Testimony before the Committee on Finance,
U.S. Senate

on

Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net

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June 29, 2005

Chairman Grassley, Senator Baucus, and members of the Committee, I'm pleased to have the opportunity to testify before you today on long-term care. My testimony will reflect more than twenty-five years of research experience in long-term care, at Georgetown University and, before that, the Urban Institute. Based on that research, my policy conclusions are the following:

- Today, 10 million people of all ages are estimated to need long-term care, close to 40 percent of whom are under the age of 65. Among the roughly 8 million who are at home or in the community, one in five report getting insufficient care, frequently resulting in significant consequences—falling, soiling oneself, or inability to bathe or eat.

- The need for long-term care is unpredictable and, when extensive service is required, financially catastrophic—best dealt with through insurance, rather than personal savings. But the nation lacks a policy that assures people of all ages access to quality long-term care when they need it, without risk of impoverishment.

- Private insurance for long-term care is expanding and will play a growing role in long-term care financing. However, even with improved standards and special "partnerships" with Medicaid, it does nothing for those currently in need, is not promoted as a means to serve the under-65 population and, in the future will be affordable and valuable for only a portion of the older population—most likely, the better off.

- Medicaid is the nation's only safety net for those who require extensive long-term care. Rather than serving as a deterrent to the purchase of private insurance or—as some argue—as an "asset shelter for the rich", it serves overwhelmingly to assure access to care for those least able to afford insurance or care. But its invaluable services become available only when and if people become impoverished; its protections vary substantially across states; and, in most states, it fails to assure access to quality care, especially in people's homes.

- A growing elderly population will mean greater demand on an already significantly stressed Medicaid program, squeezing out states' ability to meet other needs and, at the same time, likely reducing equity and adequacy across states.

- Policy "solutions" that focus only on making Medicaid "meaner" or limiting public obligations for long-term care financing do our nation a disservice. Although individuals and families will always bear significant care-giving and

> financial responsibility, equitably meeting long-term care needs of people of all ages and incomes—throughout the nation—inevitably requires new federal policy and a significant investment of federal funds.

The following will lay out inadequacies in current long-term care financing; the implications of growth in the elderly population for future inadequacies; and the importance of federal policy to sustain and improve long-term care protection. Unless otherwise noted, I am drawing on research from the Georgetown Long-term Care Financing Project, funded by the Robert Wood Johnson Foundation, and available at our web site: **ltc.georgetown.edu.** The opinions I present are, of course, only my own.

People who need extensive assistance with basic tasks of living (like bathing, dressing and eating) face the risk of catastrophic costs and inadequate care. Today, almost 10 million people of all ages need long-term care. Only 1.6 million are in nursing homes. Most people needing long-term, especially younger people, live in the community. Among people not in nursing homes, fully three quarters rely solely on family and friends to provide the assistance they require. The range of needs is considerable—with some people requiring only occasional assistance and others needing a great deal. Intensive family care-giving comes at considerable cost—in employment, health status and quality of life—and may fail to meet care needs. Nationally, one in five people with long-term care needs who are not in nursing homes report "unmet" need, frequently resulting in significant consequences—falling, soiling oneself, or inability to bathe or eat. The cost of paid care exceeds most families' ability to pay. In 2002, the average annual cost of nursing home care exceeded $50,000 and 4 hours per day of home care over a year were

estimated to cost $26,000. Clearly, the need for extensive paid long-term care constitutes a catastrophic expense.

The likelihood of needing long-term care is also unpredictable. Although the likelihood increases with age, close to 40 percent of people with long-term care needs are under the age of 65. And the need for care among the elderly varies considerably. Over a lifetime, projections of people currently retiring indicate that about 30 percent are likely to die without ever needing long-term care; fewer than 17 percent are likely to need one year of care or less, and about 20 percent are likely to need care for more than five years.

Because long-term care needs are unpredictable and may be financially catastrophic, insurance is the most appropriate financing strategy. Reliance on savings alone is inefficient and ineffective. People will either save too much or too little to cover expenses. However few people have adequate private or public long-term care insurance. Although sales of private long-term care insurance are growing (the number of policies ever sold more than tripled over the 1990s), only about 6 million people are estimated to currently hold any type of private long-term care insurance. Growing numbers of older people, especially of the segment with significant resources, will create the potential for substantial expansion of that market. But private long-term care insurance policies remain a limited means to spread long-term care risk. Private long-term care insurance

- Is not available to people who already have long-term care needs;
- Is not priced to meet the needs of younger people who are also at risk of needing long-term care;
- Is not affordable to the substantial segment of older persons, now and in the future, with low and modest incomes;

- Limits benefits in dollar terms in order to keep premiums affordable, but therefore leaves policyholders with insufficient protection when they most need care; and
- Lacks the premium stability and benefit adequacy that can assure purchasers who pay premiums year after year that it will protect them against catastrophe.

