrollment of groups can mitigate the problem of adverse selection, and because marketing and sales costs per purchaser may be significantly lower for group insurance, due to economies of scale. The cost difference between group and individual policies may make the difference between a small and a substantial private market.²⁸

The availability of group insurance might also encourage the purchase of insurance at younger ages. Insurance companies state that premiums for long-term care insurance are low if the insurance is purchased at a relatively young age, but become prohibitively expensive for many at sufficiently advanced ages.

The question is why long-term care policies are rarely offered on a group basis. One possibility is that the group market has been simply slow to develop, but will do so over time. Another is that employees have preferred other fringe benefits to long-term care insurance. Employers' uncertainty about the tax treatment of long-term care insurance may also have inhibited their offering such policies. Clarification of the tax law may be of some use in encouraging employers or other affinity groups to offer long-term care insurance.

CHAPTER 5: TAX PROVISIONS AFFECTING LONG-TERM CARE FINANCING

I. FEDERAL TAX POLICY TOWARD PRIVATE PENSION AND HEALTH PLANS

In addition to financing and providing long-term care directly, the Federal government indirectly supports those with long-term care needs through a variety of tax provisions. By encouraging private pension and health insurance coverage of employees, the Federal government aims to reduce the number of individuals who have inadequate means for retirement years or insurance to cover catastrophic health needs. This section examines these policies. Other government programs and policies affecting long-term care are outside the scope of this Report.

A. The Basic Pension, Health Insurance, and Annuity Models

Tax incentives for retirement, disability and health benefits fall generally into one of three models. Although there are exceptions, an understanding of these three models is crucial in understanding incentives that might be applied to long-term care benefits. Part of the debate over private provision of long-term care relates to the model into which long-term care benefits might be put. Long-term care benefits do not fit easily into any of the three models. They are not primarily health benefits because they may cover many expenses of ordinary living, as do typical retirement plans. But neither are they identical to a pension nor to an annuity. Long-term care insurance might be prefunded, as are employer-provided pension plans, or paid for on an annual basis, as are most employer-provided health insurance plans. It might be paid for out of after-tax dollars, as in the case of many private annuities, or out of before-tax dollars, as in the case of many employer-provided pension plans. Distributions might be taxable, as are pension and some disability payments, or they might be nontaxable, as are payments from most health insurance plans.

The Basic Pension Model. Under the basic pension model, an employee is not subject to tax at the time payments are made by an employer into a pension plan on behalf of the employee. Instead, taxation of such payments is deferred until the employee retires or otherwise receives distributions from the pension plan. There is also deferral of taxation of income earned on deposits in the pension plan until distributions from the plan are made. If a taxpayer is in the same tax bracket at the time of receipt of pension benefits as at the time that payments were made into the pension plan, then the value of deferral of taxation is equal (in present value terms) to current taxation of payments into the pension plan as if they were wages, but nontaxation of the income earned on pension fund deposits. The basic pension model, therefore, provides the equivalent of consumption tax treatment: taxation of income when consumed, not when earned.

The basic pension model applies to all tax-qualified retirement plans. Thus, the basic pension model applies to employer contributions to retirement plans, to deductible contributions to Individual Retirement Accounts (IRAs), and to employee contributions to so-called section 401(k) plans. On a current cash flow basis, the tax expenditure budget indicates that annual outlays in excess of \$70 billion would be required to provide a similar subsidy through direct expenditures to pensions, Keogh plans, and IRAs.

The Employer-Provided Health Insurance Model. The major tax provision favoring health insurance is the exclusion from an employee's income of the value of employer-provided health insurance. Most health insurance is paid for and provided on an annual basis. Further, welfare benefit fund rules require that a tax be paid on the interest earned on deposits in prefunded health benefit plans. There is, therefore, generally no tax subsidy for savings in health plans (the exception is the prefunding of health benefits on a tax-favored basis through pension plans, discussed below). As a consequence, the employer-provided health model is equivalent to nontaxation of a wage payment when received in the form of health insurance. The tax expenditure budget for the U.S. Government lists this as among the largest of all income tax expenditures--outlays in excess of \$37 billion per year would be required to provide a similar subsidy directly through the Department of Health and Human Services. Another \$19 billion would be required to match the loss in Social Security tax revenues.

In addition, for tax years beginning in 1987, 1988, or 1989, and for part of 1990, a self-employed individual may deduct 25 percent of the cost of providing medical insurance to the individual and his or her spouse and dependents.²⁹ This is a temporary provision, added by the Tax Reform Act of 1986 and extended by the Omnibus Budget Reconciliation Act of 1989. It expires on October 1, 1990. The President's 1991 Budget proposed a permanent extension.

The Private Annuity Model. Private annuities (outside of those under the basic pension model) are purchased with after-tax income; no deduction is allowed for the purchase of the annuity. However, taxation of the interest earned on the deposits in an annuity is deferred until receipt. Eventual annuity payments are then composed of payments of both previously taxed deposits and untaxed interest earnings. The latter are subject to tax, while the former are not again subject to tax.

The private annuity model provides tax benefits very different from both the employer-provided health insurance model and the basic pension model. Recall that employer-provided health insurance can be viewed as equivalent to nontaxation of wages spent immediately on health insurance, while pensions can be viewed as providing taxation of wages (in the form of payments into a pension plan) but not the interest earned on pension funds. With private annuities, the initial amount is subject to tax and the interest income earned on the annuity is only deferred from taxation. Thus, the pension model generally provides a greater tax subsidy than does the annuity model.

The private annuity model applies not only to many annuities offered by insurance companies, but also to certain IRAs. For employees covered by an employer pension plan who also have income above a limit, deposits to IRAs are not deductible, but are taxable under the rules applying to annuities. Similarly, the private annuity model applies to employee contributions of after-tax income to retirement plans.

Benefits Practice. In practice, tax preferences for almost all forms of health, pension, and annuity income fall under one of these models. Almost no expenditures on health are granted a combination of the benefits of the basic pension model and the employer-provided health insurance model. That is, there are few prefunded health plans that receive the combination of a deduction

for deposits into the plan, nontaxation of interest earned on plan deposits as it accumulates, and an exclusion of distributions from the plan. Such generous tax treatment would be almost without parallel anywhere in the Tax Code. While technically such tax treatment might be allowed under current tax law in certain circumstances (see the discussion on prefunding of health plans, below), there appear to be few benefits that currently qualify.

B. The Itemized Deduction for Medical Expenses

Although little income qualifies directly for the combined benefits of both the basic pension model and the employer-provided health insurance model, many elderly individuals are able nonetheless to achieve essentially the same results through another means.

Approximately 40 percent of the elderly are not subject to Federal income tax. The decline in taxability between years of work and retirement effectively allows many to receive nontaxable health benefits. In addition, for those elderly and nonelderly with taxable income and with significant nonreimbursed medical expenses, an itemized deduction is allowed when such expenses are in excess of 7.5 percent of adjusted gross income. This deduction is also allowed for expenses of a spouse or dependent, as well as for expenses of persons who would be dependents of the taxpayer (the taxpayer provides one-half of support and meets certain other tests), except that the supported person had more than \$2,050 in income (in 1990). For example, an itemized deduction for the medical expenses of an elderly parent who lived with a daughter could be taken by the daughter if she provided one-half of the parent's income, even though the parent had income over \$2,050.

The cost of institutional care may be treated as a medical expense under some circumstances.³⁰ In effect, many of the elderly with pension income will find that during many years of retirement their income is nontaxable, they are in lower tax brackets than when employers made deposits to pension plans on their behalf, or they are eligible for the itemized medical deduction. Only higher-income elderly persons without substantial medical expenses effectively will fail to benefit both from the basic pension model and from nontaxation of retirement income spent on medical expenses.

C. Qualifications and Limits on Tax Benefits Under the Models

There are many qualifications and limits to the use of the three basic models applying to pensions, employer-provided health insurance, and private annuities. These are summarized below and described in more detail in Appendix A.

Limits on Tax-Preferred Contributions, Benefits, and Employer Funding. There are a number of restrictions on annual contributions and benefits that may be provided to any individual under defined contribution plans and defined benefit pension plans of an employer. The separate plan limit for defined benefit plans, for instance, provides that an individual's annual retirement benefit beginning at age 65 (or Social Security retirement age) may not exceed \$90,000 in 1987 and \$98,064 in 1989. This figure is indexed in subsequent years. The annual contributions made to an individual's account in a defined contribution plan may not exceed the lesser of 25 percent of the individual's compensation, or \$30,000.

There are also limits on the deductibility of contributions. For example, in the case of a defined benefit plan, an employer may deduct only contributions that are necessary under reasonable actuarial methods to fund retirement benefits within the current limits on annual benefits. In determining the deductible level of prefunding, the employer may project salary increases of employees (and thus prefund for a projected retirement benefit) but may not project increases in the annual \$90,000 limit. If a plan provides a cost-of-living increase as part of the benefit, the employer may prefund for this projected increase but only within the \$90,000 limit.

Distribution Rules. Qualified retirement plans are also subject to minimum distribution rules that require that the distribution of an individual's retirement income commence by a certain age and that the benefits be paid out at least as rapidly as on a level, nonincreasing basis. Generally, all distributions from qualified plans are taxable, except to the extent that they are allocable to basis (i.e., employee contributions from after-tax income). Basis is generally recovered on a pro rata basis.

Single lump-sum distributions may be eligible for special forward averaging which generally results in lower tax. Forward averaging provides an incentive to make early lump-sum withdrawals of retirement savings, thereby potentially encouraging the spending down of savings.

Nondiscrimination Rules. To be eligible for tax-favored treatment, health benefits provided pursuant to a self-insured, employer-sponsored health plan must be provided on a comparable per capita basis to a broad cross-section of employees. For pension plans, nondiscrimination rules require generally that benefits be proportional to compensation (defined in various ways, such as average earnings for the highest years of pay). The nondiscrimination criteria, therefore, limit the degree to which the plans offered by an employer may distinguish among classes of employees in terms of coverage and benefits and amount of employer contributions.

There are a broad number of exceptions to these nondiscrimination rules, although recent changes have tended to tighten up on the ability of plans to "discriminate" by favoring higher-income persons. For example, the Tax Reform Act of 1986 strengthened the minimum requirements regarding the proportion of lower-income workers that must be covered under a pension plan relative to the number of higher-income workers covered under the plan. Similarly, the degree to which a pension plan's benefit obligations to an individual may be offset by the individual's Social Security benefits was limited in the Tax Reform Act of 1986.

One explanation of the need for nondiscrimination rules is the belief that higher-paid workers have a greater desire and ability to save than lower-paid workers.³¹ The advantages of pooling savings resources through the employment group (e.g., the ability to hire professional money management and lower costs per investment transaction) lower the costs of employer-based saving arrangements, even in the absence of any tax subsidies. Deferral of tax liability is also relatively more valuable to higher-paid workers because their marginal tax rates are higher than those of lower-paid workers. Higher-paid workers, therefore, may be more likely than lower-paid workers to prefer to receive part of their pay through claims to future pension payments.

Because higher-paid workers have differentially higher tax incentives for retirement saving through pension plans compared to lower-paid workers, the benefits of these incentives would, in the absence of nondiscrimination rules, accrue mainly to higher-income taxpayers. Offering pension benefits without rules requiring that they be provided in a nondiscriminatory manner to lower-paid employees would be viewed by many as providing tax treatment that unduly benefited higher-income workers. Moreover, since high-income individuals have greater resources to use for retirement savings, much of the tax saving would simply represent a windfall gain to a selective group of employees with little effect on retirement outcomes. Most importantly, low-income individuals might not save as much outside the employer context and, hence, there would be much greater pressure on the public retirement system and on welfare agencies to provide greater incomes to low-income elderly. Empirically, these notions are supported by the much broader participation of low-income workers in universal, nondiscriminatory, employer plans than in voluntary plans for salary reduction or in individual retirement accounts.

D. Level Benefit Payments from Pension Plans

The goals of the Federal government in encouraging private pension plans include both insuring adequate wage replacement for workers upon retirement and limiting private reliance upon the public sector for support in old age. The design of pension plans, however, is not correlated closely with these goals. In particular, pension plans have not fully accommodated changes in the characteristics and needs of the retired population. The design of many pension plans is similar to that of many decades ago, and, in particular, has not adjusted to the increased expected number of years in retirement and the impact of inflation on replacement rates in retirement. Benefits are paid at the same level in the early years of retirement as in later retirement years, when the need for long-term care is greatest.

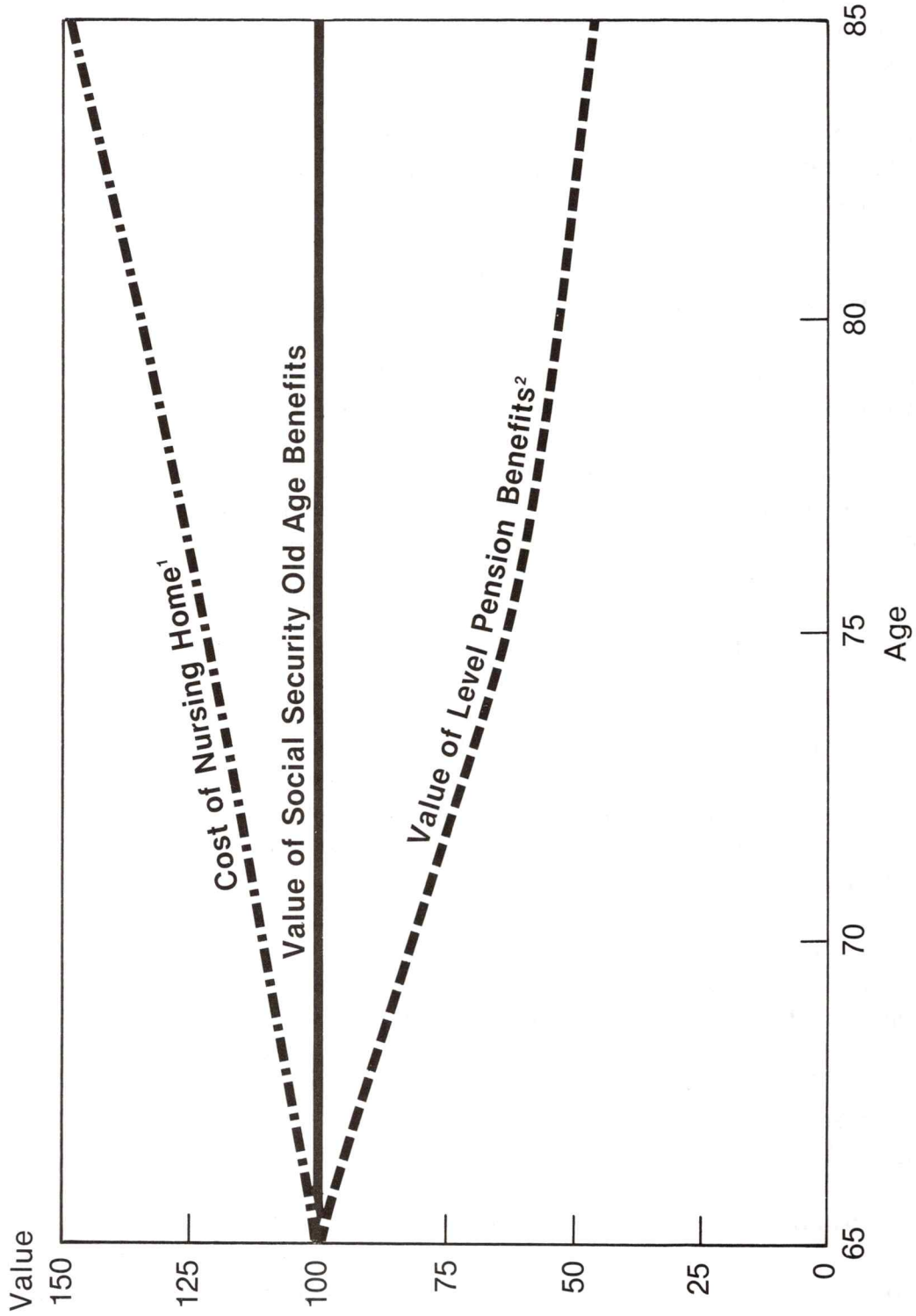
Even at moderate rates of inflation, many pension and annuity plans provide for real benefit levels that are reduced by one-half and sometimes more between early retirement and later ages (as illustrated in Figure 5.1). Thus, private pension plans often provide the greatest real levels of support to higher income younger more healthy individuals and decreasing real levels of support as retirees age and are more likely to need additional resources to cover expenses associated with long-term care.

