



Abt Associates Inc.

Financing Long-Term Care for the Baby Boom Generation

HSRE Working Paper 8

Cambridge, MA
Lexington, MA
Hadley, MA
Bethesda, MD
Washington, DC
Chicago, IL
Cairo, Egypt
Johannesburg, South Africa

May 2001

Abt Associates Inc.
55 Wheeler Street
Cambridge, MA 02138

Prepared by
Steven D. Pizer
Austin B. Frakt
Frederic H. Decker

FINANCING LONG-TERM CARE FOR THE BABY BOOM GENERATION

Steven D. Pizer, Austin B. Frakt, and Frederic H. Decker

May 17, 2001

Abstract. We use a new microsimulation model to analyze long-term care (LTC) financing policy alternatives including expansion of Medicare benefits and tax credits for private LTC insurance. Our model predicts that Medicaid spending as a fraction of gross domestic product will grow by 60% over the next 50 years, raising doubts about the viability of the current financing system. Few realistic policy options save money relative to current law, but some are worth considering because they have the potential to stabilize funding and improve access to LTC services, without substantially increasing spending.

Steven Pizer is a Health Economist in Health Services Research and Evaluation with Abt Associates Inc., Austin Frakt is a Senior Analyst also in Health Services Research and Evaluation with Abt Associates Inc., and Frederic Decker is Senior Director of Health Services Research and Evaluation at the American Health Care Association. Questions or comments should be directed to Steven Pizer, Abt Associates, 55 Wheeler Street, Cambridge, MA 02138; (617) 520-2988; steven_pizer@abtassoc.com.

Introduction

Over the next 50 years, the baby boom generation will enter the age range when long-term care (LTC) services are most commonly needed, further stressing the nation's already unstable LTC financing systems. A variety of policy alternatives have been suggested to help federal and state governments cope with the resulting financial pressures. In this paper we use a new microsimulation model to evaluate several of these alternatives including the expansion of Medicare to cover LTC services and the creation of favorable tax treatment for private LTC insurance premiums. Our predictions indicate that by 2050 Medicaid spending as a fraction of gross domestic product will grow by 60% and few realistic policy options can meaningfully slow this growth. However, some policies are nevertheless worthy of consideration because they could stabilize funding, improve access to formal LTC, and promote coordination of care.

Background

LTC financing in the United States is widely considered to be inadequate. Few can afford formal care with their own resources, private insurance coverage is uncommon, and public insurance either offers limited benefits (in the case of Medicare) or coverage only to the poor (in the case of Medicaid). Consequently, most disabled individuals rely on informal, unpaid care.¹

Access to formal LTC is further undermined by the financial structure of Medicare and Medicaid. Because the federal government funds Medicare and states partially fund Medicaid, incentives exist to shift costs from one level of government to the other, resulting in administrative conflict rather than cooperation.² Coordination of care also suffers since

Medicare emphasizes acute and primary care while Medicaid provides more LTC assistance.³ Finally, Medicaid is less able than Medicare to absorb increasing costs because Medicaid is partially funded from state budgets, which frequently are subject to balanced budget and tax limitation requirements.

We examine several alternatives to this financial structure using a microsimulation model recently developed by Abt Associates Inc. for the American Health Care Association. As input, the model takes assumptions about demographic, economic, and health trends, as well as changes in LTC policy. These assumptions are applied to empirical relationships estimated from survey data to construct measures of public and private costs and LTC utilization that are consistent with past behavior.⁴ As the model runs, it outputs a set of these measures for each year simulated. Because it forces disciplined specification of assumptions and predicts the consequences of policy change using consistent, data-driven methodology, this model is a valuable tool for fairly evaluating and comparing policy options.

In what follows we use the model to consider four main questions: (1) Will there be a LTC financing crisis? (2) Should LTC insurance be provided publicly or privately? (3) Should participation in the public or private program be compulsory? (4) Should LTC insurance be subsidized and, if so, at what level?

Analysis of Policy Alternatives

We will shed light on the above questions by considering the long-range consequences of five policy alternatives: maintenance of current law, expansion of Medicare to cover LTC, mandatory private insurance, refundable tax credits to encourage growth in the private LTC

insurance market, and a policy that provides relief from Medicaid eligibility requirements for individuals who purchase LTC insurance.