We need only look at experience in health insurance to recognize that reliance on the individual market—plagued by risk selection, high marketing costs, benefit exclusions, and other problems—for long-term care will be grossly inadequate to assure adequate protection to most people.

Current public policy also falls far short of assuring insurance protection. Medicare, which provides health insurance to many who need long-term care, covers very little long-term care. Its financing for nursing home care and home care is closely tied to the need for acute care and is available for personal care only if skilled services—like nursing and rehabilitation therapy—are also required.

It is Medicaid that provides the nation's long-term care safety net. Most nursing home users who qualify for Medicaid satisfy Medicaid's income and asset eligibility requirements on admission. But 16 percent of elderly nursing home users begin their nursing home stays using their own resources and then become eligible for Medicaid as their assets are exhausted. Because the costs of long-term care are so high relative to most people's income and resources, the opportunity to "spend down" to eligibility—spending virtually all income and assets in order to qualify—is essential to assure access to care.

To qualify for Medicaid nursing home benefits, individuals must reduce their "countable" assets (explicitly exempting certain items—including a home, a car, and funds designated for burial purposes) to $2000 or less and must contribute all their monthly income, with the exception of a "personal needs allowance" of $30 to $90, toward the cost of care. Federal law allows married couples to set aside additional income and assets for a spouse remaining in the community, but many states allow community spouses to keep only the federal minimum levels of income ($1561 per month) and assets ($19,020)—hardly enough assets to assure financial security in retirement.[1]

Some have labeled impoverishment a "fallacy", arguing that the bulk of Medicaid resources go to finance nursing home care for people who could afford to pay for themselves, but who "transfer" their resources in order to qualify for Medicaid benefits. Such exaggeration relies on anecdote, not evidence. As reviewed by my Georgetown University colleague, Ellen O'Brien, the research literature evaluating actual experience reveals the following[2]:

- **Most elderly people lack the financial resources to pay for extended nursing home stays.**

  Among elderly women living alone (those who are most likely to become nursing home residents), median household income is less than $12,000.[3] In 2000, the median net worth—excluding houses—of elderly households was $23,885.[4]

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[1] CMS, "2005 SSI FBR, Resource Limits, 300% Cap, Break Even Points, Spousal Impoverishment Standards," http://www.cms.hhs.gov/medicaid/eligibility/ssi0105.asp.

[2] Ellen O'Brien, "Medicaid's Coverage of Nursing Home Costs: Asset Shelter for the Wealthy or Essential Safety Net?", Issue Brief, Georgetown University Long-term Care Financing Project, May 2005, ltc.georgetown.edu.

[3] Robert Clark and Joseph F. Quinn, *The Economic Status of the Elderly,* Medicare Brief, no.4, Washington, D.C.: National Academy of Social Insurance, 1999. Figures are for 1996. Kaiser Family Foundation analysis of 1999 data indicate little change: elderly women over age 85 (in all living arrangements) had a median income of $15,615.

[4] Shawna Orzechowski and Peter Sepielli, *Net Worth and Asset Ownership of Households: 1998 and 2000*, Current Population Reports, P70-88, Washington, D.C.: U.S. Census Bureau, 2003.

Although, as a group, the elderly have more resources than younger people, financial wealth is very unevenly distributed among them. Assets are almost nonexistent for the elderly in the bottom 30 percent of the wealth distribution, while the top 5 percent have financial wealth (excluding home equity) in excess of $300,000. Elderly people in poor health or with functional impairments likely to create the need for long-term care have even more limited resources than other elderly.[5]

- **The majority of nursing home residents pay in full or in part for their nursing home care.**

Estimates of lifetime nursing home use of the elderly show that 44 percent of nursing home users pay for their nursing home care using only private funds and 16 percent begin as private payers, exhaust their resources and then convert to Medicaid.[6] That 27 percent of elderly nursing home users qualify for Medicaid at admission reflects the limited resources of elderly in the community, not the transfer of assets.