Current tax law allows companies to provide pension benefits which vary over retirement years. For example, instead of providing one fixed level of benefits throughout retirement, actuarially equivalent benefits could be set at a fixed lower level during early retirement years and a fixed higher level in later retirement years. Alternatively, actuarially equivalent benefits could be set to reflect an expected rate of inflation during retirement. Both of these alternative benefit payment streams would serve to provide a higher level of real benefits in later retirement years when the need for long-term care is greatest.

E. Prefunding for Retiree Health Benefits

Employees' post-retirement health benefits might be prefunded in one of three ways: through separate accounts in a tax-qualified pension plan, through a welfare benefit fund (or a voluntary employees' benefit association, or VEBA), or through a life insurance plan.

Figure 5.1
Decline in Value of a Level Pension Benefit
(Value at Age 65 = 100)



1. Example assumes a 2 percent annual increase in the real cost of nursing home care.
2. Example assumes a 4 percent annual rate of inflation.

Under the pension rules, prefunding without immediate taxation of the interest is allowed for certain post-retirement health benefits provided under a pension plan. These rules have not been widely utilized in the past because of the various limitations under the current rules. Most importantly, to be eligible for this tax-favored treatment, the medical benefits must be subordinate to the retirement benefits provided by the plan. This requirement is met only if the aggregate contributions to provide health benefits do not exceed 25 percent of the aggregate contributions to the pension plan (other than contributions to fund past service credits) made since the medical benefits were first included in the plan. There are additional requirements, such as separate accounting for health benefits and a prohibition against the use of amounts in this separate account for other purposes prior to the satisfaction of all liabilities with respect to the post-retirement health benefits.

Under the welfare benefit fund (or VEBA) rules, payments to a prefunded account are excluded from employees' income, but interest income earned in a trust or account set aside for post-retirement health benefits is taxable as it accrues. Essentially, the VEBA rules provide for taxation in a manner similar to the employer-provided health insurance model, although the time at which the wage is excluded from taxation is separated from the time health benefits are received.

Finally, under rules governing the taxation of insurance companies, health benefits provided under a noncancellable accident and health insurance contract might be prefunded and no tax assessed immediately on the fund's interest earnings. However, Internal Revenue Service rulings have yet to be issued to clarify operation of these rules, particularly as they might apply to an employer-maintained plan. (An IRS ruling has clarified the treatment of reserves maintained by an insurance company for individually-purchased group long-term care policies. See Appendix A.) Most important is the interaction between the welfare benefit fund rules and the life insurance rules in the context of an employer-maintained health plan.

A decision has yet to be made under current law regarding which of these rules govern the tax treatment of long-term care insurance, whether individually purchased or employer-provided. Given the wide disparity in these rules and the potential for significant revenue effects, a legislative solution is more appropriate to provide certitude of treatment, as well as to insure that the optimal social solution is decided in a formal way and not just in a happenstance manner.

In 1984, Congress restricted the tax preferences that apply to prefunded health plans under welfare benefit rules, mainly by imposing current taxation of income earned within the account. Understanding the rationale for these restrictions may help determine the proper tax treatment of prefunded long-term care insurance.

According to the General Explanation of the Revenue Provisions of the Deficit Reduction Act of 1984, "The Congress concluded that prior-law favorable tax treatment of employer contributions to welfare benefit plans, as compared with employer payments of wages and salary, was inappropriate. In addition, Congress believed that prior-law rules...allowed excessive tax-free accumulation of funds...Congressional concern was caused by...the tax-shelter potential of welfare benefit plans... [I]n view of the advance deductions provided to employers for these [post-retirement medical] benefits, it was determined that the allowance of...a tax-exempt reserve would provide an unnecessary tax incentive with respect to these benefits."

Another difficulty in prefunding health plans is ascertaining both the amount of funding that is required and the rate at which benefits accrue and should be vested. It is extraordinarily hard to estimate how utilization of health benefits would change over time, especially in the case of insured benefits for which there is little experience. Changes in technology and provider practices also make prediction difficult. Moreover, in the case of the retired population, there is always a good chance that the government would change the rules under Medicare and thereby change dramatically the amount of funding needed. The recent addition of catastrophic care to Medicare, and its subsequent repeal, provides a case in point.

Determining a "fair" accrual and vesting rule is a related complication. Unlike cash benefits, which can accrue according to the number of years of service with an employer, it is much more difficult to provide, say, one-half or one-third of a health insurance policy for an employee who has spent only one-half or one-third of the time spent by the most senior employees. This is especially true if vested rights are stated in terms of services or benefits provided rather than dollars that might be available to purchase a health plan. Some sort of cliff vesting is often used. Many employers that provide health benefits to retirees provide such benefits only to employees who actually retire from that employer. Thus, many employees who work many years for an employer but leave before reaching the requisite retirement age will receive no retiree health benefits from the employer. If the subsequent employer does not provide health benefits to retirees, or imposes a minimum years of service requirement, these retirees may retire with no health benefits.

The Administration has proposed allowing employers to use pension plan funds to pay certain retiree health liabilities. Generally, the proposal would permit employers to transfer excess funds from their pension plans to health accounts which would pay retiree health liabilities to current retirees. The proposal would require certain safeguards in the pension plan to protect the security of the pension benefits, such as vesting. In addition, in light of uncertainty about the appropriate treatment for retiree health liabilities and concerns about the long-term revenue effects of such a proposal, the proposal would be effective for only relatively short period. An open-ended rule, permitting prefunding of other health and welfare benefits, would result in a significant revenue loss.

F. Individual Retirement Accounts

Because many proposals to deal with long-term care make use of the individual retirement account type of system, it is useful to review briefly this particular form of benefit. For most purposes, the individual retirement account follows the basic pension model in terms of its tax treatment.

Individual retirement accounts (IRAs) were never designed to provide the basic means of providing for retirement income of employees. Instead, such accounts were established in 1974, as part of ERISA, to provide a tax-favored means of savings for workers not participating in employer-provided pensions. Eligible individuals under the age of 70-1/2 were entitled to deduct contributions to IRAs from gross income, up to the lesser of \$2,000 or 100 percent of compensation. Taxes on interest accumulated in IRAs were deferred until withdrawal, and a penalty was imposed on early withdrawals.

In 1981, in response to concern about low levels of national savings, eligibility for IRAs was expanded to include all workers whether or not they participated in employer-provided pension plans. Participation in IRAs grew rapidly, from 3.4 million returns claiming an IRA deduction in 1981 to 12.0 million in 1982 and 17.3 million in 1984, before falling to 15.5 million by 1986. The Tax Reform Act of 1986 largely returned eligibility rules for upper-income taxpayers to those of pre-1981 law, although all individuals are now able to make nondeductible contributions to IRAs, with tax on interest still deferred.

Suggestions that long-term care be financed through a medical IRA, or Individual Medical Account (IMA) have attracted attention. The next section describes these proposals.

II. INDIVIDUAL MEDICAL ACCOUNTS: AN ANALYSIS OF PROPOSALS

A number of proposals have been made to establish tax-favored medical Individual Retirement Accounts (IRAs) or Individual Medical Accounts (IMAs) to finance long-term health care. President Reagan's mandate for this study included the requirement that the Treasury Department analyze the desirability of this approach for financing long-term care. Our analysis concludes that IMAs would be too narrowly focused to be a broadly attractive saving incentive. However, our analysis also suggests the option of allowing adjustments to Individual Retirement Accounts (IRAs) so that distributions from IRAs were associated with long-term care needs as part of a broader pension and long-term care package. In effect, IRAs could be modified to contain a long-term care insurance component.

A. Description of IMA Proposals

Many IMA proposals have been offered. These proposals vary in several ways. First, the relationship of the IMA with existing IRAs may differ. One proposal would allow tax-free withdrawals from existing IRAs for the purchase of long-term care insurance. Alternative proposals would allow contribution limits on current IRAs to be raised to include the IMA, or would allow IMAs to be established separately from IRAs. In each case, the proposals would alter the current IRA rules by allowing withdrawals for long-term care expenditures made after age 65 to be tax-free.

IMA proposals also vary in the type of care and the individuals to whom they would apply. Long-term care is sometimes defined to cover only care in nursing homes, while other proposals would also cover home care and community-based services. Some proposals include a pre-hospitalization requirement; others do not. Tax-free withdrawals from IMAs under some proposals would be used only for the long-term health care of the IMA holders, while other proposals would allow tax-free withdrawals for the care of spouses or other dependents.

The specific tax treatment afforded IMAs also varies among proposals. Contributions would be deductible from taxable income or, alternatively, would generate tax credits. These differing tax treatments affect the distribution of IMA utilization across income groups because deductibility is of greater value to high-income taxpayers while a tax credit has equal value for all taxpayers. Most proposals would allow tax-free withdrawals for designated purposes, thereby giving IMAs more favorable tax treatment than IRAs.

Proposals can also be distinguished by the extent to which IMAs would be combined with the risk-pooling aspect of insurance. In a "Pure IMA" plan without any risk pooling, each individual would rely on his or her own IMA savings to finance long-term care. Because there is great variation in the utilization of long-term care--with a few individuals consuming a great deal, while many require none--some form of risk-pooling might be desirable. Some proposals therefore would combine a portion of the IMA contributions and interest to form a pooled fund, presumably separate from the pooled funds that private insurance companies would establish.³³

Proposals also differ in what happens to account balances upon death. Under some proposals, the entire balance would go to the individual's estate while under other proposals, some or all of the remaining principal and interest would go into the risk pool.

B. Analysis of Proposed IMAs

IMAs would share certain features of current IRAs, but would generally be more restrictive in terms of the uses of funds. IMAs could, therefore, be expected to be less effective than IRAs in stimulating savings, to treat different taxpayers unfairly, and to be more difficult to administer than are IRAs. Further, the availability of Medicaid would restrict IMA use. While the analysis of IMAs would differ in certain aspects depending on which of the many alternatives is considered, these common issues remain.

Effect on Savings. IMA participation could be expected to be well below that for IRAs and other, more general, savings vehicles. This is largely due to the fact that IMAs would constrain savers much more narrowly than do such vehicles. Individuals ineligible for tax-deductible IRAs can still contribute to a nondeductible IRA, with a continued deferral of the tax on the earnings on these nondeductible contributions and unlimited uses of the funds in retirement. The relative attractiveness of a nondeductible IRA compared to a deductible IMA depends on an individual's current and expected future tax rates and subjective probability of requiring future long-term care.

Use by Income Groups. One reason offered in support of IMA proposals is that IMAs would help low-income households who most need to save to provide for long-term care. However, IMA usage is likely to be more skewed toward high-income savers than IMA proposals; lower income households are unlikely to place their limited savings in such a restrictive savings vehicle.

Inequities. Reliance on IMAs to finance long-term care would lead to unequal treatment of individuals with equal long-term care expenditures and lifetime incomes and wealth, but different sources of long-term care funds. Those who paid for long-term care out of ordinary savings would be worse off, other things equal, than those who paid for long-term care out of an IMA account. This differing treatment could be viewed as unfair.

In addition, two individuals with IMAs of the same size but with different needs--medical or otherwise--would also be treated differently under most IMA proposals. For instance, a taxpayer with children requiring expensive health care would be unable to receive the same benefits as someone requiring long-term care. Again, this differing treatment could be viewed as unfair.

Administrability. In the typical proposal, withdrawals from IMAs would be tax-free as long as the funds were used to finance long-term care or long-term care insurance. The Internal Revenue Service would need to monitor the use of withdrawn funds to ensure that they were actually used for long-term care. This would impose large recordkeeping and enforcement requirements. Further, defining "long-term care" would be difficult for IMAs, as it would for any type of long-term care plan. For instance, it is not simple to determine when paying for cooking and housekeeping is a long-term care expenditure and when it is simply an expenditure for services.

Effect of Medicaid. To the extent that the existence of Medicaid as a payor of last resort makes long-term care insurance less desirable, Medicaid also would make IMAs less desirable.

C. Tax-Free IRA Withdrawals for Long-Term Care

A proposal similar to the IMA proposals would allow tax-free withdrawals from IRAs for long-term care expenditures.³² The potential beneficiaries, depending on the specifics of the proposals, would be all individuals who have IRAs, or only those with tax-deductible IRAs. In the short run, the proposal would make IRAs more attractive only to those taxpayers who currently participate in IRAs. Approximately 5 percent of taxpayers currently hold tax-deductible IRAs, primarily those in the \$20,000 to \$50,000 categories. If the provision were extended to nondeductible IRAs, participation would be somewhat higher for higher-income groups.

D. An IRA Option for Further Consideration

The IRA option presented in Chapter 6 aims to accomplish many of the same goals as IMA proposals, but in a way that would likely stimulate greater utilization by incorporating the insurance aspect directly into the IRA.

E. Conclusions

Special-purpose tax-favored savings accounts are not the most desirable mechanisms to finance long-term care. Such narrowly targeted accounts are unlikely to induce broad participation, and that which is induced is likely to be from high-income individuals.

IMAs would result in the inequitable treatment of individuals with similar long-term care expenses but different sources of funds. In addition, individuals who made identical contributions to IMAs but had different long-term care needs would also experience differences in treatment. The IMA would also pose administrative difficulties.

CHAPTER 6: OPTIONS FOR FINANCING LONG-TERM CARE FOR THE ELDERLY

I. BASIC OPTIONS

A. Adjust Pension Payments for Long-Term Care

One of the current problems in financing long-term care is that both public and private retirement benefits focus on income needs in the early retirement years. Because of that fact, the elderly are most likely to have resources comparable to the rest of the population in the early retirement years, when the elderly are least likely to need long-term care. The problem arises in late retirement years, when the older elderly are much more likely to need long-term care but also to have fewer resources than the rest of the population. The structure of private pension benefits contributes to the problem by making little, if any, adjustment in the size of the benefits to meet the cost of long-term care.

An option that would make pension benefits more adaptable to needs arising in later retirement years is to allow plans to vary benefit payments according to the long-term care needs of the beneficiary. As discussed elsewhere in this Report, the greatest incentive for moderate income employees to purchase private long-term care policies is when those policies are part of a broader retirement compensation package rather than a benefit that must be separately purchased or provided.

Choosing a long-term care benefit option within a pension plan need be no more complicated for an employee than checking a box on the pension form. Employees who choose this option might, for a modest reduction in current benefits receive an additional payment if certain serious impairments that require custodial care arise. The additional payment, together with regular pension benefits and other retirement income, may cover the cost of needed household custodial or nursing home care.

A long-term benefit in a pension plan might be particularly attractive to consumers because the benefit could be paid in cash. Cash payments would permit beneficiaries to choose forms of care that meet individual circumstances and take account of variations in family and community resources. For instance, if home care provided by nonfamily members were to become more affordable over time, pension holders requiring long-term care could simply redirect their cash to home rather than nursing home care. Moreover, such benefits would eliminate the need to purchase separate insurance policies geared to specific events, such as the onset of a chronic illness. Consumers who can choose how to spend their increased pension income will also retain incentives to search for forms of care that meet their needs at minimum cost. This option could provide for long-term care at lower costs than would insurance limited to nursing home care. Note, however, that this option would not prevent pension plans and insurance companies from limiting benefits to nursing home care; it would only make it easier to offer options with greater choice.

Benefits paid under this long-term care option would continue to be treated as pension benefits for purposes of the pension funding rules. Thus, an individual's overall pension benefit, including benefits payable under a long-term care option, would be subject to the general limits on pension benefits. This restriction on maximum combined benefits is needed to restrain revenue costs and to

limit the extent to which the tax benefits inure to the benefit of highly compensated employees. Similarly, benefits payable under a long-term care option would not be subject to the current law restriction on the aggregate amount of contributions that may be made to a pension plan to provide medical benefits. The pension option would effectively allow tax-favored prefunding of cash payments related to health and long-term care. Because this is an issue of considerable controversy for pension and health policy, as well as long-term care policy, limitations that restrain revenue losses and target the benefits are important. It may be difficult to specify some of these limits far in advance because of the difficulty in knowing future changes in Social Security or other government policies, as well as nursing home costs. Pension plans could be allowed to determine these limits on the basis of reasonable projections. In addition, a private pension plan could take into account the real decline in the pension benefit in determining future long-term care benefit limits. The purpose of the limits is simply to target the additional tax benefits to long-term care assistance and those most in need.

B. Adjust Annuities, IRAs, and Life Insurance for Long-Term Care

A set of rules consistent with adjustments for long-term care within pension plans could be applied to annuities and individual retirement accounts (IRAs). The rules would provide consistency in financing long-term care between employment-related and individual settings. Symmetric treatment would allow long-term care payment adjustments as an option under normal annuity policies provided by life insurance companies. Current law does not allow a tax deduction for the purchase deposit when an individual buys an annuity outside of the normal pension context. However, interest earned on the deposit is not subject to tax until it is distributed to the purchaser. This option would allow insurance companies to sell not only prefunded long-term care policies, but to combine the policies with other individual annuity policies. Payments from these annuities could then be based partly upon future long-term care needs.