As we present projections for the first two options (current law and Medicare expansion), we illustrate how the microsimulation model's forecasts are affected by changes in three underlying assumptions: expected disability rates, medical inflation rates, and the magnitude of the insurance inducement effect.⁵ In this context, insurance inducement (sometimes known as "moral hazard" or the "woodwork effect") refers to the fact that individuals will use more services if insured than they would if they were paying out-of-pocket. As we demonstrate, variations in these assumptions can have large impacts on the estimated cost of a policy change. Therefore, in our analysis of policy options we apply assumptions consistently so that relative differences in costs between options reflect differences in policy, not differences in assumptions.

Current Law

The burden on government budgets generated by the Medicaid program is illustrated in Exhibit 1, which shows total Medicaid spending as a percentage of GDP in selected years as predicted by our LTC microsimulation model. Three different scenarios are considered. The first is generated using baseline settings of all parameters, initialized at reasonable values and calibrated to produce forecasts of standard items (e.g., population, GDP, etc.) that agree with other mainstream projections. The second scenario is based on an assumption of lower medical inflation (0.75 percentage points above the consumer price index (CPI) as opposed to the baseline of 1.5 percentage points). The third scenario is based on lower disability rates (shown in Exhibit 2).

Exhibit 1 indicates that baseline settings lead to a prediction that Medicaid will account for 3.0% of GDP in 2050, about a 60% increase over its value in 2000. Also evident is the tremendously important effect of expected medical inflation. If the baseline medical inflation expectation is cut in half, our simulations show that Medicaid spending is reduced by one-third in 2050 (2.1% of GDP as opposed to 3.0% under baseline settings). Finally, a modest decrease in expected disability rates (see Exhibit 2) has a noticeable, but small, effect on Medicaid spending (shown in the last row of Exhibit 1). Of course, if medical inflation or disability rates turn out to be higher than the baseline, Medicaid spending also will be higher.

Expansion of Medicare

The first alternative LTC policy option we consider is universal, compulsory, federally administered insurance. Although such a program need not be part of Medicare, it is often thought of as an extension or “modernization” of current Medicare benefits.

Medicare expansion has advantages and disadvantages. Individuals would enjoy universal access to coverage, protection from impoverishment, low cost, and coordination of care through integration of acute and LTC payors. Advantages for LTC financing include dedicated financing (if funded through earmarked taxes), broad pooling of risk, low administrative cost, and strong purchasing power. Another advantage is the relief provided to state budgets through the reduced role of Medicaid, although there would be a commensurate increase in the federal government’s burden.

Opponents of Medicare expansion point to a number of disadvantages. First, it would face the same problems that Medicare currently faces: an aging population that will lead to a large burden on future wage earners.⁶ Second, prices and quality standards would be set not

through market competition but through a political process which is subject to gamesmanship. Third, a public insurance program will have a uniform benefits package and, thereby, limit consumer choice. Finally, there is concern that Medicare expansion benefits individuals and, through asset protection, families who do not need public assistance. Those who can afford LTC or private LTC insurance would receive the same coverage as those who cannot. By eliminating the need to spend down income and assets to become eligible for Medicaid, Medicare expansion essentially provides estate protection, a role that many do not consider an appropriate public function.

Medicare expansion is more costly than the status quo due to demand induced by an expansion of benefits. This is illustrated in Exhibit 3, which shows total government LTC and acute and primary (A&P) care costs as a percentage of GDP for three different scenarios: current law with baseline settings, Medicare expansion with baseline settings, and Medicare expansion with increased insurance inducement.⁷ Notice that Medicare expansion using baseline settings results in a significant increase in government long-term care spending (to 2.8% of GDP in 2050 as compared to 1.7% under current law) and that Medicare expansion with increased insurance inducement results in an even larger increase (to 3.3% of GDP in 2050).

Mandatory Private Coverage

Two potential disadvantages of Medicare expansion are that it places a large financial burden on the federal government and that workers may feel that they pay taxes into the program to fund care for others, rather than for their own care. An alternative that does not suffer from these problems is mandated private coverage. Under a mandate, individuals

would be required to obtain LTC insurance from a qualified private carrier. Private insurance companies, not government, would pay claims and individuals would contribute to their own future care through premiums rather than taxes. Note that Medicare expansion and an individual mandate use different means to achieve the same ends: universal coverage and a reduction in reliance on Medicaid.