- **Disabled elderly people have too little wealth to warrant hiring an attorney to arrange asset transfer.**

Analysis of resources among people likely to need long-term care reveals that the majority of disabled elderly in the community have such modest resources that they are either financially eligible for Medicaid before entering the nursing home or would quality immediately on admission. Researchers Frank Sloan and Mae Shayne concluded from their analysis that it is a lack of any significant wealth accumulation beyond a home that accounts for the high likelihood of eligibility, not asset transfers.[7]

- **People in nursing homes are more likely to conserve than to exhaust assets.**

Research indicates that nursing home residents spend down to Medicaid at a much lower rate than would be expected given their income and assets. Rather than transferring assets to become Medicaid eligible, some of the elderly may be receiving transfers from children or others, or voluntarily converting housing equity into liquid assets, to extend the period before they become Medicaid eligible—behavior reflecting a “strong aversion to welfare”[8] rather than an effort to qualify.

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[5] Clark and Quinn.

[6] Brenda Spillman and Peter Kemper, “Lifetime Patterns of Payment for Nursing Home Care,” *Medical Care* 33, No. 3 (1005): 280-96.

[7] Frank Sloan and Mae Shayne, “Long-Term Care, Medicaid, and the Impoverishment of the Elderly,” *Milbank Quarterly* 71, no. 4 (1993):575-99.

[8] Edward C. Norton, “Elderly Assets, Medicaid Policy, and Spend-Down in Nursing Homes,” *Review of Income and Wealth* 41, no. 3 (1995): 309-329.

- **Transfers occur far more frequently for tax purposes than for Medicaid eligibility.**

Analysis of trusts indicates that they are far more commonly established by wealthy people seeking to reduce tax burdens and avoid probate than by modest income people seeking to avoid spend-down for nursing home care. Based on their analysis, researchers Donald Taylor, Frank Sloan and Edward Norton concluded that "the vast majority of the group most likely to benefit from the use of trusts to spend down [to Medicaid] did not have one" and found "limited rationale for further public policy efforts designed to limit the use of trusts to achieve spend down because such behavior is rare."[9]

- **Asset transfers among elderly people are both unrelated to and too modest for attaining Medicaid eligibility.**

Analysis of transfers made by the elderly over time out of their accumulated assets show that only 1 in 100 of the elderly gave gifts to their children that would be large enough to qualify them for Medicaid nursing home coverage.[10] Among "middle class" elderly at risk of spending down to Medicaid if they need a nursing home, an estimated 29 percent gave gifts to children or grandchildren of $500 or more; the typical gift was $2000 and the average gift was $5000. The largest transfers were made by those who perceived themselves as least likely to be entering a nursing home in the next five years.[11] Overall, the most frequent asset transfers have been among elderly people with assets exceeding the estate tax filing threshold rather than for other elderly. Indeed, transfers have been least likely among elderly people with modest assets who are in poor or declining health—leading researchers to conclude that these elderly are actually holding onto assets (not transferring them), in order to pay for care.[12]

- **Transfers aimed at establishing Medicaid eligibility are not significant contributors to Medicaid costs.**

A 1993 GAO review of 400 Medicaid applications for nursing home assistance in Massachusetts (a state thought to have a high level of estate planning) found that 1 in 8 applicants had transferred assets averaging $46,000. Half of these applicants, however, were denied eligibility.[13] Cost estimates of state proposals to restrict asset

[9] Donald Taylor, Frank Sloan, and Edward Norton, "Formation of Trusts and Spend Down to Medicaid," *Journal of Gerontology: Social Sciences,* 54B, no. 4 (1999):S194-201.
[10] Taylor, Sloan and Norton.
[11] William F. Bassett, "Medicaid's Nursing Home Coverage and Asset Transfers," working paper, Board of Governors of the Federal Reserve System, March 26, 2004.
[12] Jonathon Feinstein and Chih-Chin Ho, "Elderly Asset Management and Health," in *Rethinking Estate and Gift Taxation,* ed. William G. Gale, James R. Hines, and Joel Slemrod, Washinton, D.C.: Brookings Institution Press, 2001.
[13] U.S. General Accounting Office, *Medicaid Estate Planning,* GAO/HRD-93-29R (Washington, D.C.:GAO, 1993).

transfers produce only modest Medicaid savings—e.g. 0.6 percent of Medicaid nursing home spending in Massachusetts; 1.4 percent in Connecticut.[14] OMB estimates of the savings from the President's proposal to tighten current law amount to less than 0.2 percent of total federal Medicaid spending between 2006 and 2015.[15]

- **Medicaid does not serve as a significant barrier either to savings or to the purchase of private long-term care insurance.**

Analysis of savings behavior among the elderly indicates that elderly people most likely to qualify for Medicaid reduced savings more slowly than wealthy elderly, as they aged;[16] and that people who expect to need long-term care have higher savings than those who don't.[17] Finally, analysis of actual purchases of private long-term care insurance found no impact on purchase decisions among older workers and found the slight impact on purchasers over age 70 too small to explain the very low proportion of elderly holding policies.[18].