The rules governing IRA accounts could also be amended to permit distributions to vary with the type of long-term care required. The rules for deductible IRA deposits would be similar to the rules for qualified pension plans. The rules for nondeductible IRA deposits would be similar to the rules for individual annuity accounts. This option would not be expected to increase significantly the purchase of long-term care insurance. The purpose of the option would be to make IRA rules consistent with other pension and annuity rules.

To make life insurance rules consistent with other pension and annuity rules, individuals could be allowed to use assets in life insurance policies to purchase long-term care insurance without incurring a tax penalty.

C. Clarify Tax Treatment of Distributions from Long-Term Care Policies

The current law tax treatment of long-term care benefits could be clarified. In all cases, whether long-term care benefits are provided through pension plans, annuities, prefunded welfare benefit plans, or individually purchased long-term care insurance, a common tax treatment should be provided for distributions from such plans. Whether any portion of such distributions could be deducted from income could be determined at the individual level through the rules affecting itemized medical expenses. This approach would provide an appropriate level of tax preference and

allocate the tax preference where needs are greatest, would insure the maximum consumer choice among long-term care options, and would preserve the flexibility of future decision-makers to balance the tax preference of long-term care expenditures with revenue constraints. Appropriate tax treatment makes it less likely that employers would defer providing long-term care benefits to their employees because of concern that the government will later establish a universal, but secondary, system of medically-related long-term care. Under such a government system, taxable benefits that could be used towards non-medical long-term care expenses would still be valuable.

Taxpayers currently are allowed to deduct medical expenses in excess of 7.5 percent of income. Over 38 percent of the elderly are not subject to Federal income tax. For higher-income elderly who pay Federal income taxes, those with large medical expenses generally are allowed a deduction for most of these expenses. For instance, a couple with \$25,000 of adjusted gross income would exceed the 7.5 percent threshold once expenses exceed \$1,875. (Recall that the average amount of medical expenditures, public and private, for a couple is in excess of \$4,000.) The medical portion of long-term care expenses would receive an appropriate tax preference through the itemized medical expense deduction. In addition, because the availability of the tax preference relates to individual income levels, benefits are related to ability to pay such costs.

Allowing the tax treatment of long-term care benefits to be determined at the time the benefits are paid relieves the law and regulations related to long-term care from ex ante requirements on the use of benefits. A taxpayer receiving cash payments, some of which were not spent on medical aspects of long-term care, would not need to be concerned about violating requirements on its use. Ex ante requirements that cash payments from long-term care policies be used for medical expenses would have several consequences for long-term care insurance. Policies would be less likely to provide additional cash payments and more likely to be restricted to those institutional and formal care arrangements where determining the medical portion of future long-term care expenses would be more clear-cut.

D. Analysis of Options

Maximize consumer choice. The preceding options maximize consumer choice by making many benefits payable as cash benefits, leaving individuals to decide how to spend them.

Constrain revenue loss. The options could constrain the revenue loss from favorable tax treatment of long-term care savings and benefits. Because much of long-term care expenses are for the costs of daily living (such as food and shelter) and custodial, rather than medical care, a significant portion of the revenue loss from favorable tax treatment of long-term care would be attributable to these ordinary expenses rather than to health-related expenses. Some recipients of long-term care may live in plush surroundings and enjoy considerable amenities. Others may join retirement facilities that provide initially for little in the way of health or custodial care, but increase the level of such services as the person ages and has greater need for custodial type of care. These are all worthwhile arrangements, and individuals should be allowed to choose to spend their money as they best see fit. Nonetheless, it clearly would be inefficient for tax laws to encourage these arrangements over other equally worthwhile arrangements for living or obtaining custodial care.

Increase flexibility to meet future needs. The preceding options would leave future decisionmakers much greater flexibility to determine whether tax preferences for long-term care are targeted at the greatest needs and benefit a broad cross-section of the population. The issue of what portion of long-term care expenses represents health expenses, expenses over and above normal living expenses, or truly extraordinary expenses is difficult to determine. It would be a mistake to spend scarce revenues now to provide additional benefits for ordinary health expenses and ordinary expenses of daily living when the revenues could more appropriately be spent addressing more pressing needs.

Retain private incentives. The preceding options, in contrast to some proposals that have been made, would not discourage employers from providing long-term care benefits to employees. As discussed more thoroughly in other parts of the Report, few employers are going to offer long-term care benefits restricted to health or institutional care that might later be provided by the government. The concern is that the government might one day adopt a public universal long-term care policy, but make its payments secondary to those of the private sector. Then those employers and employees who negotiated long-term care packages would get the least benefit from the new public policy. The options in this Report favor making long-term care payments in cash and not tied to particular expenditures; the payments would be made regardless of their use by the taxpayer. There would be less likelihood that the government could require that private insurance payments be made first. These private payments would function more like annuity or pension payments that currently do not pre-empt other universally available benefits, such as Medicare.

II. VARIATIONS ON BASIC OPTIONS

A. Alternative Triggers to Long-Term Care Payments

The tax laws could be amended to permit pension plans to adjust the level of payments for certain conditions associated with long-term care requirements. The pension plan could self-insure this risk, or, as would likely be common, provide the long-term care protection through the purchase of insurance. For example, a long-term care option based on attainment of age 85 could work as follows: An individual entitled to a pension of \$10,000 per year for life beginning at age 65 could elect an actuarially equivalent long-term care option that would pay them \$9,000 per year prior to age 85, and then receive \$30,000 per year upon attainment of age 85. Since this option is actuarially equivalent to the payment of \$10,000 per year beginning at age 65, the pension plan incurs no additional cost from the election of the option. Alternatively, the plan might provide an option under which the individual chooses to reduce the amount of the pension in exchange for a promise of an additional specified amount in pension benefits upon the onset of certain medical conditions that require increased care.

B. Alternative Limits to Long-Term Care Option in Pensions

Long-term care options in pension plans would have some revenue cost since the options effectively permit a greater deferral of pension income than current law. Limits could be imposed to restrain the revenue cost, and to insure that long-term care options do not permit excessive deferral. The allowable reduction of the current pension benefit could be limited to an amount (for

example, \$1,000 per year adjusted for age at which reductions begin and indexed for price changes) sufficient to fund a basic long-term care benefit. Limiting the reduction would also help to assure that the additional deferred income is used for reasonable and necessary long-term care expenditures. An additional limit to long-term care payment options would pay increased benefits only where the individual satisfies the conditions for payment; the options could not contain any refund feature.

For plans that offer long-term care as an option, rather than as a benefit for all participants, the limit might be made more restrictive. In this case, the amount of additional cash benefit allowed to be paid as long-term care insurance might be limited approximately to the difference between the basic pension benefit (in the case of a couple, one-half the benefit) plus any Social Security benefit, and the average cost of a nursing home in the United States. Thus, a single person with a total of \$10,000 of private pension and Social Security benefits might be allowed an additional \$12,000 payment when conditions requiring long-term care were present. However, one with \$25,000 of Social Security and pension benefits would not be allowed to benefit from the additional deferral available with a long-term care option.

C. Alternative Limits on Maximum Pension Contributions

Another option to reallocate tax preferences received by pension contributions in order to offset revenue losses due to long-term care options would be to limit the tax-preferred prefunding of the expected value of future pension payments at retirement age. The limit would apply to both regular pension payments and to any long-term care options in the plans. The limit would increase equity among workers who have the same pension eligibility because they would all receive an actuarially equivalent benefit stream. It would also target the tax preference more towards lower-income workers.

III. REVENUE EFFECTS

Adding a long-term care option to private pension plans would reduce Federal revenues by roughly \$1 billion in 1993. A similar adjustment in annuities, IRAs, and life insurance would cost about \$100 million in 1993. The revenue cost of the options would grow over time. These options could be financed by reallocating the tax preferences for pensions and health insurance as discussed elsewhere in this Report.

The pension options would effectively allow tax-favored prefunding for cash payments which are related to health and long-term care. This is an issue of considerable controversy for pension and health policy in general, not just long-term care policy.

As noted earlier in this Report, Congress concluded in 1984 that blanket allowance of prefunding can easily create tax shelter potential, so any changes in prefunded health rules must carefully guard against additional unwarranted tax preferences. However, the options presented here would somewhat liberalize the treatment of prefunded long-term care within the context of normal pension and annuity policy. The options therefore would incorporate existing rules to prevent unwarranted preferences.

An open-ended rule on employee-benefit plan prefunding might set a precedent for prefunding of other health and welfare benefits. Such changes could involve significant revenue losses over the long-term and lead to an increase in tax rates on other forms of income.

PART THREE

FINANCING HEALTH INSURANCE FOR THE NONELDERLY

CHAPTER 7: INTRODUCTION AND SUMMARY

Health care for nonelderly individuals accounts for about two-thirds of the Nation's direct health care expenditures.¹ The government influences the availability of health care for those under age 65 primarily through two mechanisms, public outlay programs including Medicaid and tax subsidies. The government is often the direct payer of last resort. When individuals meet Federal and state determined criteria related to income, wealth, family status, and health expense, they become eligible for Medicaid.

For the majority of nonelderly the Federal government supports health care through the tax system. This support is primarily in the form of the exclusion of the value of employer-provided health insurance premiums from employees' income subject to income and Social Security taxes. For an employee who is subject to a 15 percent income tax rate and a combined employer and employee Social Security tax rate of slightly over 15 percent, the resultant reduction is over 30 cents for each dollar spent on health insurance. The income tax expenditure associated with this exclusion of employer-provided payments was estimated to be about \$37 billion in fiscal year 1990.² The exclusion reduces Social Security system revenues by an estimated additional \$19 billion. Nearly all of these tax expenditure subsidies were received by nonelderly individuals.

Deductions from individual income taxes are also allowed for medical expenses in excess of 7.5 percent of adjusted gross income. This itemized deduction was changed in the Tax Reform Act of 1986, primarily by raising the percentage floor for deductible expenses from 5 percent to 7.5 percent. The Federal tax expenditure for the itemized medical expense deduction was estimated to be \$2.9 billion in fiscal year 1990.

Part Three is concerned with the ways in which the tax system affects access to health insurance for the nonelderly. Although Medicaid and other direct programs for providing medical care to the nonelderly are not examined in detail, some important interactions between the system of providing tax incentives and the system of providing direct medical care are discussed briefly.

I. CURRENT FINANCING OF HEALTH INSURANCE FOR THE NONELDERLY

Most Americans under the age of 65 obtain access to health care through a combination of their own expenditures and employer-provided health insurance. Employment is the major source of health insurance for the nonelderly. Approximately two-thirds of the nonelderly population in 1985 obtained health insurance through their own employment or that of a family member. Another 9 percent of the employed nonelderly population and their families were covered by public insurance such as Medicaid. A significant number of employees, however, are not covered by health insurance. Altogether including workers and persons not in the labor force, approximately 35 million persons did not receive any insurance coverage in 1985 through either private or public programs, including Medicaid, and many others lacked coverage for large medical expenses. Of those without health insurance, about 55 percent were employed.

Insurance coverage is less likely to be provided by small businesses. This lower coverage seems to result mainly from the high cost of insurance to small businesses and the lower overall compensation--wages and fringe benefits--paid to employees of small businesses.

As noted above, employer-provided health insurance receives favorable tax treatment under the Federal tax law: premiums are deductible by the employer, but are excluded from the income of employees for both income and Social Security tax purposes. This tax treatment extends to owners of corporate businesses who are employees of the businesses. Self-employed owners of noncorporate businesses may deduct 25 percent of their health insurance premiums in the years 1987-89 (and proposed permanently in the President's 1991 Budget), and may take the itemized deduction if the premium and other health care costs exceed 7.5 percent of adjusted gross income, but may not otherwise deduct or exclude health insurance premiums.

There are a number of reasons why individuals may not have insurance. Workers may prefer cash to fringe benefits such as health insurance, even though insurance is subsidized by the tax system. Small businesses may find that the cost of insurance is high because of higher administrative costs and greater risks to insurance companies from selling to smaller groups. For many individuals, health insurance may be foregone so that other needs can be met. Individuals between jobs may be willing to go without health coverage for a while or believe they can postpone coverage until a new job is obtained. Medicaid provides a fallback position for many individuals. Some individuals in good health may simply be willing to gamble that they can do without health insurance for awhile.

Even among insured individuals, there is wide variation in the range of services covered by health insurance policies. Limits include the specific kinds of care that are insured, the maximum amount that the insurance will pay, and the fact that coverage often is terminated with employment.³

II. EXISTING TAX INCENTIVES FOR HEALTH INSURANCE

A tax incentive for the private purchase of health care insurance is usually justified on the grounds that there are benefits to society from widespread insurance coverage. Individuals with adequate coverage, and so access to health care, may be more likely to receive health care than those without insurance, and all of society may benefit from this.

In addition, when the government serves as payer of last resort, taxpayers benefit from not having to provide the funds to cover expenses of those who, without insurance, would have inadequate means to meet medical expenses. For some individuals with moderate or low income, Medicaid or free community health center or hospital care may provide a type of insurance against catastrophic events. A tax incentive may then be considered as an offset to the disincentive to pay for private catastrophic insurance, especially when private insurance covers events that would be covered under the public programs.

There are a number of reasons, however, to consider alternatives to the current unlimited exclusion from taxable income of health insurance provided through employers. Workers receive the tax benefits while nonworkers do not. Those who work for employers with generous plans receive much higher levels of tax benefits than those who work for employers with less generous plans. Finally, those in higher tax brackets receive the largest amounts of tax benefits because the exclusion is of greater value to them.

The current exclusion, because it is unlimited, encourages purchases of health insurance that are not worth their full cost. An individual saving 30 cents of taxes for each dollar spent on health insurance will demand an additional dollar of health insurance until such point as the insurance

is worth only 70 cents to him or her. The individual gets 70 cents worth of insurance at a private cost of 70 cents but a social cost of \$1, with the additional 30 cents being paid by other taxpayers. This unlimited subsidy for the purchase of medical insurance leads to insurance coverage of medical care that should not be subsidized. Since most workers would purchase at least some insurance for catastrophic events and since employers are efficient providers of insurance for large groups, many modest policies would be purchased in any case. With the unlimited tax subsidy, however, policies are much more likely to provide first-dollar coverage and to cover relatively predictable and routine expenses. Such broad coverage provides little incentive to control medical spending. The increased demand for health care also tends to raise prices of medical services.

III. SUMMARY

The following three chapters provide a detailed description and analysis of actual and proposed financing sources for increasing access of the nonelderly population to health insurance. Chapter 8 provides an overview of the role of insurance in current health care expenditures, and the characteristics of those with insurance. Chapter 9 contains an analysis of existing incentives for private health insurance. Chapter 10 presents a set of options for further consideration and analysis that would increase access to health insurance for the nonelderly population.

CHAPTER 8: HEALTH INSURANCE FOR THE NONELDERLY: THE CURRENT SYSTEM

I. EXPENDITURES ON HEALTH CARE

Total direct health care expenditures in 1987 were an estimated \$500 billion.⁴ The total includes expenditures on the elderly and the nonelderly, including individuals who were institutionalized. Estimates of the share of expenditures going to the nonelderly, and the sources of funds that pay for their health care, are given in Table 8.1.⁵ The Health Care Financing Administration (HCFA) estimated that in 1987, 64 percent of personal health care expenditures, the major component of national health expenditures, was spent on persons under 65.^{6,7} HCFA also estimated that between 1965 and 1987 the private share of personal health care expenditures for all persons between 19 and 64 years of age fell from 81 to 75 percent (see Table 8.1). For those under 19, the private share similarly fell from 85 percent to 74 percent.⁸

Direct out-of-pocket payments by individuals and private insurance payments each accounted for about half of private health care expenditures for the nonelderly, as shown in Table 8.2.⁹ Note that these expenditure estimates exclude the amount of subsidy provided through preferential tax provisions.

The public share of medical costs for the nonelderly had increased to approximately 26 percent by 1987. Medicaid alone provided about 17 percent of total 1987 personal health care expenditures for those under 19, and about 9 percent for those between 19 and 64. Medicare paid another 4 percent for those between 19 and 64. Public programs other than Medicare and Medicaid--in particular, Defense, Veterans' Administration, Indian Health Service, and workers compensation--are major sources of public health care expenditures for the nonelderly. In 1987, these other programs paid about 9 percent of health care expenditures for persons under 19. For persons between 19 and 64, these other programs paid nearly 13 percent of health expenditures.

