Project Title: The Distribution of Benefits from a Universal Long-term Care Benefit

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The most glaring gap in the US social health insurance system arguably is the lack of universal coverage for long-term care (LTC). Many Americans are part of the so-called “forgotten middle,” too “wealthy” to qualify for Medicaid yet not wealthy enough to afford LTC (Pearson et al. 2019). Rising rates of Alzheimer’s Disease and Alzheimer’s Disease Related Dementias (AD/ADRD) have led to increased LTC needs among older adults (Davis et al. 2022). Consistent with federal policy, more individuals are attempting to avoid long-term nursing home residency, although many require considerable support to do so (CMS 2020). Medicaid coverage for LTC fills some of this gap, but only for those who have spent down all their assets, putting healthy spouses of those with LTC needs at risk of becoming destitute (McGarry and Grabowski 2023).

This gap in coverage presents an enormous financial risk for aging Americans. Nursing home care costs $108,000 per year on average, while home care costs around $60,000 per year (Gruber and McGarry 2023). This risk can be insured against via private LTC insurance, but this market has long been plagued by failures that lead to extremely limited take-up (Brown and Finkelstein 2004). The high cost of LTC also presents broader risks, as children of aging parents may leave jobs to provide these services,12 an externality that affects society broadly due to lower labor supply and economic productivity (Van Houtven et al. 2013). Given evidence of different caregiver burden and out-of-pocket spending for adults with AD/ADRD, the burden of long-term care for this population is of particular concern. Over the years, there have been many proposals to add a long-term care benefit to Medicare, yet there is little work studying who would be the beneficiaries of such a benefit.

In this project, we propose to study the equity and efficiency trade-offs of an expansion of public LTC insurance benefits to older adults using existing programs. The private benefits of a Medicare long-term care benefit can be thought of as consisting of two pieces. First, (the “transfer” component) individuals who are already paying for long-term care services out-of-pocket (the “private pay” population) and those whose family members are taking care of them (informal care) will benefit directly in the form of large financial transfers (to the private pay population) and more time for labor or leisure (the informal care population). Importantly, almost all of these benefits will accrue not to the patient themselves but to their spouses and children. Second, (the “behavioral response” component) for some individuals a long-term care benefit will allow them to access services that they would like to use but can’t afford. These individuals also benefit, though the value of this additional utilization of long-term care services is more difficult to quantify.

There is reason to believe that the transfer component will accrue largely to higher-income individuals. Those paying out-of-pocket for long-term care services (or through private long-term care insurance) are likely quite wealthy, as these services are quite expensive. Further, the ultimate beneficiaries, their children, are also likely wealthy. However, there is little empirical evidence establishing this or quantifying disparities across racial, ethnic, or socio-economic groups or across different disease groups (ADRD versus other conditions) in the financial benefits stemming from a long-term care benefit.

It is also unclear whether the second component, the behavioral response, would result in larger benefits for the rich or the poor. If affordability is the primary barrier to use of formal long-term care services, then the poor may benefit the most. However, if other structural barriers are

primarily responsible for limited use of long-term care services among the poor, then coverage will not result in more increased use by them versus wealthier beneficiaries.

We propose use this two-part framework to study the distributional consequences of a universal long-term care insurance benefit. We will do so in two pieces. First, we will study the transfers provided by such a benefit, *holding utilization of long-term care services fixed.* We will focus on disparities in the transfers by socio-economic status, as measured by education, race, income, assets, and other measures, both of the patient and their spouses and children. Second, we will study the behavioral response to long-term care coverage, both overall and differences in this behavioral response across groups. To do so, we will leverage variation in coverage for certain types of long-term care services stemming from a new policy allowing Medicare Advantage plans to cover home- and community-based services. We will also leverage variation across states and over time in eligibility rules for Medicaid long-term care coverage, as in prior work (Grabowski and Gruber 2007; Mommaerts 2018).

We will use data from two sources. First, we will use data on the universe of nursing home stays (Medicare-paid, Medicaid-paid, and private pay) from the Minimum Dataset, linked to Medicare data, Medicaid data, and CAHPS survey data (which includes data on education and self-reported race). This data is already sitting at Harvard and ready to be used for this project. The Medicare data will allow us to observe a history of zip codes where the patient lived before entering the nursing home, allowing us to characterize their socio-economic status based on where they used to live. We will also leverage novel education data in the CAHPS survey to further characterize socio-economic status.

Second, we will leverage data from the HRS to study both institutional *and non-institutional* long-term care and to characterize the socio-economic status of spouses and children of patients. The HRS allows children-parent linkages that facilitate these types of investigations.

Ultimately, this project will provide a complete evaluation of the equity and efficiency trade-offs of a public long-term care benefit. With our estimates, we will explore various types of long-term care benefits, specifically studying the trade-offs of universal (Medicare) versus more-targeted (Medicaid) long-term care benefits, hopefully providing a the set of parameter estimates policymakers need in order to design a benefit that achieves both efficiency *and* equity goals.

Aim 1 – Assess how the financial benefits of a universal long-term care benefit vary across groups (education, race, income, ADRD, etc.), holding utilization fixed.

Aim 2 – Estimate behavioral response to long-term care coverage, leveraging variation in long-term care coverage stemming from changes in Medicaid eligibility rules and new Medicare Advantage coverage of home- and community-based services.