The efficacy of mandated coverage is attenuated by features of the LTC insurance market, not all of which are easily remedied through regulation. The most serious problem is that LTC insurance premiums are higher than most elderly can afford. In fact, it has been estimated that no more than 10% to 20% of elderly individuals can afford LTC insurance at current prices.⁸ Requiring pre-retirement purchase would reduce premiums (premiums for a 40 year old can be one-tenth those for an 80 year old), but a 40 year old would have to pay premiums for decades before use of the benefits became likely. With other pressing demands on income, like mortgage payments and the expenses associated with raising children, individuals in their forties are unlikely to look kindly on a mandate. Consequently, one is faced with a problem that is both financial and political: the elderly cannot afford what they may soon need and the non-elderly must buy what they do not want.

An alternative is to offer subsidies and encourage early purchase but to make purchase optional, not compulsory. The right level of subsidization would make LTC insurance affordable and would help individuals maintain their coverage. Failure to maintain coverage is a problem in today's LTC insurance market with only about 60% of policies sold through June of 1998 still active.⁹ Although subsidization can improve affordability, it does not solve the problem that LTC insurance is not a high priority for non-elderly workers.

Tax Incentives to Encourage Private Coverage

If LTC insurance is not made compulsory either through Medicare or an individual mandate, then meaningful policy change will have to confront the rarity of private coverage. Fewer than 10% of the elderly have private LTC coverage today, fewer than 20% can afford it, and only 7% of LTC spending is financed by private insurance.¹⁰ In principle, tax incentives could encourage growth in the private LTC insurance market; however, the extent to which increased market penetration results in decreased Medicaid spending depends on who buys insurance and how it is used.

One type of tax incentive would provide a tax benefit to employers who offer LTC insurance to their employees. Another approach would encourage individual purchase by allowing the deduction of premiums from taxable income or offering a tax credit equal to some fraction of the premium. In this section we focus on tax incentives to encourage individual, not employer, purchase. We consider the following questions: (1) What is the appropriate level of subsidization? (2) What is the cost to the federal government in lost revenue? (3) What are the savings to Medicaid?

Tax deductions would do little to solve the long-term financing problem. A tax deduction is, in effect, a premium subsidy linked to the marginal tax rate. Consequently, wealthier individuals with higher marginal tax rates receive a higher subsidy than less well-off individuals. Very low-income individuals with no tax liability receive no benefit. Since low-income individuals are more likely to qualify for Medicaid, the incentives associated with tax deductions are backwards. They assist those who are least likely to need help and require public assistance.

Tax credits are more promising. There are two kinds of tax credits, refundable and non-refundable. A refundable credit is, in effect, a subsidy through the tax code; individuals receive the full amount of the credit regardless of tax liability. A non-refundable credit is potentially less beneficial because an individual receives a tax credit only up to his or her tax liability. Non-refundable credits suffer from some of the same problems as tax deductions since lower income individuals with little or no tax liability receive little or no benefit.

Exhibit 4 illustrates the financial impact on individuals of a specific refundable tax credit policy. The first column lists income as a percent of the federal poverty level (FPL).¹¹ The second column contains the refundable tax credit amount as a percent of LTC insurance premium (the subsidy level). The third column reports the resulting financial burden: the out-of-pocket premium (premium less subsidy) as a percentage of income. A burden under 10% is considered reasonable for the elderly and 5% is considered reasonable for the non-elderly.¹² The refundable tax credit rates presented in Exhibit 4 are reasonable by these standards. Note that the model does not assume that low income individuals purchase long-term care insurance. On the contrary, the model is designed so individuals preferentially purchase insurance when their incomes and assets are high. However, incomes change over time, sometimes decreasing due to disability, loss of work, or retirement. Thus, tax credits for low-income individuals make it possible for more people to maintain coverage when their incomes decline.