Health care expenses vary by age, overall state of health, and income. Health expenses generally rise with age. Health expenses, as expected, also rise as health worsens, regardless of age and income level. Health expenses generally are a higher proportion of income for lower-income individuals, and lower-income individuals typically paid more out-of-pocket than did higher-income individuals. Because out-of-pocket expenditures fall as income rises, the proportion of income spent on health care falls with income. (Detailed tables are in Appendix B.)

II. SCOPE OF CURRENT HEALTH INSURANCE COVERAGE

Most nonelderly Americans are covered by health insurance. In 1985, an estimated 83 percent of nonelderly individuals not in institutions were covered by some form of private or public health insurance, as shown in Table 8.3. Employer-provided health insurance covered 66 percent of the nonelderly, noninstitutionalized population, including many nonworkers such as spouses and children, as well as workers themselves. Other private insurance covered 11.5 percent of this group. Public health insurance, primarily Medicaid, was available to 12 percent of this group. Because some individuals in this group were covered under more than one form of insurance, coverage figures are not additive.

Table 8.1 Percentage Distribution of Funding for Personal Health Care, Selected Calendar Years 1965 to 1987

Age Group	1987	1977	1965
(Percent)			
All Ages:			
Total	100.0	100.0	100.0
Private	60.8	61.6	78.9
Public	39.2	38.4	21.1
Medicare	18.2	14.5	10.1 ^{1/}
Medicaid	11.0	11.2	11.0 ^{2/}
Under 19:			
Total	100.0	100.0	100.0
Private	73.5	73.5	84.5
Public	26.5	26.5	15.5
Medicare	0.1	0.1	9.4 ^{1/}
Medicaid	17.2	15.3	6.1 ^{2/}
19 to 64:			
Total	100.0	100.0	100.0
Private	74.2	72.8	80.8
Public	25.8	27.2	19.2
Medicare	3.8	3.1	8.3 ^{1/}
Medicaid	9.0	8.0	11.0 ^{2/}
65 and Over:			
Total	100.0	100.0	100.0
Private	37.4	35.1	70.1
Public	62.6	64.9	29.9
Medicare	44.6	42.3	15.4 ^{1/}
Medicaid	12.0	15.5	14.4 ^{2/}

Department of the Treasury
Office of Tax Analysis

^{1/} For 1965, all Federal sources.

^{2/} For 1965, all State and Local sources.

Source: Data for 1965 from Charles R. Fisher, *Differences By Age Groups in Health Care Spending, Health Care Financing Review*, Spring 1980, Table 6.

Data for 1977 and 1987 from Daniel R. Waldo *et al.*, Health expenditures by Age Group, 1977 and 1987, *Health Care Financing Review*, Summer 1989, Table 3.

Table 8.2 Percentage Distribution of Health Care Expenditures by Channels of Payment for Hospital Care, Physicians' Services and All Other Health Care Services, Calendar Year 1977

Age Group	Private				Public			
	Total	Total	Direct Payments	Private Health Insurance Other	Total	Medicare	Medicaid	Other
All Ages	100.0	61.0	31.8	27.9	39.0	14.6	11.2	13.2
Under 19	100.0	71.5	38.1	32.7	28.5	.1	15.6	12.8
19 to 64	100.0	71.2	31.9	37.4	28.8	3.0	8.9	16.9
65 and Over	100.0	36.1	29.1	6.6	63.9	44.2	13.8	5.9

Department of the Treasury
Office of Tax Analysis

Source: Charles R. Fisher, Differences by Age Groups in Health Care Spending, *Health Care Financing Review*, Spring 1980, Table 9.

Table 8.3 Nonelderly, Noninstitutionalized Population by Selected Sources of Health Insurance Coverage, Own Work Status, and Poverty Status, 1985

Work Status	Total	With Health Insurance ¹				Without Health Insurance	
		Private Coverage		Public Coverage			
		Total	Employer	Other	Total		Medicaid
Total	199.8	147.6	131.8	23.0	23.9	16.0	34.8
Workers	123.3	97.1	87.6	14.8	10.8	6.1	19.1
Family Head	78.8	60.3	53.6	10.0	8.7	5.4	12.3
Others	44.5	36.8	34.0	4.8	2.1	0.7	6.8
Nonworkers	76.5	50.6	44.3	8.2	13.1	10.0	15.6
Children	56.4	37.7	34.9	4.1	9.1	7.9	11.1
Others	20.2	12.8	9.4	4.1	4.0	2.1	4.6
Part A. Population (millions)							
Total	199.8	147.6	131.8	23.0	23.9	16.0	34.8
Workers	123.3	97.1	87.6	14.8	10.8	6.1	19.1
Family Head	78.8	60.3	53.6	10.0	8.7	5.4	12.3
Others	44.5	36.8	34.0	4.8	2.1	0.7	6.8
Nonworkers	76.5	50.6	44.3	8.2	13.1	10.0	15.6
Children	56.4	37.7	34.9	4.1	9.1	7.9	11.1
Others	20.2	12.8	9.4	4.1	4.0	2.1	4.6
Population in Families Below Poverty Level							
Total	29.5	6.2	3.9	2.5	13.1	12.2	11.2
Workers	13.5	3.3	2.0	1.5	5.1	4.4	5.6
Family Head	12.1	2.8	1.6	1.3	4.8	4.2	4.9
Others	1.4	0.5	0.4	0.2	0.3	0.2	0.7
Nonworkers	16.0	2.8	1.9	1.0	8.0	7.7	5.7
Children	12.9	2.2	1.6	0.7	6.8	6.6	4.3
Others	3.2	0.6	0.3	0.3	1.2	1.1	1.4

Table 8.3 Cont.

Work Status	Without				Total
	Total	Private Coverage Employer	Public Coverage Other	Public Coverage Medicaid	
	100.0 %	100.0 %	100.0 %	100.0 %	
Total	61.7	66.5	45.2	100.0 %	100.0 %
Workers	30.4	40.7	36.4	38.1	54.9
Nonworkers	22.3	25.8	8.8	4.4	35.3
Children	38.3	33.6	54.8	62.5	19.5
Others	28.2	26.5	38.1	49.4	44.8
	10.1	7.1	16.7	13.1	31.9
					13.2
Part C. Percent Within Coverage Group					
	Total Population				
	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
Total	45.8	51.3	60.0	38.9	36.1
Workers	41.0	41.0	52.0	36.6	34.4
Family Head	4.7	10.3	8.0	2.3	1.6
Others	54.2	48.7	40.0	61.1	63.1
Nonworkers	43.7	41.0	28.0	51.9	54.1
Children	10.8	7.7	12.0	9.2	9.0
Others					
Population in Families Below Poverty Level					
	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
Total	45.8	51.3	60.0	38.9	36.1
Workers	41.0	41.0	52.0	36.6	34.4
Family Head	4.7	10.3	8.0	2.3	1.6
Others	54.2	48.7	40.0	61.1	63.1
Nonworkers	43.7	41.0	28.0	51.9	54.1
Children	10.8	7.7	12.0	9.2	9.0
Others					

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Office of Tax Analysis

¹ Due to multiple coverage of some individuals, detail will not add to totals.

Source: Chollet, D., "Uninsured in the U.S.: The Nonelderly Population Without Health Insurance." EBRI, pp. 10-102.

Private and public health insurance in 1985 did not cover over 17 percent of the nonelderly, noninstitutionalized population, or nearly 35 million persons. Over half of those without coverage, 55 percent, were employed. Workers with low incomes--incomes below the poverty level--were more than three times as likely as other workers not to have health insurance. Nearly one-third of those without any insurance coverage in 1985, 11.2 million individuals, were in families with incomes below the poverty level.

As the data in Table 8.3 show, the persons without insurance are not a single, easily identified or targeted group. Uninsured individuals are found not only among the unemployed and the poor, but also among the employed and those with higher incomes. Access to health care varies between the uninsured and the insured and according to personal and financial characteristics of individuals. The next section provides more detail on the access to health insurance among different groups in the population.

Although having some form of health insurance increases access to health care and decreases significantly the probability that the government will be payer of last resort, there are significant variations in the expenses covered by various forms of health insurance. Depending on the standards that are applied, not all persons with health insurance can be viewed as having full access to health care. Two issues about coverage are raised most often in this context. First, the combination of insurance and income may be considered inadequate to ensure that individuals have access to routine and preventive health care as well as to less frequent, but expensive, care such as hospitalization. Second, coverage for costly events may be limited so that individuals still may bear out-of-pocket expenses that are large relative to their incomes.

There is a wide variation among health insurance plans in the coverage provided for insured expenses. The amount of first-dollar coverage, coverage which requires no out-of-pocket expenditures by the insured in traditional, fee-for-service plans, appears to be declining. Data from a survey of benefits offered by medium and large firms show that the proportion of participants who have only major medical coverage increased from 19 percent in 1983 to 35 percent in 1986.¹⁰ Major medical benefits cover many categories of care but typically require the participant to pay both an initial deductible amount and a portion of hospital charges. The average amount of these required deductible payments in traditional plans has been rising in nominal terms. The proportion of participants in major medical plans who paid a deductible of \$150 or more rose from about 8 percent in 1979 to 36 percent in 1986. Over the same period, the proportion who paid deductibles of \$50 or less fell from 30 percent to about 11 percent.¹¹

Although deductibles have become larger, coinsurance rates have shrunk. Nearly seven-eighths of the 1986 participants were in plans that pay at least 80 percent of expenses beyond the deductible. For about 80 percent of the participants, the proportion of expenses paid by the insurance plan rises to 100 percent after specified levels of total expenditures have been reached. By comparison, in 1979, less than half of the participants in major medical plans were covered by maximum expenditure limits.¹² The proportion of employees who pay part of their own health insurance costs has been rising, as has the proportion who pay part of the costs of insuring family members. Insurance fully paid for by employers for individual and family coverage fell from 72 and 51 percent

in 1980 to 54 and 35 percent in 1986.¹³ Payments are more likely to be required in individual than group plans. Another trend in health insurance coverage has been the increasing proportion of coverage in health maintenance organizations and preferred provider organizations.

Data for 1977 indicate that over half of persons with group insurance received coverage for the full costs of a semi-private room, but nearly one-fourth received either a limited daily benefit or a limited hospital indemnity. The probability of full coverage increased with the size of the insurance group. Levels of coverage also varied with industry, employment status, and sex. Details are shown in Appendix Table B-10.

III. HEALTH INSURANCE COVERAGE

Health insurance coverage differs among the employed, unemployed, nonworkers, and self-employed. Thus, it is useful to consider each group separately.

A. The Employed

Employment is the major source of health insurance coverage for the nonelderly. Table 8.3 shows that about 71 percent of all workers had employer-provided insurance in 1985. However, nearly 36 million workers did not, and an estimated 19 million workers were completely uninsured. That is, they were not covered by insurance provided by their own employer or that of family members, through privately purchased insurance, or through public insurance programs, including Medicaid. The absence of insurance among workers also affects the insurance coverage of their families. Over half of the nonelderly without health insurance were in families where the head was employed full time for the full year.¹⁴

Workers with employer-provided insurance differ systematically from workers without it in terms of age, earnings, industry, and size of firm. Most uninsured workers are employees, rather than self-employed business owners. Employees in larger firms are far more likely to be insured than employees in smaller firms. Over 85 percent of employees in firms with 500 or more workers had employer-provided health insurance, compared to slightly over one-third of workers in firms with fewer than 25 employees. Table 8.4 shows that the proportion of employees with health insurance increases with firm size, and that this relationship remained stable between 1979 and 1983. Workers without employer-provided health insurance were also more likely to work in goods-producing industries, where firms tend to be larger, than in service-producing industries.¹⁵ Just over half of the self-employed had direct or indirect employer-provided insurance.¹⁶

Workers with health insurance tend to have relatively higher earnings, with two-thirds earning at least \$10,000 in 1985. The proportion of workers with insurance was similarly higher among those earning over \$10,000 annually. Between 90 and 98 percent of workers in this earnings category were insured, compared to 72 percent of those earning less than \$10,000.

There is no single reason why many employees receive employer-provided medical insurance while others do not. The explanations commonly offered include both costs to the firm and factors related to worker characteristics.

Table 8.4 Group Health Insurance Coverage of Wage-and-Salary Workers by Employment Size of Firm, 1979 and 1983

	All Firms	Employment Size of Firm			
		1-24	25-99	100-499	500+
(Percent)					
Included in Employer's Health Plan					
1979	67.2	36.3	65.0	76.8	86.4
1983	67.2	38.7	65.4	75.2	85.4
Included in Employer's Health Plan or Covered by Household Member's Policy					
1983	81.8	66.4	80.2	86.7	91.8

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Source: *The State of Small Business*, 1985, Table 5.18.

Health insurance costs tend to be somewhat higher for workers in small firms than in larger firms. Insurers typically charge higher premiums to recover the costs of handling smaller accounts or accounts with higher turnover. The administrative costs to the small firm itself may also be higher per employee. Rates for small groups also tend to be based on characteristics of individual employees rather than a flat group rate. Basing insurance premiums on characteristics of individual employees tends to raise costs and can also cause some employees to be denied insurance. Evidence suggests that dollar outlays per policy are, in fact, higher in smaller firms, while fewer services tend to be covered.¹⁷

Whether in large or small firms, some workers may simply prefer cash compensation to fringe benefits, such as health insurance. For instance, workers who receive insurance through other family members would likely prefer cash even to insurance that was subsidized. Such indirect coverage is important, providing insurance for 15 percent of all workers and 28 percent of workers earning less than \$10,000.¹⁸

Determining the extent to which employees bear the cost of health insurance is difficult, although the standard economic analysis of legally-required benefits such as Social Security and unemployment payroll taxes concludes that workers bear almost the entire cost of both the employer and employee contributions through reduced cash compensation. It is likely, therefore, that a significant portion of the costs of employer-provided insurance are borne by workers in the form of reduced wages. Lower-paid workers may be less willing or able to reduce their money income in order to receive health insurance. For workers initially at the minimum wage, a wage reduction is not possible.

Employers may secure some advantage, such as decreased hiring and turnover costs, from providing certain types of benefits, and could therefore bear some of the costs of health insurance.

Agreements collectively bargained between workers and employers could potentially exclude health insurance in explicit exchange for other fringe benefits or work arrangements. Although such tradeoffs are possible, analyses show that unionized workers are more likely to have employer-provided health insurance than are nonunion workers.¹⁹ The evidence available, however, is not sufficient to permit satisfactory tests of whether the higher benefit levels observed in collective bargaining agreements actually are caused by the negotiations or whether they reflect other factors.²⁰

Another set of workers may be uninsured because they are new hires who have not yet fulfilled waiting periods for eligibility. Half of the full-time participants in medium and large firms that offered employer-provided health in 1986 were in plans with waiting periods. These periods typically were one or three months.²¹ Note, however, that waiting periods have generally been decreasing. Some workers may also be affected by clauses excluding pre-existing conditions.

Finally, some employees may not want employer-provided health insurance because public programs are available, although the number of such employees is likely to be small.

B. The Unemployed and Nonworkers

Employment-based health insurance plays a prominent role in providing private insurance. The unemployed and those who are not in the workplace are less likely to benefit from the incentives of an employer-based system.

Individuals may be without jobs either because they are not in the labor force or because they are in the labor force but currently are not employed. Individuals not in the labor force include children, adults whose health prevents them from working, and adults who choose not to seek outside employment. The unemployed include individuals searching for their first job as well as individuals who have separated from a job.

Many nonworkers have health insurance coverage. Employed family members, private purchases, and public programs provide alternative sources of health insurance. However, about 15.6 million of the nonworking, nonelderly population did not have private or public health insurance, in 1985, as shown in Table 8.3. Of these, an estimated 11.1 million, or over 70 percent, were children and 4.6 million were adults. Nonworkers accounted for nearly half--45 percent--of all uninsured individuals. Nonworkers were more likely than workers to be uninsured, with 20 percent of nonworkers uninsured compared to about 15 percent of workers. Nonworkers also were more likely than workers to receive public insurance, but less likely to have either employer-provided coverage through another family member or other private insurance coverage.

A number of unemployed persons are offered extended coverage through their former employers. Over the years, many employers have offered the option to continue participation in health plans. The Consolidated Omnibus Budget Reconciliation Act of 1985 requires that for health plan years beginning after June 30, 1986, most employers extend to employees an option to purchase group insurance for 18 months after leaving employment.²² The average duration of unemployment, by contrast with the 18 month requirement, has ranged between 14 and 20 weeks in the last few years. Unemployed persons, nonetheless, may find the full out-of-pocket cost of their former employer's health insurance unaffordable. This may be especially true if the former employer offers fairly complete coverage and does not offer any lower-cost option.

Some persons are uninsurable due to pre-existing conditions. Insurers may categorically refuse to cover such persons or may offer insurance only at actuarially fair, but very high, prices. There is little evidence, however, that this problem applies to more than a small portion of those without insurance coverage.