The evidence indicates that the real problem with Medicaid is not its use or abuse by people who do not need its protections; rather it is insufficient protection for people who do. Despite Medicaid's essential role, its protections differ considerably from what we think of as "insurance". Medicaid does not protect people against financial catastrophe; it finances services only after catastrophe strikes. Further, Medicaid's services fall far short of meeting the needs and preferences of people who need care. Medicaid's benefits focus overwhelmingly on nursing home care—an important service for some, but not the home care services preferred by people of all ages. In the last decade, Medicaid home care

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[14] CMS, "Waiver Research and Demonstration Projects," http://cms.hhs.gov/medicaid/1115.
[15] Office of Management and Budget (OMB), *Major Savings and Reforms in the President's 2006 Budget,* Washington, D.C., OMB, 2005,188, http://whitehouse.gov/omb/budget/fy2006/pdf/savings.pdf and Ellen O'Brien.
[16] Frank Sloan, Thomas Hoerger and Gabriel Picone, "Effects of Strategic Behavior and Public Subsidies on Families' Savings and Long-Term Care Decisions," in *Long-term Care: Economic Issues and Policy Solutions,* ed. Roland Eisen and Frank A. Sloan, (Boston, MA: Kluwer Academic Publishers, 1996).
[17] Anthony Webb, *The Impact of the Cost of Long-Term Care on the Saving of the Elderly,* (New York: International Longevity Center, 2001).
[18] Frank A. Sloan and Edward C. Norton, "Adverse Selection, Bequests, Crowding Out and Private Demand for Insurance: Evidence from the Long-Term Care Insurance Market, *Journal of Risk and Uncertainty* 15, no.3,1997: 201-219.

spending has increased from 14% to 29% of Medicaid's total long-term care spending. But nursing homes still absorb the lion's share of Medicaid's support for long-term care.

Medicaid protection also varies considerably from state to state. As a federal-state matching program, Medicaid gives states the primary role in defining the scope of eligibility and benefits. A recent Urban Institute analysis emphasized the resulting variation across states in service availability as a source of both inequity and inadequacy in our financing system. In an examination of 1998 spending in 13 states, long-term care dollars per aged, blind, or disabled enrollee in the highest spending states (New York and Minnesota) were about 4 times greater than in the lowest (Alabama, Mississippi)—a differential even greater than that found for Medicaid's health insurance spending for low income people.

Both our own research and that conducted by the Government Accountability Office tells us that differences in state policies have enormous consequences for people who need long-term care. Studies comparing access for individuals with very similar needs in different communities show that people served in one community get little or no service in another. Georgetown research finds that the same person found financially eligible or sufficiently impaired to receive Medicaid services in one state might not be eligible for Medicaid in another—and, if found eligible, might receive a very different mix or frequency of service. And a comparison of use of paid services in 6 states finds almost twice the incidence of unmet need (56%) in the state with the smallest share of people likely to receive paid services as in the state with the largest (31 %).

This variation—as well as ups and downs in the availability of benefits over time—undoubtedly reflects variation in states' willingness and ability to finance costly long-term care services. The recent recession demonstrated the impact on states of changes in their economies and the vulnerability of Medicaid recipients to states' reactions. In 2001, Medicaid accounted for 15 % of state spending, with long-term care responsible for 35% of the total. Virtually all states were cutting their Medicaid spending as budget pressures struck, endangering access either for low income people needing health insurance, older or disabled people needing long-term care, or both.

In sum, under current policy, neither public nor private insurance protects people against the risk of long-term care. Despite Medicaid's important role as a safety net, the overall result for people who need care is catastrophic expenses, limited access to service, and care needs going unmet.

Given inequities and inadequacies in our current approach for long-term care, it is no wonder that we are concerned about the future, when a far larger proportion of the nation's population will be over age 65 than are today. Experts disagree on whether disability rates among older people in the future will be the same as or lower than they are today. But even if the proportion of older people with disabilities declines, the larger number of older people will likely mean a larger number of older people will need long-term care in the future than need it today. The population aged 85 and older, who are

most likely to have long-term care needs, is likely to double by 2030 and quadruple by 2050.