There are limitations associated with refundable tax credits. First, assistance may arrive as much as a year after purchase, making it difficult for low-income individuals to pay the premium even though they will ultimately be reimbursed through a tax refund. Second, the increase in private coverage induced by a tax subsidy would not necessarily lead to savings

for the Medicaid program. The extent to which Medicaid spending is reduced depends on whether individuals who would otherwise go on Medicaid obtain private coverage and whether benefits obtained through private insurance cover expenditures that Medicaid would otherwise have made. If induced private insurance mainly covers those who would not have enrolled in Medicaid or utilization that would not have occurred in the absence of private coverage then no savings to Medicaid will result.

The impact of market penetration is reflected in Exhibit 5 which illustrates the cost to the federal government of financing refundable tax credits, the resulting savings to the Medicaid and Medicare programs (relative to current law), the amount of formal LTC provided, and the percentage financed privately.¹³ The first two rows provide results for current law and an eventual market penetration (27%) consistent with the financial burden results of Exhibit 4. The third row corresponds to a much higher eventual market penetration (41%).

Given a 27% market penetration in 2050, refundable tax credits do not save Medicaid a substantial amount of money (\$5.27 billion annually). Although refundable tax credits do not provide substantial relief to Medicaid budgets, they significantly expand the private LTC insurance market, thereby improving access and stabilizing funding for LTC while potentially improving coordination of care, all for about \$10 billion per year in net new spending.

Although \$10 billion per year may seem high, greater market penetration can increase the benefits of tax credits while actually reducing the net cost to the government. This occurs because as the private market expands, those with lower income and assets (more likely to qualify for Medicaid) become more likely to purchase insurance. Exhibit 5 shows that if

market penetration climbs by 50% (to 41%) Medicaid can save over 150% more (\$13.33 billion annually), reducing net new spending to about \$7 billion per year. Achieving this level of market penetration would require substantial changes in the incentives facing potential LTC insurance purchasers. Clearly, making insurance more affordable is one component. Another is education.¹⁴ Yet another set of inducements can be found in changes to Medicaid, discussed next.

Restructuring Medicaid

Some evidence suggests that potential consumers of LTC insurance can be influenced by Medicaid program configuration differences.¹⁵ Therefore, policy options that restructure Medicaid may encourage private coverage.¹⁶

We have tested a policy that involves such a restructuring of Medicaid. The program would shift LTC financing from Medicaid to the federal government. It would aggressively encourage the purchase and maintenance of private LTC coverage in two ways: (1) subsidies would be provided to low-income policyholders and (2) qualification for the new federal LTC benefit would be more difficult than under the current Medicaid program, with stricter limitations on asset protection. The combination of these incentives is projected, under optimal conditions, to raise LTC insurance market penetration to 53% in 2050. Exhibit 6 illustrates the decrease in Medicaid spending as a result of this policy. Note that our estimates assume very favorable conditions and are based on the experience of the few large employers that have aggressively promoted LTC insurance to their employees.¹⁷ This intentionally extreme example illustrates the approximate maximum savings to Medicaid that could be generated by voluntary LTC insurance.

Conclusion

In this paper we analyzed a variety of policy options both in light of today's needs and, using a new LTC microsimulation model, in terms of long-range sustainability. These options included maintenance of current law, expansion of Medicare benefits to include LTC, mandatory private LTC insurance, preferential tax treatment of private LTC insurance premiums, and restructuring of Medicaid. Although the most promising of these (Medicare expansion and refundable tax credits with Medicaid restructuring) would not reduce public spending on LTC, they could strengthen the LTC financing system, making it more able to absorb the growth in costs projected over the next 50 years.

Elements of these options can be combined and sequenced. For example, one could consider beginning with a tax credit designed to make LTC insurance more affordable. After LTC insurance market penetration has grown as result of this policy, one could consider changing the Medicaid program, perhaps shifting responsibility for LTC to the federal level and tightening asset protection rules. Ultimately, this might lead to high enough market penetration that mandatory coverage would be considered a natural next step. If a LTC financing crisis develops as predicted, its onset will be sufficiently far in the future that such a slow and deliberate policy progression will be feasible. However, as with other issues related to financing the future needs of the baby boom generation, this problem will become more difficult to address as the baby boom approaches retirement.