Even in the absence of Medicaid, many may simply wish to self-insure. Persons whose own resources would be inadequate to cover catastrophic expenses may be expressing a preference, say, for \$1,000 in cash now rather than \$1,000 spent on insurance against the unlikely event of incurring catastrophic health expenses. Many may simply wish to take a gamble. In many cases, the gamble is sensible. If the period of unemployment is expected to be short, for instance, it may be thought that some medical services can be postponed. Or the person may be in good health and simply believe that the gamble has a high probability of payoff. Of course, the possibilities of turning to Medicaid or to the community should dire circumstances arise make the gamble more attractive to the individual.

C. The Self-Employed

The term "self-employed" has several meanings. Working owners of unincorporated businesses--sole proprietorships and partnerships--are "self-employed" for Federal tax purposes. The Federal tax law meaning is used here. Under Federal tax law, owners of incorporated businesses who are employed by the businesses, regardless of the size of the business and their ownership share, are treated the same as other employees of the corporation and are not "self-employed." (Special rules apply in the case of certain S corporation shareholders.) Insurance provided to employees (as opposed to the owners of unincorporated businesses) has been and remains deductible for all types of businesses.

For many persons who are self-employed, their businesses may not be their only activity. Forty-four percent of the owners of nonagricultural business do not work full-time at their business. Self-employed persons often obtain health insurance either through another job or under the policy of a spouse.

The self-employed are a heterogeneous group, and include many who move back and forth between employment and self-employment. The self-employed also tend to be older than the work force in general. About 87 percent of the self-employed were between 30 and 64 years old in 1986, compared to about 65 percent of all employed workers. Correspondingly, about 82 percent of the uninsured self-employed were between 30 and 64 years old.

Approximately 3 million persons without health insurance in 1985 (9 percent of all nonelderly uninsured) were in families whose head was self-employed.²³ Compared to the nonelderly population as a whole, individuals in families whose head was self-employed are more likely to be uninsured (25 percent versus 17 percent) and less likely to be covered by employer-provided insurance (49 percent versus 66 percent).²⁴

Based on data from the Survey on Income and Program Participation, it is estimated that 16 percent of all business owners were uninsured in 1984, compared to about 10 percent of wage and salary employees. Sole proprietors and partners in 1984 were nearly four times more likely to be uninsured than were owners of incorporated businesses (20 percent versus 5.4 percent).²⁵

The availability of health insurance to employees and owners of unincorporated businesses seems mainly to depend on the size of the business and the average income or wage paid by the business. These relationships are likely due to considerations such as the cost of providing insurance to small groups. In this regard, there is little difference between unincorporated and incorporated businesses.

There is, however, one tax limitation that discourages the purchase of health insurance by the self-employed. Except for the years 1987-1989 and the first 9 months of 1990, a self-employed person is not allowed to deduct expenses for his or her own health insurance as a cost of business, but instead is treated like nonworkers and workers without employer-provided insurance. That is, insurance purchases are treated as non-deductible individual expenses. In the Tax Reform Act of 1986, self-employed persons were allowed to deduct 25 percent of their own health insurance premiums for the years 1987 through 1989. The Omnibus Budget Reconciliation Act of 1989 extended

the deduction through October 1, 1990, and the President's Budget would make the deduction permanent.

Targeting a deduction to the self-employed is not easy because many are self-employed only part time or have employed spouses with health insurance coverage. Because targeting is difficult, the 1986 Act included restrictions such as that the 25 percent deduction cannot exceed self-employment income, and that the self-employed may not claim the deduction if they are eligible to participate in a subsidized health plan of their own employer or their spouse's employer.

CHAPTER 9: CURRENT INCENTIVES FOR PRIVATE HEALTH INSURANCE

I. THE EXCLUSION FOR EMPLOYER-PROVIDED INSURANCE

A. Resource Allocation

Current tax treatment lowers the net price of health insurance to individuals who receive it from their employers because it allows them, in effect, to purchase health insurance out of before-tax dollars. There is relatively little evidence on precisely how much the exclusion increases health insurance coverage. It does seem clear, however, that the reduction in the price of employer-provided health insurance has stimulated overall demand for health insurance, although some of the rise in employer-provided insurance has simply replaced purchases of individual health policies. Feldstein and Friedman (1977) suggest that the effect of the exclusion on insurance coverage can be substantial. They estimate that the exclusion from both income tax and Social Security payroll tax substantially reduces the amount of medical care costs paid for directly by individuals through out-of-pocket funds. For instance, the average coinsurance rate individuals are willing to bear falls from 0.58 to 0.37.²⁶

This reduction in the proportion of medical care costs paid through out-of-pocket funds in turn encourages consumers to increase their consumption of health services, and to purchase health care that would not be purchased in the absence of third party payments. For instance, with a 30 percent subsidy, individuals would demand one dollar of medical care as long as they would pay at least 70 cents for the care. This result might be desirable if the medical care provided substantial external benefits, but for the additional care that the subsidy purchases, this may not be the case. Therefore, some of the resources used in providing this tax subsidy might be more cost-effectively used elsewhere.

A number of studies have found that changing the extent of patient cost-sharing strongly influences the use of medical services. Estimates vary somewhat from study to study, but a consensus view is that reducing the price faced by consumers of medical care by 10 percent would lead to an increase in health care services consumed by between 1 and 3 percent.²⁷ The impact on demand appears to be greater for outpatient medical care than for hospital care.²⁸

The last dollars of tax subsidy provided for health insurance are likely to be the least cost-effective. Since most individuals would want some insurance for catastrophic events, modest policies provided by employers would normally replace purchases of similar individual policies, with little impact on the overall level of coverage. However, the additional, or marginal, health insurance expenditures that the current unlimited exclusion encourages are more likely to go toward first-dollar coverage and coverage of relatively predictable and routine expenses, such as eye care or dental care. The tax exclusion also gives individuals less reason to enroll in health maintenance organizations (HMOs) and other types of programs designed to constrain costs.²⁹ Thus, the least cost-effective portion of the tax exclusion is in the last dollars spent on the tax subsidy. Correspondingly, the greatest gains in cost-effectiveness from limiting the subsidy would come from limiting the tax benefit rather than from taking away tax benefits for the first dollars spent.

Overinsurance can result in additional and uneconomic administrative costs, rather than changes in actual medical services obtained. Administrative costs--costs of processing and paying claims--while small relative to large health bills, can be quite large relative to small bills. It is the relatively small purchases that insurance covering first-dollar expenditures and routine care is most likely to stimulate. Another inefficiency of the exclusion is to encourage employer-provided insurance relative to other types of group insurance.

The inefficiencies that the exclusion introduces into the health care market and the economy in general suggest that some of the resources it directs into health care could be used more cost-effectively. Estimates imply that the amount of resources involved is large. The exclusion will reduce Federal income tax receipts by an estimated \$37 billion in Fiscal Year 1990, and Social Security receipts by an estimated \$19 billion.

B. The Price of Medical Care

The exclusion for employer-provided health insurance increases demand for health insurance and thereby increases demand for health care services. This rise in the demand for health care services can increase not just the quantity of services provided, but their price as well. The price of medical care has risen over the past 20 years at a rate significantly exceeding the general rate of inflation.

This sustained relative price rise has several important implications. Those who lack health insurance or who must purchase their own individual coverage pay more for health care than they would in the absence of an exclusion. Even those who have some limited employer-provided insurance may find that the health care price increases for their out-of-pocket expenses outweigh the tax-subsidized cost of their insurance. The price increases also place additional strains on the Medicaid and Medicare programs.

It is difficult to estimate precisely how much the exclusion affects price increases. A 30 or 40 percent subsidy will increase prices by the entire amount of the subsidy if the amount supplied varies little with price changes. If, on the other hand, the amount supplied varies substantially, the price increases are less. For most goods, a subsidy increases both the price and the amount supplied. It has been argued that when a large proportion of the population faces trivially small out-of-pocket costs, and so saves little or nothing by demanding low-cost services, the demand side of the market ceases to exert any control over the market.³⁰ Some also argue that the over-consumption of insurance may lead in the longer run to further increases in both demand and price. The available data do not allow this assertion to be tested.³¹

II. EFFECT ON COVERAGE

The current unlimited exclusion for employer-provided insurance, in addition to introducing inefficiencies in the market for health care, creates disparities in the tax treatment of individuals. Persons at similar income levels are treated differently, depending on the amount of health insurance (if any) their employer provides. Because persons with higher incomes are more likely to have access to employer-provided insurance, the exclusion provides greater benefits to those with higher incomes.

CHAPTER 10: OPTIONS FOR FINANCING HEALTH INSURANCE OF THE NONELDERLY

I. OPTIONS RELATING TO EMPLOYER-PROVIDED HEALTH INSURANCE

A. Limit Employee Exclusion

Individuals who are eligible for employer-provided health insurance would continue to receive a tax subsidy, but a fixed dollar limit per month on the exclusion would replace the current unlimited exclusion. Employer contributions for health insurance in excess of a fixed dollar limit per month would be included in the employee's gross income. Separate limits would be set for family and individual plans. The limits would be adjusted annually for inflation. If the employer contribution exceeded the limit, the employee would be subject to both income and Social Security taxes on the excess in the same manner as wages. For purposes of the exclusion, all tax-preferred money spent on health care should count towards the exclusion limit, whether the funds are termed employer contributions or employee salary reductions. The cap could be set sufficiently high that it would apply to relatively few employees.

A limit on the exclusion of employer-provided health insurance has been proposed before.³² President Reagan's Budget for Fiscal Year 1985 proposed to limit employer contributions to health and accident plans to \$175 per month for a family plan and \$70 per month for an individual plan. A similar limit was proposed in Treasury I, The Department of the Treasury Report to the President on Tax Reform for Fairness, Simplicity, and Economic Growth.

Effects of Limit. Limiting the exclusion could increase the efficiency of the health care system and help restrain health care cost inflation. The increase in cost-effectiveness would depend on the long-term response of employers and consumers. However, any reduction in the rate of health care price increases would most likely be shared by both consumers of health care and taxpayers (who pay for the cost of the public health care system). A slower rate of health care cost inflation would be helpful to government health programs. A limit might also restrain future growth in health expenditures and help people make explicit choices about the health care they receive.

Employers would remain free to provide any level and type of health insurance plan they and their employees desire, and would still have a tax incentive to provide health insurance up to the limits. Under this option, the trend towards plans with explicit cost-sharing between employers and employees (or other cost management characteristics) would continue with the employer share at or below the limit. Employees might purchase supplemental policies, but those purchases would be out of their own after-tax income.

Disparities would be lessened among workers in firms that offer insurance and workers and nonworkers without access to it. For workers with employer-provided insurance, the subsidy would no longer increase without limit as the amount of employer-provided health insurance increases. The limits could generally be set to exceed employer contributions for most employees (and so not directly affect them), yet indirectly benefit many employees as well as many nonworkers.

The number of persons affected by a limit on the exclusion, and the consequences for Federal tax revenues, would depend on the levels chosen. Monthly limits on employer contributions of \$400 for families and \$160 for individuals could affect about 16 percent of current recipients if such limits were fully in place in 1992, depending on the structure of the exclusion limit. Lower limits, such as \$300 and \$120, would affect an additional 19 percent of current recipients or about 35 percent of current recipients.

Design Considerations. A number of design features need to be considered in developing a limit to the exclusion. These features take account of a number of measurement and administrative issues that reflect the diversity and complexity of the employer-provided health insurance system. The services that the excluded employer contribution may cover must be defined. In addition, the employer contribution for those services for each employee must be determined. It would be possible to draw on several years of employer experience in making similar determinations under COBRA continuation rules.

Account also may also need to be taken of insurers' pricing practices. For example, underwriting practices may cause price variations when a single set of insured services is purchased by employers whose workforces, working conditions, or group size differ. Employers that operate in more than one area may have contracts with a number of different insurers. Price variations across areas may reflect variations in insurer characteristics, practice patterns, and health care prices. Some employer practices, such as tracking the number of employees choosing a plan or plan option (high- and low-options, self or family), but not which employees chose it, will need to be addressed. Self-insuring firms pose additional design considerations because they may not currently have a calculation corresponding to a third-party insurer premium available until after the employee's tax year.

Alternative definitions of the payments that count towards the employee exclusion or employer deduction limits would have to be considered. In current practice, employer-provided insurance commonly includes services such as physician visits and hospital and surgical charges. In many firms, related benefits such as dental and vision services are provided as part of a health insurance plan, while the same services may be provided separately in other firms. The concept of health sometimes expands further to include a range of home health care services and various other services that are more difficult to distinguish from ordinary expenses of living. The definition matters because of the differing tax treatment the benefits would receive if they do not qualify under the limits as health benefits.

B. Allow Exclusion Only for Policies with Specific Provisions

An alternative option would be to allow employees to exclude from income only those employer-provided insurance policies with certain key provisions, such as a minimum deductible and coinsurance rate. The option is design-based and would exclude from employee income all employer contributions for health insurance coverage of the costs of specified health care and preventive (e.g., well-baby care) services, provided the insurance required deductibles and copayments from the beneficiaries. For example, an annual deductible of \$500, a 20-percent copayment rate, and an annual out-of-pocket maximum of \$3,000 (all indexed), would protect beneficiaries from the costs of extensive illnesses yet give them meaningful incentives to review and monitor their use of insured

health care. The deductible and copayment amounts could be set to provide the desired Federal tax subsidy, and could be altered to control the cost of the subsidy. Employers and employees would remain free to choose any additional health insurance options they wish, but without Federal tax subsidy.

Design Considerations. Many of the design considerations that apply to a limit on the exclusion, such as underwriting, geographical and firm size variations in the cost of similar policies, would not necessarily need to be imposed on employers in implementing this option because it would be the design of the plan rather than cost that would lead to the exclusion. Private insurers could continue to determine the price of the insurance they offer. Measurement issues could not be avoided entirely in implementing this option, however. For example, it might be necessary to calculate the national average of the cost of excludable insurance plans to determine how much of employer contributions to Health Maintenance Organizations would be excludable: If the entire contribution were excludable that might give HMO subscribers a much greater subsidy than beneficiaries of regular insurance. The exclusion for HMO subscribers might, for example, be set at the national average of the cost of excludable insurance plans.

The health and tax policy effects, as well as the revenue effects, of this option could depend on the precise language chosen. If the language were not reasonably specific, it would be possible for workers in the same firm to receive very different Federal subsidies if they participate in different plans. If the allowable coverages were not clearly delineated, it would be possible for any potential revenue gain to be eroded by expanded coverage of other medical services.

C. Limit Employer Deduction for Health Insurance

Another option is to apply the exclusion limit at the firm level. The limit could be applied at the firm level by disallowing the employer deduction for insurance premium payments in excess of a limit or by placing an excise tax on the employer. Applying the limit at the employer level could be somewhat simpler administratively than applying the exclusion at the individual level.

However, applying an employer limit also presents several difficulties. Disallowing the employer deduction would affect only employers who pay Federal income tax; it would not affect state and local governments or nonprofit institutions. Either disallowing the employer deduction or imposing an employer excise tax is less visible to employees than is imposing the limit on individual workers. Employees would be made less aware of the cost of their health insurance than they would be with individual limits. Applying the deduction limit to average premiums in a firm rather than to individual premiums also could be less equitable. Employers could choose to achieve an average that equaled the limit by lowering the premiums they pay on behalf of some workers while raising the premiums they pay on behalf of other workers.

Design Considerations. Many of the design considerations affecting the preceding options would also apply to limits on the employer deduction.

II. CREDIT FOR HEALTH INSURANCE

One option for increasing access to health insurance coverage for persons who currently do not benefit from Medicare, Medicaid, or employer-provided health insurance is a tax credit for health insurance. The credit could be made refundable.

A refundable credit could, for example, apply only to health plans meeting certain criteria that would help make insurance available to owners and employees of small businesses and to other groups who otherwise find it difficult to purchase insurance. Its value could be adjusted annually for inflation. The credit might not provide enough money for all the health insurance a family desired. But many would be able to contribute additional amounts for their policies. This option would increase access to standard care.

A credit option would have attractive budgetary features. Its cost could be controlled over time by controlling the value of the credit. For example, actual usage of the credit might exceed original projections because existing data do not allow an accurate assessment of why persons are uninsured. The value of the credit could be controlled until total costs stayed within the desired budgetary total.