States will vary in the aging of their populations—with resulting differences in the demand for long-term care and the ability of their working-aged population to support it. To identify future demands on Medicaid, a Georgetown study examined census data on the ratio of elderly people to working-age adults between 2002 and 2025. Nationally, this ratio changes from about one to five (one person over age 65 for every 5.2 people of working age) in 2002 to one to three—an increase of about 66 percent. But the changes differ across states, with some states well below the national average (e.g. California, Connecticut, D.C., Massachusetts) and others, far above. In many states, the ratio increases by more than three quarters and in a few (e.g. Colorado, Utah, and Oregon), it more than doubles. All states will be challenged to meet increased long-term care needs.

States are already struggling with Medicaid's fiscal demands, which challenge their ability to meet equally pressing needs in education and other areas. And state revenue capacity varies considerably. If current policies persist, pressure to make difficult tradeoffs will only get stronger. In the future, states with bigger increases in the elderly-to-worker ratio will face the greatest pressure. And, since many of the states with above average changes currently spend relatively little per worker on Medicaid long-term care, there is a strong likelihood that in the future, long-term care financing will be even less equitable and less adequate across the nation than it is today.

What's needed for a different future is public policy action. Developing better policy requires an assessment of options to assure access to affordable quality long-term care and to distribute financing equitably between individuals who need long-term care and their families, on the one hand, and the rest of federal and state taxpayers, on the other. Consideration of federal budgetary implications is an important part of the assessment process. But allowing budgetary constraints to drive that process distorts the nation's policy choices. Last April's CBO report on long-term care financing did precisely that. Explicitly focusing on the achievement of only one policy goal—alleviation of "pressure" on the federal budget—the report treated as legitimate only policy options with the potential to reduce federal spending, without regard to the consequences for people in need.

From this perspective, the report's first set of policy options—cutting back already inadequate Medicaid and Medicare protection—is not surprising. But its implications are nevertheless horrifying. CBO straightforwardly states that such action could reduce the number of people dependent on public programs—a fairly obvious conclusion. But it presents no evidence that people inappropriately rely on Medicaid today; and no evidence that savings or private long-term care insurance would provide adequate protection if Medicaid were made more restrictive for the future. Indeed CBO explicitly recognizes that this approach implies greater burdens on family and friends, greater difficulty in obtaining care, and greater bad debt for long-term care providers. If the policy goal is—

as it should be—to improve care and distribute costs equitably, such cutbacks seem unconscionable, not desirable.

Proposals aimed at tightening existing restrictions on resource transfers may similarly do more harm than good. Claims that Medicaid serves as an asset shelter for the wealthy rather than a safety net are simply not supported by the evidence. Broad action to tighten those restrictions would frighten some elderly people out of contributing to their grandchildren's education, helping their adult children overcome economic hurdles, or making donations to their favorite charities. Unexpected penalties for people who do make gifts would require enforcement actions against unsuspecting families and would likely leave providers without payment. Policy that targets specific abuses—where there is evidence they exist—makes sense. But penalizing all modest income older people and their families for just living their lives cannot be justified.

The CBO report's second set of options to alleviate fiscal pressure aim to "improve the functioning of the market for private long-term care insurance"—a strategy that is less likely than public cutbacks to reduce access but still unlikely to significantly improve either access or equity. Standardizing long-term care insurance policies might facilitate consumers' ability to make choices in the marketplace and improve the adequacy of private long-term care insurance. But, as CBO notes, standards that improve policies would likely increase insurance premiums. The result might be better protection for those who can afford private insurance—a worthy goal, but it is highly unlikely to be an increase in the numbers of people willing or able to buy insurance.