Form of Credit. A modest refundable credit of \$200 per individual for those not eligible for coverage by employer-provided insurance or public insurance would be equivalent to about \$600 per family. A credit of this size would help a currently uninsured family purchase an insurance policy covering fairly conventional care for major accidents and illness, or a comprehensive managed-care option such as an HMO. But the credit alone would not be sufficient to cover most of the costs of a policy or to pay for all routine care and the costs of minor illnesses and injuries. For example, the 1990 cost of the standard Blue Cross policy available to Federal workers is \$3,700. The credit also could be structured to dovetail with community health programs to provide care at lower costs and to provide for a greater sharing of the cost of care. For example, states could choose to supplement this Federal credit.

A credit could be structured in several ways. For example, the credit could be extended to everyone, rather than only to persons without employer-provided insurance or public health care program. Structuring the credit this way would reduce one component of administrative costs, because it would eliminate the need to verify that credit recipients received no other Federal health care subsidy. However, the revenues required to fund even a modest credit and to administer it would rise because far more persons would be eligible. Approximately 90 million households would be eligible for a general refundable credit, while approximately 30 to 33 million individuals who lack access to any insurance would be eligible for a targeted refundable credit. Also, the general refundable credit would be available to persons who already receive a Federal subsidy for health care through the exclusion of employer-provided insurance below the limit or through direct services.

Whatever form a credit takes, most eligible individuals and families would claim the credit on their tax returns at the end of the year. However, if the credit were refundable, insurance companies could be allowed to file for a credit on behalf of individuals and their families who are not required to file a tax return. To receive a credit, companies would file statements with the Federal government showing that the insurance had been issued and listing the Social Security numbers of individuals receiving it. This option would continue to relieve these individuals of the burden of filing an income tax return when they otherwise would not need to do so. Administrative issues would need to be considered in implementing this option.

Scope of Credit. There also are options on the scope of health insurance to which a refundable credit could be applied. One option would be to allow the credit to apply towards any insurance

policy that meets relevant state laws as health insurance. However, policies that meet state mandates may not be the most effective in assuring access to care for primary health needs. An alternative would be to require specific classes of care to be covered. For example, the insurance might be required to insure against catastrophic financial losses by covering all hospital and doctors' costs beyond a specified deductible. For the modest levels of credit discussed in this Report, the deductible level is likely to be high. Individuals could insure themselves against more routine out-of-pocket costs only by buying additional insurance with their own funds. The credit could also be designed to apply to policies that cover cost-effective preventive care, or to cover routine health care that is deemed essential to the public health, such as immunizations for children.

Access to Insurance. A modest refundable credit alone may not provide meaningful access to insurance for many individuals. Individuals may not have insurance because they lack the means to pay for it, but also because of other barriers, such as being able to buy only policies with individual, rather than group, underwriting. Individual underwriting raises the cost of insurance; a credit may not offset enough of the increased cost. To improve access, plans eligible for the credit could be required to be offered uniformly to all credit recipients on a risk-shared basis. By allowing the credit only for plans participating in an effective risk pool, the cost of individual policies would be lowered, and the credit would be worth more.

The credit is unlikely to be sufficient to purchase insurance that covers both routine, predictable health care expenses and high-cost, unpredictable expenses. The credit could be limited to insurance against high-cost, unpredictable expenses. This restriction would prevent persons of modest means from facing financial disaster in the event of a major illness. It would also prevent people from relying on the insurance to cover routine and predictable health care expenses and relying on Medicaid or other public insurance for the rare but costly expenditures.

The credit also would allow the private sector to continue to make choices about the optimal designs of insurance packages (within any criteria that might be set). Individuals purchasing insurance would be able to respond to market changes and to new and changing needs for care. The limit to the credit, like the limit to the employer exclusion, would remove incentives for purchases of insurance that are, at the margin, of limited cost-effectiveness.

III. ADDITIONAL OPTIONS

In implementing any of the options discussed in this chapter, there are some groups whose circumstances might be considered separately.

A. Groups of Special Concern

The Self-Employed: Deduction Instead of Credit. The self-employed could be permitted to deduct the full cost of their health insurance instead of receiving the credit. The deduction could make health insurance more affordable for the self-employed (by the amount that the tax-saving from the deduction exceeds the value of the credit), but would not affect the cost of insurance for any employees of the self-employed. However, the deduction alone is unlikely to remove important

problems that the self-employed face in purchasing insurance, and a full deduction involves significant revenue costs.

The Self-Employed: Permanent 25 Percent Deduction. Instead of allowing the self-employed to deduct the full cost of their health insurance, the current 25 percent deduction for health insurance for the self-employed could be extended permanently. The deduction is scheduled to expire on October 1, 1990. A permanent extension has been proposed in the President's Budget for 1991. The 25 percent deduction makes health insurance more affordable for the self-employed and reduces the inequity in treatment for this group of direct health insurance payments in contrast to full exclusion of employer-paid premiums. Like the full deduction, however, it does not address the cost of insurance for their employees or lower any of the barriers the self-employed face in purchasing insurance.

Early Retirees. Persons who reach the age of 65 generally are eligible for the benefits of the Federal Medicare program. Many persons currently retire at much younger ages. Many of these early retirees have employer-provided health insurance that continues to be the main source of their health care coverage until they become eligible for Medicare. Retirees who do not have employer-provided health insurance and who are not eligible for Medicare may currently receive no Federal subsidy for health care. They could be made eligible for a health insurance credit or for direct outlay programs.

B. Design Considerations

These additional options would need to address many of the same design considerations as the limit on the employee exclusion.

IV. REVENUE EFFECTS

Federal revenues, as well as the number of persons affected by a limit on the exclusion, depend on the form and levels chosen for the limits. The higher the limit, the fewer current recipients of employer-provided health insurance who would be affected. But the relationship among dollar limits, affected recipients, and revenues is not straightforward. Revenues would also be affected by specific choices (for example, in measuring employer contributions) that would have to be addressed in implementing any option.

Illustrative examples of the number of persons affected by two alternative pairs of monthly limits, and the corresponding estimated increase in Federal revenues, are shown in Table 10.1. Monthly limits of \$400 for a family and \$160 for an individual would increase revenues by approximately \$3.1 billion by 1992. Lower limits of \$300 and \$120 would generate an estimated additional \$7.0 billion in 1992.

In the long run, the additional taxable wages generated by this proposal would result in somewhat higher Social Security benefit payments and improve the Medicare trust fund balance. Thus, in the very long run, the additional resources made available would come mainly from the income tax.

The cost of a modest refundable credit of \$200 per individual for those not covered by employer-provided insurance or public insurance would be about \$6 billion in 1992. A relatively high limit on the exclusion (such as \$400 and \$160) would not initially raise sufficient revenues to cover the credit, but lower (\$300/\$120) limits would appear to be sufficient.

The cost of making permanent the current 25 percent deduction for the self-employed would be about \$400 million in 1992.

Table 10.1 Illustrative Revenue Estimates for Selected Options

	1991	1992	1993	1994	1995
	(\$ in billions)				
<u>Monthly Limit on Exclusion</u>					
\$400 families/ \$160 individuals					
Total receipts	\$1.5	\$3.1	\$4.5	\$6.7	\$9.6
Percent of affected recipients	15 %	16 %	19 %	22 %	26 %
\$300 families/ \$120 individuals					
Total receipts	\$5.4	\$10.1	\$13.6	\$18.4	\$23.6
Percent of affected recipients	32 %	35 %	39 %	40 %	42 %
<u>Annual Refundable Credit</u>					
\$200 per individual, up to \$600 per household					
Total Cost	-\$0.4	-\$6.1	-\$6.6	-\$7.3	-\$7.8
<u>Permanent 25% Deduction for Self-Employed</u>					
	-0.2	-0.4	-0.5	-0.5	-0.6

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Note: Estimates assume that contributions to cafeteria plans for health will be included in the computation of employer contributions.

The monthly exclusion limit and the value of the refundable credit for 1991 and beyond are indexed by the Consumer Price Index for all items.

The refundable credit is available to persons who do not have employer-provided insurance or public health insurance.

APPENDIX A

SYNOPSIS OF FEDERAL INCOME TAX RULES

RELATING TO HEALTH, PENSION, AND LONG-TERM CARE BENEFITS

**SYNOPSIS OF FEDERAL INCOME TAX RULES
RELATING TO HEALTH, PENSION, AND LONG-TERM CARE BENEFITS**

I. HEALTH BENEFITS

A. Current Health Benefits

Employer-provided health benefits. An employer may deduct the cost of providing current health benefits to employees, whether through insurance or otherwise. An individual employee may fully exclude from income the value of employer-provided health benefits. This exclusion applies both for income tax and FICA tax purposes. The exclusion is limited in the case of certain highly compensated individuals who receive health benefits under a self-insured, employer-maintained health plan that discriminates in favor of such highly compensated individuals (Secs. 105 and 106, of the Internal Revenue Code of 1986).

An employer may maintain a cafeteria plan under section 125 of the Code that permits employees to purchase health benefits on pre-tax basis through a salary reduction feature. This tax preferred treatment is limited in the case of certain highly compensated individuals who participate in a discriminatory cafeteria plan.

Individual medical expenses. Under section 213 of the Code, an individual may deduct nonreimbursed personal medical expenses to the extent that they exceed 7.5 percent of the individual's Adjusted Gross Income. This deduction applies for income tax purposes and does not apply for FICA or SECA tax purposes. Personal medical expenses include expenses for medical care of the individual's spouse or dependents.

The entire cost of institutional care, such as nursing home care, may in some cases be treated as a medical expense even though the cost covers such items as meals and lodging. Whether the entire cost of institutional care may be treated as a medical expense requires a factual determination. Internal Revenue Service regulations provide that if "an individual is in an institution because his condition is such that the availability of medical care in such institution is a principal reason for his presence there, and meals and lodging are furnished as a necessary incident to such care, the entire cost of medical care and meals and lodging at the institution, which are furnished while the individual requires continual medical care, shall constitute an expense for medical care." If the individual's presence in the institution does not satisfy this test, then only the portion of the cost of care in the institution attributable to medical care may be treated as a medical expense.

In addition, section 162(m) provides that for tax years beginning after 1986, but not after 1990, a self-employed individual may deduct 25 percent of the cost of providing medical insurance to the individual and the individual's spouse and dependents. The deduction does not apply to amounts expended on coverage for periods after October 1, 1990. The deduction applies for income tax purposes, but not for SECA purposes.

B. Post-Retirement Health Benefits

Employer-provided post-retirement health benefits. Generally, if an employer provides current health benefits to retired employees, the rules discussed above relating to current health benefits apply. Thus, if an employer provides health insurance to retirees on a current, pay-as-you-go basis, the employer may deduct the cost of such insurance and the individual retirees may fully exclude the value of the insurance.

Within certain limits, an employer may prefund on a tax-favored basis the cost of providing health benefits to retirees. Under the general rules, an employer may not deduct the cost of providing a benefit to employees until the year in which the benefit is received by the employees. Thus, the fact that an employer promises in the current year to provide a certain benefit to an employee in a later year is not sufficient to enable the employer to deduct the cost of the benefit in the current year. The Code provides special rules, however, under which an employer may currently deduct contributions made to prefund the cost of providing health benefits to retirees. This may be accomplished through either a welfare benefit fund, or through a pension plan.

Welfare benefit funds. The term "welfare benefit fund" encompasses a broad category of vehicles in which an employer has set aside funds to provide various benefits (such as health, life insurance and disability benefits) to employees. Section 419(e) of the Code defines a welfare benefit fund to include any fund through which an employer provides benefits to employees. A fund is in turn broadly defined to include any of certain tax-exempt trusts (such as a VEBA--a Voluntary Employees' Beneficiaries Trust under section 501(c)(9) of the Code), any taxable trust or corporation, and any account held for the employer by another person. Thus, for example, a trust established by the employer to provide health benefits to the employer's employees is a welfare benefit fund.

An employer may establish, through a welfare benefit fund, a reserve to pay post-retirement health benefits to future retirees. The employer may currently deduct contributions to this reserve within specified limits. An employer may deduct the contributions only to the extent that the contributions do not exceed the amount necessary to fund such benefits on a level basis over the working lives of the employees. In addition, the funding level must be based on current medical costs. No projection for increases in medical costs in the future may be taken into account. Finally, the fund must satisfy certain nondiscrimination rules.

Generally, any income earned by the post-retirement health benefits reserve is taxable currently. If the reserve is held by any of certain tax-exempt trusts, such as a VEBA, then the income is taxable to the trust, despite the trust's otherwise tax-exempt status (Sec. 512(a)(3)(E)(i)). If the fund is held by any other organization, such as a taxable trust or an insurance company, then the income is taxable currently to the employer (Sec. 419A(g)).

A post-retirement health benefits reserve must maintain separate accounts for funds set aside to provide benefits to key employees. Amounts allocated to such separate accounts are taken into account in applying certain limits on contributions to qualified retirement plans (See part II. A).

Pension plans. Section 401(h) of the Code provides that a qualified pension plan may provide health benefits to retired employees, their spouses and dependents. Contributions to fund the health benefits will be accorded the same tax-favored treatment as contributions to fund the pension benefits--the contributions will be currently deductible by the employer and will accumulate tax-free in the pension trust--provided that such benefits are provided on a nondiscriminatory basis and are "subordinate" to the retirement benefits under the plan. Under Treasury Department regulations, health benefits will be "considered subordinate to the retirement benefits if at all times the aggregate of contributions (made after the date on which the plan first includes such [health] benefits) to provide such [health] benefits and any life insurance protection does not exceed 25 percent of the aggregate contributions [to the plan] (made after such date) other than contributions to fund past service credits." The health benefits may be funded on the basis of a level annual amount, or a level annual percentage of compensation, over an employee's working life.

The contributions made to fund the health benefits must be accounted for separately from the funds set aside for retirement purposes. In addition, separate individual accounts must be established with respect to funds set aside to provide health benefits to key employees. Contributions to such separate individual accounts are taken into account in applying certain limits on annual contributions to qualified retirement plans (See Part II. A., below).

II. PENSION BENEFITS

In general, amounts paid as deferred compensation are deductible by an employer only as they are included in the income of employees. Moreover, income on amounts set aside by an employer to fund deferred compensation is generally taxable to the employer as earned. Exceptions to these general rules are provided for deferred compensation provided under tax-qualified retirement plans. Thus, within certain limits, employer contributions to such plans are currently deductible by the employer even though employees will not be taxable until they receive distributions from the plans. In addition, the income earned on assets held in a tax-favored retirement plan is not subject to tax while it remains in the plan.

A. Limits on Contributions and Benefits

An employer maintained retirement plan receives tax-favored treatment only if it satisfies certain qualification requirements specified in the Internal Revenue Code. Among the qualification requirements are restrictions on the annual contributions and benefits that may be provided with respect to any individual under the defined contribution plans and defined benefit plans of the employer. Separate limits apply to each individual in a defined contribution plan and to each individual in a defined benefit plan ("separate plan limits"). A *"combined plan limit" also applies to any individual covered by both a defined contribution and a defined benefit plan. For this*

purpose, defined contribution plans generally include profit-sharing, stock bonus, money purchase pension and annuity plans, certain tax-sheltered annuities and simplified employee pensions. Defined benefit plans for this purpose are limited to defined benefit pension plans.

Defined benefit plans. The separate plan limit for defined benefit plans provides that an individual's annual retirement benefit at normal retirement age may not exceed \$90,000. The \$90,000 was the applicable figure for an individual retiring in 1987, and is indexed (in a manner similar to the indexing of the FICA wage base) beginning in 1988. For 1989, the figure was \$98,064.

A defined benefit pension plan may provide for an automatic cost of living adjustment to the pension benefit. However, an individual's benefit in a given year may not exceed the limit on annual benefits in effect for that year.

Section 415(k) provides for special cost of living arrangements in defined benefit plans. These are voluntary arrangements under which employees may make after-tax contributions to prefund for cost of living adjustments to their pension benefits. The employee contributions to such arrangements are not taken into account for purposes of the annual limits on contributions although they are taken into account for purposes of the combined plan limit. In addition, an employee may transfer employer contributions (and income) from a defined contribution plan to fund a cost-of-living arrangement. Such transfers are not again taken into account under any of the plan benefit limits. The benefits funded by such employee and transferred employee contributions are not taken into account in determining whether annual benefits under the plan exceed the annual limit on benefits.

Key employees (certain officers and owner-employees) may not be eligible to participate in a cost-of-living arrangement.

Defined contribution plans. The annual contributions, forfeitures and other additions made to an individual's account in a defined contribution plan by or on behalf of an individual may not exceed the lesser of 25 percent of the individual's compensation and \$30,000. The \$30,000 limitation will be indexed for inflation beginning with the year in which the annual defined benefit limit reaches \$120,000. In addition to contributions to defined contribution plans, allocations to separate individual accounts for post-retirement health benefits for key employees count toward the \$30,000 (but not the 25 percent) limit.