CBO's consideration of so-called "partnerships for long-term care"—which would allow benefits paid by private insurance to offset (or protect) assets for Medicaid users who purchase approved private long-term care insurance policies—also reveals this strategy's limitations. These partnerships have been advocated as a means to save Medicaid money by preventing "spend-down" and asset transfers. The hope is that allowing the purchase of asset protection, along with insurance, will encourage modest income people to purchase private long-term care insurance. Experience with these policies in four states has produced only limited purchases, primarily among higher income people, and has affected too few people for too short a period to assess its impact on Medicaid spending (Alexis Ahlstrom, Emily Clements, Anne Tumlinson and Jeanne Lambrew, "The Long-Term Care Partnership Program: Issues and Options", Pew Charitable Trusts' Retirement Security Project, George Washington University and The Brookings Institution, December 2004). The partnership has contributed to improved standards for long-term care insurance policies and more partnership policies are being sold to more modest income people as the standards that apply to them are also applied to the broader market. However, as CBO notes, if these policies simply substitute for policies individuals would otherwise have purchased or increase the likelihood of using long-term care services, they may eventually increase rather than decrease Medicaid expenditures. From the budgetary perspective, advocacy of reliance on Medicaid to essentially subsidize private long-term care insurance alongside promotion of budget legislation to curtail federal Medicaid contributions seems both disingenuous and risky. Further, from the broader equity perspective, targeting private long-term care insurance to modest income people

seems questionable. The purchase of a limited long-term care insurance policy could easily absorb close to 10 percent of median income for a couple aged 60—a substantial expenditure for a cohort acknowledged as woefully unprepared to meet the basic income needs of retirement.

Even more questionable are proposed tax preferences for private long-term care insurance. CBO does not analyze these proposals, perhaps because they would clearly increase rather than decrease public expenditures. Nevertheless, they are consistently on the policy agenda, despite the likelihood that they will be poorly targeted to improve insurance protection. Experience with health insurance tells us that such credits are likely to primarily benefit those who would have purchased long-term care insurance even in the absence of credits—substituting public for private dollars—and, as currently proposed, are not even designed to reach the substantial portion of older and younger Americans with low and modest incomes.

Indeed, the whole focus on reducing public spending and promoting private insurance ignores the public responsibility to address for all Americans what should be our fundamental policy choice: do we want to live in a society in which we assure affordable access to long-term care for people who need it or in a society in which we leave people in need to manage as best they can on their own?

There is little question that to address both current and future long-term care needs requires not a decreased but an increased commitment of public resources—and, to be adequate and effective in all states—federal resources. Expanded public financing for long-term care could take a variety of forms and by no means need eliminate private contributions. One option, modeled on Social Security, would be to provide everyone access to a "basic" or "limited" long-term care benefit, supplemented by private insurance purchases for the better-off and enhanced public protection for the low income population. Another option would be establishment of a public "floor" of asset protection—a national program assuring everyone access to affordable quality long-term care—at home as well as in the nursing home—without having to give up all their life savings as Medicaid requires today. The asset floor could be set to allow people who worked hard all their lives to keep their homes and modest assets, while allowing the better off to purchase private long-term care insurance to protect greater assets. Either public/private combination could not only better protect people in need; it could also provide substantial relief to states to focus on health insurance, education and other pressing needs—relief that governors have explicitly requested by calling on the federal government to bear the costs of Medicare/Medicaid "dual eligibles". Because Medicaid serves the neediest population and, in the current budgetary environment is at risk, my highest priority for expenditure of the next federal dollar would be responding to this call (along with supporting more home care and better quality care) with more federal dollars to Medicaid.

Some will undoubtedly characterize proposals like these as "unaffordable", given the fiscal demands of Medicare and Social Security and the current federal budget deficit. But that deficit reflects policy choices. I would far rather see expenditure of the next federal dollar devoted to enhanced Medicaid long-term care financing than to tax credits for long-term care or tax cuts in general. Indeed, the estate tax is especially appropriate for long-term care financing: taxing everyone's estate at certain levels, to provide reasonable estate protection for those unlucky enough to need long-term care.

As we look to the future, examination of the choices being made by other nations of the world is instructive. Analysis by the Organization for Economic Cooperation and Development (OECD) of long-term care policy in 19 OECD countries (presented at the June 2004 research meeting of AcademyHealth) found that the number of countries with universal public protection for long-term care (Germany, Japan and others) is growing. Public protection, they report, does not imply the absence of private obligations (cost sharing and out-of-pocket spending), nor does it imply unlimited service or exploding costs. Rather, in general, it reflects a "fairer" balance between public and private financing—relating personal contributions to ability to pay and targeting benefits to the population in greatest need. Many of these nations have substantially larger proportions of elderly than the U.S. does today and therefore can be instructive to us as we adjust to an aging society.

Clearly, we will face choices in that adjustment. If we are to be the caring society I believe we wish ourselves to be, we too will move in the direction of greater risk-sharing

and equity by adopting the national policy and committing the federal resources which that will require.