Combined plan limits. Combined plan limits operate to prevent an individual from receiving both the maximum annual contribution under a defined contribution plan and the maximum annual pension benefits under a defined benefit plan.

B. Deductions and Funding

An employer's deduction for contributions to a qualified retirement plan is subject to the following limits.

In the case of a defined benefit pension plan, the amount deductible may not exceed the lesser of two limits. First, the deductible amount may not exceed contributions necessary under reasonable actuarial methods to fund the retirement benefits under the plan. In determining this deductible level of prefunding, the employer may project salary increases of employees (and thus prefund for a projected retirement benefit) but may not project increases in the annual (\$90,000) limit. If a plan provides a cost-of-living increase as part of the benefit formula, the employer may prefund for the projected cost-of-living benefit increases (within the \$90,000 annual limits). Second, a contribution is deductible only to the extent that the contribution does not result in total plan assets in excess of 150 percent of the plan's current liability.

An employer's contribution to a profit-sharing or stock bonus plan is limited to 15 percent of the aggregate compensation paid during the taxable year to all employees in the plan.

If an employer contributes to both a pension plan and a profit-sharing or stock bonus plan, the total deduction for a year is limited to the greater of 25 percent of the aggregate compensation paid during the year to employees covered by the plans and the contribution necessary to fund the pension plan.

C. Distribution Rules

Required distribution rules (Sec. 401(a)(9)). Qualified retirement plans are subject to minimum distribution rules that require that distribution of an individual's retirement income commence by a certain time, and require that the retirement income then be paid out at least as rapidly as a specified minimum rate. Similar rules apply to Individual Retirement Accounts. (There are additional rules regarding required distributions after an employee's death to the employee's spouse and other beneficiaries; those rules are not discussed here.)

Minimum commencement rule. In general, distributions of an individual's retirement income must commence no later than the April 1 following the year in which the individual attains age 70-1/2. Distributions may, of course, commence earlier.

Minimum rate rule. In general, an individual's retirement income must be distributed as least as rapidly as substantially nonincreasing annual payments commencing at the required commencement date over the individual's life or life expectancy (or over the lives or joint life expectancy of the individual and the individual's beneficiary). Distributions may decrease over time. Distributions commencing as of the required commencement date may increase only if the increase is based on a recognized cost-of-living index or results from benefit improvements under the plan.

For example, in the case of a defined benefit pension plan, equal annual distributions made over an individual's life (a life annuity), or over a period not exceeding the individual's life-expectancy (a term certain annuity) will satisfy the requirements. Similarly, a life annuity that provides for increasing annual payments, where the increase is based on a recognized cost-of-living index, will satisfy the minimum distribution rules.

In a defined contribution plan, distributions commencing at the required commencement date will satisfy the rules if the amount distributed in a year equals at least the product of the account balance multiplied by a fraction equal to one divided by the individual's life expectancy. For example, say an individual retires after attaining age 70-1/2 with a life expectancy of 15 years. In the first year, he must withdraw at least 1/15 of his account balance. In the second year, 1/14, and so on. The individual may recalculate his life expectancy each year.

Taxation. Generally, all distributions from qualified plans are taxable, except to the extent allocable to basis. Basis is generally recovered on a pro rata basis.

Lump-sum distributions received after age 59-1/2 are eligible for special forward averaging which generally results in lower tax. Forward averaging provides an incentive to make early lump-sum withdrawals of retirement savings, and thereby potentially encourages the spending down of savings.

III. LONG-TERM CARE BENEFITS

Under IRS Revenue Ruling 89-43, reserves established by an insurance company under a level premium, guaranteed renewable group long-term care policy are generally considered life insurance reserves for income tax purposes. Accordingly, increases in such reserves, to the extent such increases are within limits prescribed under the income tax law, are deductible in determining the life insurance company's taxable income. Generally, this treatment enables the insurance company to set aside reserves for future unaccrued claims (within the prescribed limits) on a deductible basis, and enables such reserves to grow on a substantially tax-free basis.

APPENDIX B

DETAILED TABLES FOR CHAPTERS 2, 3, 4, and 8

Table B-1 Average Real Income of Families, Adjusted for Family Size, by Age of Head, 1967, 1979, and 1984

Age of Head	1967	1979	1984
	(1987 dollars)		
20-24	12,846	14,046	11,614
25-29	15,939	18,348	17,464
30-34	15,301	19,678	18,875
35-39	15,575	20,151	20,513
40-44	17,036	20,819	21,487
45-49	18,936	22,364	23,369
50-54	20,275	23,670	23,979
55-59	19,388	24,098	24,013
60-64	17,720	21,220	21,437
65-69	14,201	16,778	19,512
70-74	11,682	14,359	17,034
75-79	9,778	13,281	14,924
80-84	8,866	11,941	13,566
85 and Over	8,410	11,098	13,987
All Ages	16,014	18,974	19,272

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Note: Real income in 1987 dollars based on the Consumer Price Index for all items.

Source: Current Population Survey (1967, 1979, 1984), calculated from Radner (1987).

Table B-2 Median Real Income of Families, Adjusted for Family Size, by Age of Head, 1967, 1979, and 1984

Age of Head	1967	1979	1984
	(1987 dollars)		
20-24	10,965	12,169	10,023
25-29	13,061	16,079	15,465
30-34	12,336	16,974	16,377
35-39	12,395	17,040	17,793
40-44	13,655	17,884	18,600
45-49	15,440	19,913	20,360
50-54	16,397	20,394	20,815
55-59	15,595	20,578	19,830
60-64	13,701	16,709	16,610
65-69	9,216	12,545	14,741
70-74	7,519	10,658	12,451
75-79	6,004	9,212	10,847
80-84	5,357	8,369	9,255
85 and Over	4,767	7,584	8,785
All Ages	12, 441	15,488	15,702

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Note: Real income in 1987 dollars based on the Consumer Price Index for all items.

Source: Current Population Survey (1967, 1979, 1984), from Radner (1987).

Table B-3 Percent of Total Income by Source, Age, and Income Quartile, 1984

Age	Earnings	Savings Income from Savings and Investments	Public and Private Pension Income	Social Security	Cash Welfare	Other Income ¹	Total
Lowest Income Quartile							
0 to 4	62.4	1.7	0.4	3.7	19.7	12.3	100.0
5 to 9	68.4	.1	.9	6.4	11.2	13.0	100.0
10 to 14	71.8	.7	.8	8.2	8.6	9.8	100.0
15 to 19	70.0	1.9	1.6	12.4	7.4	6.8	100.0
20 to 24	80.3	1.6	1.3	5.3	4.4	7.1	100.0
25 to 29	83.5	1.1	.4	3.1	5.1	6.9	100.0
30 to 34	83.0	1.6	.2	4.3	3.5	7.5	100.0
35 to 39	83.0	.6	.4	5.8	3.9	6.4	100.0
40 to 44	79.0	2.3	1.1	6.7	4.6	6.4	100.0
45 to 49	75.1	3.4	2.4	9.4	4.1	5.6	100.0
50 to 54	64.4	3.8	5.6	13.5	6.0	6.7	100.0
55 to 59	48.1	6.2	11.7	19.6	6.9	7.5	100.0
60 to 64	27.0	5.1	8.2	47.0	6.0	6.7	100.0
65 to 69	9.8	4.2	6.5	67.8	8.1	3.6	100.0
70 to 74	5.0	3.6	3.4	76.6	8.2	3.2	100.0
75 to 79	1.9	1.0	2.3	81.9	9.5	3.3	100.0
80 to 84	3.2	6.6	1.4	76.2	8.9	3.6	100.0
Over 85	.8	3.4	1.0	80.5	10.8	3.6	100.0
Highest Income Quartile							
0 to 4	93.5	3.8	0.5	0.9	0	1.3	100.0
5 to 9	94.2	3.3	.5	.4	0	1.5	100.0
10 to 14	92.8	3.6	.7	.9	0	2.0	100.0
15 to 19	90.0	4.4	1.8	.9	0	2.8	100.0
20 to 24	92.7	4.2	1.0	.5	0	1.7	100.0
25 to 29	95.5	3.1	.6	.2	0	.6	100.0
30 to 34	95.1	3.4	.4	.4	0	.7	100.0
35 to 39	94.3	3.7	.3	.4	0	1.3	100.0
40 to 44	93.0	4.6	.8	.4	0	1.3	100.0
45 to 49	93.0	4.4	1.1	.3	0	1.2	100.0
50 to 54	87.6	8.0	2.7	.5	0.1	1.1	100.0
55 to 59	82.1	11.1	5.3	.6	0.1	.9	100.0
60 to 64	63.4	18.4	11.8	4.8	0	1.6	100.0
65 to 69	32.2	26.2	19.8	20.0	0.1	1.8	100.0
70 to 74	22.6	30.2	18.7	26.3	0.1	2.2	100.0
75 to 79	14.2	34.4	20.8	28.9	0.1	1.7	100.0
80 to 84	20.0	34.4	15.7	27.9	0	2.0	100.0
Over 85	20.6	41.0	12.9	24.5	0.2	.8	100.0

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¹ Other income includes: interfamily transfers, unemployment compensation, veterans payments, disability payments, and miscellaneous income.

Reproduced from: Congressional Research Service, *Retirement Income for an Aging Population*, August 25, 1987, pp. 264-265, based on Survey of Income and Program Participation (SIPP) Wave IV.

**Table B-4 Average Real Wealth of Households
by Age of Head, 1962 and 1983**

Age of Head	1962	1983
	(1987 dollars)	
Under 35	25,293	39,459
35-44	66,096	105,117
45-54	95,778	201,776
55-64	128,522	221,213
Over 65	119,170	216,996
65-69	143,967	316,574
70-74	115,033	184,408
75 +	97,844	150,111
All Ages	84,367	136,576

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Note: Real wealth in 1987 dollars based on the Consumer Price Index for all items. Data not adjusted for household size, and Social Security and pension wealth not included.

Source: Unpublished tabulations from the Board of Governors of the Federal Reserve from the 1962 Survey of Financial Characteristics of Consumers and the 1983 Survey of Consumer Finances.

**Table B-5 Median Real Wealth of Households
by Age of Head, 1962 and 1983**

Age of Head	1962	1983
	(1987 dollars)	
Under 35	3,009	8,650
35-44	26,826	48,044
45-54	42,193	64,174
55-54	52,394	72,986
Over 65	37,572	60,973
65-69	44,000	85,624
70-74	25,887	58,251
75 +	34,754	39,821
All Ages	26,582	39,091

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Note: Real wealth in 1987 dollars based on the Consumer Price Index for all items. Data not adjusted for household size, and Social Security and pension wealth not included.

Source: Unpublished tabulations from the Board of Governors of the Federal Reserve from the 1962 Survey of Financial Characteristics of Consumers and the 1983 Survey of Consumer Finances.

Table B-6 Annual Individual Expenses and Sources of Payment for Personal Health Services: Average Expense Per Person With Expense and Percent Paid By Source of Payment, 1977

Population Characteristics	Total Population With Expense	Average Expense Per Person With Expense	Source of Payment				
			Family	Private Health Insurance	Medicare	Medicaid	Other ²
Total ¹	178,217	\$594	31	34	15	9	11
Age in Years:			-----Percent Distribution-----				
Under 6	15,809	265	30	36	*	21	12
6 to 18	41,019	271	46	33	1	11	9
19 to 24	17,946	455	36	36	*	13	15
25 to 54	66,072	587	32	47	1	7	13
55 to 64	17,595	969	28	43	8	8	13
65 and Over	19,777	1,345	23	11	52	7	8
Family Income:							
Less than \$12,000	60,470	756	26	21	24	16	13
\$12,000 to \$19,000	47,777	527	33	43	9	4	10
\$20,000 or More	69,456	500	35	46	6	2	11

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¹ Includes families with negative income.

² Includes CHAMPUS/CHAMPVA, the Indian Health Service, the Veterans Administration, the military, other Federal, state, city or county payers, philanthropic institutions, and unknown sources of payment.

* Less than .05 percent.

Source: U.S. Department of Health and Human Services, Public Health Service, National Center for Health Services Research Health Care Technology Assessment, "A Summary of Expenditures and Sources of Payment for Personal Health Services from the National Medical Care Expenditure Survey," *National Health Care Expenditures Study, Data Preview 24*, May 1987, Table 8.

**Table B-7 Annual Health Care Expenses, Health Status, and Income:
Percent of Population in Good or Poor Health and Average Expense Per Person,
By Age and Income, 1977**

Age/ Income Group ¹	Total Population ² (000)	Proportion of Income Group Within Age Category	Percent of Population in Excellent/ Good Health	Average Expense Per Person in Excellent/ Good Health	Percent of Population in Fair/ Poor Health	Average Expense Per Person in Fair/ Poor Health
All Ages:						
Low	66,083	1.00	79.5%	\$520	20.5%	\$1,259
Middle	74,850	1.00	87.0	429	13.0	1,174
High	61,050	1.00	90.5	489	9.0	1,208
Under 6:						
Low	6,135	0.09	89.7	223	10.3	347
Middle	5,988	0.08	96.1	207	3.9	*1,304
High	2,403	0.04	97.0	183	3.0	*436
6 to 18:						
Low	18,611	0.28	91.0	237	9.0	562
Middle	19,231	0.26	94.4	245	5.6	371
High	10,912	0.18	96.7	301	3.3	425
19 to 24:						
Low	7,539	0.11	88.3	458	11.7	891
Middle	7,870	0.11	91.3	440	8.7	*1,058
High	6,134	0.10	95.1	320	4.9	*667
25 to 54:						
Low	18,587	0.28	77.0	532	23.0	1,132
Middle	29,143	0.39	87.0	469	13.0	995
High	28,374	0.46	91.0	511	9.0	1,091
55 to 64:						
Low	4,454	0.07	56.9	905	43.1	1,626
Middle	6,281	0.08	68.0	663	32.0	1,591
High	8,867	0.15	81.8	651	18.2	1,378
65 and Over:						
Low	10,758	0.16	61.0	1,266	39.0	1,660
Middle	6,337	0.08	69.2	1,007	30.8	1,537
High	4,360	0.07	78.7	1,043	21.3	1,770

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¹Based on relationship of income to the poverty level, which adjusts income for family size. Low income: less than 2 times the poverty level. Middle income: between 2 and less than 4 times the poverty level. High income: at or greater than 4 times the poverty level.

²Excludes persons with negative income or unknown health status.

* Relative standard error greater than 30 percent.

Source: U.S. Department of Health and Human Services, Public Health Service, National Center for Health Services Research and Health Care Technology Assessment, "A Summary of Expenditures and Sources of Payment for Personal Health Services from the National Medical Care Expenditure Survey," *National Health Care Expenditures Study, Data Preview 24*, May 1987, Table 3.

Table B-8 Annual Out-of-Pocket Expense for Personal Health Services and Private Health Insurance Premiums as a Share of Family Income for Families With Positive Family Incomes, By Selected Population Characteristics, 1977

Characteristics of Family Head and Insurance Coverage	Number of Families (000)	Out-of-Pocket Expense for Personal Health Services as Percent of Family Income ¹	Out-of-Pocket Expense for Personal Health Services and Out-of-Pocket Premiums, as Percent of Family Income ¹
Total ²	73,503	4.3%	6.2%
Age in Years:			
19 to 24	6,710	3.7	5.8
25 to 54	40,823	3.4	5.0
55 to 64	11,092	4.4	6.5
65 and Over	14,726	6.7	9.3
Family Income:			
Less than \$12,000	30,991	7.1	10.1
\$12,000 to \$19,000	18,845	2.8	5.5
\$20,000 or More	23,667	1.7	2.5
Perceived Health Status:			
Excellent	30,411	3.3	5.2
Good	27,137	4.1	6.1
Fair or Poor	13,067	6.6	8.6
Type of Insurance:			
Private, Any Group	41,908	2.9	4.7
Private, Nongroup	4,433	6.1	11.3
Medicare and Private ³	13,521	6.4	9.7
Medicare Only ³	2,525	8.9	8.9
Medicaid Only	3,510	3.9	3.9
Medicare and Medicaid ³	2,157	4.4	4.4
Uninsured	5,449	5.9	5.9

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¹Expenses in excess of income are set at 100 percent of income.

²Includes families headed by persons less than 19 years of age. Excludes families with negative or zero income.

³Excludes Medicare Part B premium.

Source: U.S. Department of Health and Human Services, Public Health Service, National Center for Health Services Research and Health Care Technology Assessment, "A Summary of Expenditures and Sources of Payment for Personal Health Services From the National Medical Care Expenditure Survey, " *National Health Care Expenditures Study, Data Preview 24*, May 1987, Table 12.

**Table B-9 Children Age 18 or Under Without Health Insurance Coverage
by Selected Sources of Health Insurance Coverage of the Family
Head and Family Income as a Percent of Poverty, 1985**

Source of Coverage for Family Head	Total	Family Income as a Percent of Poverty Level				
		0-99	100-124	125-199	200-399 400+	
Part A. Population (millions)						
Total	11.1	4.3	1.1	2.5	2.4	0.8
Employer-provided	3.2	0.4	0.2	0.8	1.2	0.5
Other Private	0.4	0.1	*	0.1	0.1	*
Medicaid	0.2	0.2	*	*	*	*
Other Public	0.2	0.1	*	*	*	*
No Health Insurance	7.1	3.5	0.8	1.5	1.1	0.3
Part B. Percents Within Poverty Income Levels						
Total	100.0%	100.0%	100.9%	100.0%	100.0%	100.0%
Employer-provided	28.9	10.1	22.3	34.3	49.7	61.2
Other Private	3.5	3.0	*	4.1	3.4	*
Medicaid	1.7	3.9	*	*	*	*
Other Public	1.9	2.8	*	*	*	*
No Health Insurance	64.1	80.3	69.2	60.6	46.2	33.9

Table B-9 Continued

Source of Coverage for Family Head	Family Income as a Percent of Poverty Level					
	Total	0-99	100-124	125-199	200-399	400+
Part C. Percents Within Family Head Insurance Groups						
Total	100.0%	39.0%	10.0%	22.3%	22.0%	6.8%
Employer-provided	100.0	13.6	7.7	26.4	37.9	14.4
Other Private	100.0	33.5	*	25.9	21.5	*
Medicaid	100.0	91.5	*	*	*	*
Other Public	100.0	58.6	*	*	*	*
No Health Insurance	100.0	48.8	10.8	21.0	15.8	3.6

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* Number too small to be statistically significant.

Notes: Tabulations cover only the noninstitutionalized population.

Tabulations from more recent Current Population Surveys suggest that the number of uninsured, particularly children, may be less than estimated for 1985 and preceding years. The differences are due to refinements and additional questions about sources of health insurance. For instance, if a child received insurance coverage through a non-custodial parent, the child would have been classified as uninsured in 1985 and as insured in 1988.

Source: Chollet, D., "Uninsured in the U.S.: The Nonelderly Population Without Health Insurance," EBRI, p. 38.

Table B-10 Benefits for Hospital Room and Board: Percent Distribution of the Privately Insured Population Under 65 With Coverage, by Type of Insurance, Sex, and Employment Characteristics of the Primary Insured, 1977

Characteristics of Primary Insured	Privately Insured Population with Hospital Room and Board Benefits (Percent)	Full Semiprivate Charge ¹		Limited Daily Benefit ³ or Hospital Indemnity
		High Maximum ²	Other	
		-----Percent Distribution-----		
All Persons ⁴	98.3	53.2	21.1	25.7
Type of Insurance:				
Nongroup	95.8	11.3	27.0	61.8
Any Group	98.6	57.2	20.5	22.2
25 or Fewer Members	98.0	47.9	18.8	33.4
26-250 Members	99.1	50.6	22.5	26.9
251-2,500 Members	99.2	53.7	22.4	23.9
More Than 2,500 Members	98.2	65.8	17.7	16.5
Sex:				
Male	98.2	54.1	21.0	25.0
Female	98.6	50.7	21.5	27.9
Employment Status:				
Full Time	98.5	56.3	20.9	22.8
Part Time	97.9	46.0	24.9	29.1
Self-Employed	97.5	35.0	20.4	44.6
Did Not Work In 1977	97.2	32.8	26.5	40.7
Industry:				
Agriculture	96.0	29.9	19.9	50.2
Manufacturing and Mining	98.9	58.3	21.7	20.0
Construction	99.0	27.2	31.3	41.5
Transportation, Communication and Utilities	98.9	60.1	20.3	19.6
Sales	98.5	42.8	27.1	30.1
Financial Services	98.7	49.3	14.7	36.0
Professional Services	98.8	55.8	20.0	24.2
Other Services	96.4	42.9	23.6	33.4
Public Administration and Military	98.3	70.7	13.0	16.3

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¹Or at least \$90 per day.

²365 days of coverage or \$50,000 of basic benefits, 90 days or \$10,000 of basic benefits with major medical benefits of at least \$100,000, or only major medical benefits and a maximum of \$250,000 or more. Persons with basic and major medical benefits are categorized by their basic benefits.

³Less than 100 percent of semiprivate charges less than \$90 per day.

⁴Includes persons for whom industry and employment status of primary insured and group size are unknown.

Source: U.S. Department of Health and Human Services, Public Health Service, National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey. "Private Insurance in the United States," *National Health Care Expenditures Study, Data Preview 23*, September 1986, Table 68.

FOOTNOTES

Part Two

¹ Doty, Liu and Weiner (1985).

² See Report to the Secretary on Private Financing of Long-Term Care for the Elderly, HHS, November 1986, pp. 2-19.

³ See Report to the Congress and the Secretary by the Task Force on Long-Term Health Care Policies, HHS, September 1987, p. 18.

⁴ Data on health expenditures cited in this chapter are from "National Health Care Expenditures, 1986-2000," Health Care Financing Review, Summer, 1987, pp. 1-36, and "National Health Expenditures, 1987," Health Care Financing Review, Winter 1988, pp. 109-122.

⁵ For a discussion of issues on the relationship between health expenditures and mortality trends, see, e.g., Fuchs (1983), Manton (1982), and Poterba and Summers (1987).

⁶ See Pauly (1987).

⁷ HHS (1986), pp. 2-22.

⁸ See "Who Can Afford a Nursing Home?" Consumer Reports, May 1988, pp. 300-311. Also, a 1985 AARP poll indicated that a majority of the elderly believed that Medicare covered most or all of the costs of a stay in a nursing home.

⁹ See HHS (1986), pp. 2-46 for additional information.

¹⁰ The household income data are from Radner (1987). These data cover three years: 1967, 1979, and 1984. The data are adjusted for differences in household size and are expressed in inflation-adjusted, 1987 dollars. The household size adjustment was made by equivalence scales implicit in U.S. poverty thresholds (see Radner, p. 15).

¹¹ The median income of a group is a middle income level if incomes are ordered by size so that as many group members have incomes above the median as below. The mean or average income is a related but different measure. The mean income is the sum of all incomes in the group divided by the number of group members. Median income typically is lower than mean income.

¹² Poverty rate data are from the U.S. Bureau of the Census, Current Population Reports, Series P-60, Numbers 95 and 160.

¹³ A series of Census Bureau studies have shown a substantial absolute and relative decrease in the poverty rate for the elderly when noncash benefits were included as a component of income. This result is sensitive to the method of calculating the dollar value of noncash benefits and to the choice of which noncash benefits are included in income. See also U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Technical Paper No. 50 for a discussion of the effect of noncash benefits on poverty, and Technical Paper Nos. 51-52 and 55-58 for poverty estimates which include the value of noncash benefits for the years 1979-1987.

¹⁴ Smeeding (1985) reports that a match by the Social Security Administration of the Current Population Survey income records with administrative data records shows that households headed by an elderly individual understated income by an average of 37 percent, compared with only 7 percent for nonelderly households. See also Radner 1987.

¹⁵ Smeeding (1985).

¹⁶ Wealth data are from the Federal Reserve Board, the 1962 Survey of Financial Characteristics of Consumers and the 1983 Survey of Consumer Finances. The data are expressed here in 1987 dollars.

¹⁷ Total assets is the sum of the value of the following: owner-occupied housing, other real estate, cash, demand deposits, savings and time deposits, certificates of deposit, money market funds, government, corporate and foreign bonds, other financial securities, the cash surrender value of life insurance and pension plans, unincorporated farm and nonfarm business equity, corporate stocks and equity in trust funds. Total liabilities is the sum of mortgage debt, consumer debt and other debt. Less fungible assets such as consumer durables and the present value of Social Security and pension wealth are not included. (The cash surrender value of a pension holding is typically only a small fraction of present value.)

¹⁸ SSA unpublished data.

¹⁹ U.S. Department of Health and Human Services, Social Security Bulletin, Annual Statistical Supplement, 1986, Table 4.

²⁰ See U.S. Congress, CBO, "Tax Policy for Pensions and Other Retirement Saving," Table 29. The data are for private wage and salary employees. Coverage includes participation in defined benefit and defined contribution pension plans, pay-as-you-go and deferred profit-sharing plans, plans of nonprofit organizations, union plans, and railroad plans. Coverage has been adjusted for participation in multiple plans. Note that employees may be covered by a pension plan but not be eligible for pension benefits until they become vested in the plan (which under the Tax Reform Act of 1986 must occur within five years of being covered).

²¹ Note that many current retirees are unaffected by the ERISA changes because those changes generally took effect after 1976, by which time persons who were 65 years old in 1984 would have been 57 years old.

²² See, for example, CBO 1987, and the General Explanations of REA, TEFRA, COBRA, and TRA86 for recent pension legislation. Appendix 1. CRS 1987, pp. 342-343, discusses the history of Federal pension legislation.

²³ U.S. Department of Labor, Employer-Sponsored Retiree Health Insurance, 1986.

²⁴ BLS 1987 Employee Benefits in Medium and Large Firms 1986.

²⁵ SSA unpublished data.

²⁶ A survey commissioned by AARP in 1987 indicated that 11 percent of the elderly believed, mistakenly, that Medicare covers a substantial portion of nursing home costs. The 1985 AARP survey indicated that a majority believed that Medicare covers a substantial portion of nursing home costs.

²⁷ See GAO "Long-Term Care Insurance: Coverage Varies Widely in a Developing Market," May 1987.

²⁸ A recent paper by Friedman and Manheim simulates demand for long-term care insurance and finds that demand for such insurance is virtually zero when administrative costs and reserves amount to 30 percent of the premium--not atypical for individual policies--while demand would be strong when administrative costs and reserves amount to 10 percent. Note, however, that certain insurance, such as Medigap policies, has been purchased on a widespread individual basis by the elderly.

²⁹ To target this deduction, certain restrictions apply, such as that the 25 percent deduction cannot exceed self-employment income and that the self-employed may not claim the deduction if they are eligible to participate in a subsidized health plan of their own employer or their spouse's employer.

³⁰ Internal Revenue Service regulations provide that if "an individual is in an institution because his condition is such that the availability of medical care in such institution is a principal reason for his presence there, and meals and lodging are furnished as a necessary incident to such care, the entire cost of medical care and meals and lodging at the institution, which are furnished while the individual requires continual medical care, shall constitute an expense for medical care." If the individual's presence in the institution does not satisfy this test, then only the portion of the cost of care in the institution attributable to medical care may be treated as a medical expense. So, for instance, the costs of living in a retirement community would likely not be deductible as a medical expense.

³¹ Lower-paid workers may take account of the structure of Social Security in forming their savings preferences. Replacement rates are relatively higher for lower-paid workers. See CBO 1987.

³² See Task Force on Long-Term Care, 1987.

Part Three

¹ This estimate is based on the age distribution of spending on the two largest categories of health care expenditures, hospital and physician services. Projections made by the Health Care Financing Administration for 2000, allowing for changes in the age and sex structure of the population, show the proportions to be similar in 1978 and 2000. In 1978, the under-65 population accounted for 71 percent of hospital expenditures and 75 percent of physician services. The proportions are projected to be 68 and 74 percent, respectively, in 2000. "National Health Care Expenditures, 1986-2000," Health Care Financing Review, Summer 1987, Table 5.

² Office of Tax Analysis estimate.

³ Provisions of the Consolidated Omnibus Reconciliation Act of 1984 (COBRA) extend to unemployed workers for 18 months the option of continuing their former employer-provided plan at their own expense. These provisions are discussed below. Employer-provided health coverage often extends into retirement, as discussed in Chapter 3.

⁴ "National Health Care Expenditures, 1987," Health Care Financing Review, Winter 1988.

⁵ The most recent Health Care Financing Administration estimates of health care expenditures and sources of funds for health care for the nonelderly were based primarily on data from the 1977 National Medical Care Expenditure Survey (NMCES). More recent data, collected in a 1987 survey of national medical care expenditures, are not yet available.

⁶ Charles Fisher, "Differences by Age Groups in Health Care Spending," Health Care Financing Review, Spring 1980, pp. 65-90.

⁷ Personal health care is one of the largest components of total national health expenditures (88 percent in 1987). It includes health care services received directly by individuals. These services include hospital and physicians' services, dentists' and other professional services, drugs, eyeglasses, and nursing home care. The remaining 12 percent of national health expenditures includes primarily government expenditures on program administration, public health, and research and construction of medical facilities.

⁸ Charles Fisher, "Differences by Age Groups in Health Care Spending," Health Care Financing Review, Spring 1980, p. 74.

⁹ Data from the NMCES, which exclude payments for institutionalized persons, showed a similar pattern for 1977. See U.S. Department of Health and Human Services, Public Health Service, National Center for Health Services Research and Health Care Technology Assessment, "A Summary of Expenditures and Sources of Payment for Personal Health Services from the National Medical Care Expenditure Survey," National Health Care Expenditures Study, Data Preview 24, May 1987, Table 8.

¹⁰ Bureau of Labor Statistics, Employee Benefits in Medium and Large Firms, 1986, June 1987, Bulletin 2281, p. 28.

¹¹ Bureau of Labor Statistics, Employee Benefits in Medium and Large Firms, 1986, June 1987, Bulletin 2281, pp. 28-29.

¹² Bureau of Labor Statistics, Employee Benefits in Medium and Large Firms, 1986, June 1987, Bulletin 2281, p. 28.

¹³ Bureau of Labor Statistics, Employee Benefits in Medium and Large Firms, 1986, June 1987, Bulletin 2281, p. 31.

¹⁴ Deborah Chollet, "Uninsured in the United States: The Nonelderly Population Without Health Insurance," Employee Benefit Research Institute, March 1987, p. 15. Tabulations are based on the March 1986 Current Population Survey which collected information on health insurance coverage in 1985.

¹⁵ Deborah Chollet, "Uninsured in the United States: The Nonelderly Population Without Health Insurance," Employee Benefit Research Institute, March 1987, p. 37.

¹⁶ Deborah Chollet, "Uninsured in the United States: The Nonelderly Population Without Health Insurance," Employee Benefit Research Institute, March 1987, p. 36.

¹⁷ Small Business Administration, The State of Small Business, 1987, pp. 162-166.

¹⁸ Deborah Chollet, "Uninsured in the United States: The Nonelderly Population Without Health Insurance," Employee Benefit Research Institute, March 1987, p. 27.

¹⁹ Wesley Mellow, "Employer Size and Wages," Review of Economics and Statistics, Vol. 63, 1982, and "Employer

Size, Unionism, and Wages," in New Approaches to Labor Unions, Research in Labor Economics, Supplement 1982, ed. R.G. Ehrenberg. Greenwich, Conn.: JAI Press. Walter Oi, "Fixed Employment Costs of Specialized Labor," in The Measurement of Labor Cost, 1983, ed. Jack E. Triplett, Studies in Income and Wealth, Vol. 48. Chicago, Ill.: University of Chicago Press for the NBER. Richard Freeman and James Medoff, What Do Unions Do? 1984. New York, N.Y.: Basic Books.

²⁰ Although most studies show that unionized workers have higher wages and higher benefit levels, it is not clear that union members, all else equal, have higher benefits. See, for example, Gregory M. Duncan and Frank P. Stafford, "Do Union Members Receive Compensating Wage Differentials?" American Economic Review, Vol. 70, 1980, for a discussion of whether there actually is a union wage premium once all factors are taken into account.

²¹ Appendix B describes the COBRA rules.

²² Deborah Chollet, "Uninsured in the United States: The Nonelderly Population Without Health Insurance," Employee Benefit Research Institute, March 1987, p. 19.

²³ Deborah Chollet, "Uninsured in the United States: The Nonelderly Population Without Health Insurance," Employee Benefit Research Institute, March 1987, p. 20.

²⁴ Small Business Administration, The State of Small Business, 1987, p. 151.

²⁵ The coinsurance rate is the percentage of each dollar spent on covered health services that is paid for by the consumer.

²⁶ See Newhouse and Phelps (1976), Newhouse, et al. (1980), Newhouse, et al. (1981), Scitovsky and McCall (1977), Wells, et al. (1981) and Manning, Newhouse, et al. (1987).

²⁷ See Manning, Newhouse, et al. (1987).

²⁸ Adamache and Sloan (1985) make this point.

²⁹ See, e.g., Newhouse (1981).

³⁰ See Goddeeris and Weisbrod (1985) and Manning, Newhouse et al. (1987).

³¹ The proposal to cap the employee exclusion originated with Enthoven (1979).

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