¹ B. Soldo et al., "Care of the Elderly: Division of Labor Among the Family, Market, and State," *Demography of Aging* (Washington, D.C.: National Academy Press, 1994): 195-216; and W. Scanlon, "Possible Reforms for Financing Long-Term Care," *Journal of Economic Perspectives* (Summer 1992): 43-58.

² J. Feder et al., "Long-Term Care in the United States: An Overview," *Health Affairs* (May/June 2000):40-56.

³ In 2000, 35% of LTC expenditures will be funded by Medicaid and 24% by Medicare. See, U.S. Congressional Budget Office, "Projections of Expenditures for Long-Term Care Services for the Elderly," March, 1999.

⁴ The surveys relied upon most heavily were the Medicare Current Beneficiary Survey, the Medical Expenditure Panel Survey, and the Health and Retirement Survey. In addition, we tabulated data as needed from the Current Population Survey and the National Health Interview Survey, and consulted a wide variety of published sources. Additional technical model documentation can be obtained from the authors.

⁵ There are other important factors but their effect is weaker than that of the insurance inducement rate. One such factor considered by the model is a substitution effect, i.e., a decrease in acute and primary care utilization due to an increase in LTC utilization. One reason to expect such an effect is that individuals using formal LTC would be healthier, on average, than they otherwise would be and therefore would use fewer acute and primary care services. Although some evidence supports this substitution of services (see, for example, S. Hughes et al., "Impact of Home Care on Hospital Days: A Meta Analysis," *Health Services Research* (October 1997):415-422.), there is a debate as to the size of the effect as well as evidence that suggests that no such effect exists (See, B. Dowd et al., "S/HMO Versus TEFRA HMO Enrollees: Analysis of Expenditures," *Health Care Financing Review*(Summer 1999): 7-23.).

⁶ M. Merlis, "Financing Long-Term Care in the Twenty-First Century: The Public and Private Roles," The Commonwealth Foundation, Publication No. 343, September, 1999.

⁷ The baseline insurance inducement assumption is that 25% of non-institutionalized individuals who are eligible for insurance benefits will use home health services and 25% will use assisted living services. Under the increased insurance inducement assumption each of these values is raised to 35%.

⁸ W. Scanlon, "Long-Term Care Insurance: Better Information Critical to Prospective Purchasers," Testimony before the Special Committee on Aging, U.S. Senate, September 13, 2000.

⁹ *Ibid.* Some of these policies may not be in force because the policyholder has died. However, considering the prevalence of underwriting by long-term care insurance carriers, it is likely that a substantial portion of this figure is due to lapsing (M. Merlis, "Financing Long-Term Care in the Twenty-First Century: The Public and Private Roles"). Indeed, in M. Cohen et al., "Long-Term Care Insurance and Medicaid," *Health Affairs* (Fall 1994): 127-139 it is reported that the annual lapse rate is between 5% and 10%. If individuals were equally likely to lapse then the low figure of 5% implies that there is only a 50% probability that an individual will maintain a policy for more than 14 years.

¹⁰ W. Scanlon, "Long-Term Care Insurance: Better Information Critical to Prospective Purchasers;" and J. Feder et al., "Long-Term Care in the United States: An Overview."

¹¹ In 1996 (the LTC microsimulation model operates entirely in 1996 dollars), the FPL for an individual was \$7,995; for a couple it was \$10,233.

¹² J. Mulvey et al., "Who Will Pay for the Baby Boomers' Long-Term Care Needs?," American Council of Life Insurance, April 1998.

¹³ The LTC microsimulation model assigns purchase of LTC insurance to those who can afford it (after taking into consideration the tax subsidy) in proportion to the assumed market penetration. This is done using a longitudinal econometric model of LTC insurance purchase estimated from Health and Retirement Survey data.

¹⁴ Among the reasons for low levels of insurance coverage today is a general misconception that Medicare, Medicaid, or other acute and primary health insurance (e.g., Medigap) cover LTC (W. Cadette, "Financing Long-Term Care: Replacing a Welfare Model with an Insurance Model.").

¹⁵ N. Kumar et al., "Understanding the Factors Behind the Decision to Purchase Varying Coverage Amounts of Long-Term Care Insurance," *Health Services Research* (February 1995): 653-678.

¹⁶ See, S. Moses et al., "Long-Term Care Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle," The Center for Long-Term Care Financing, Seattle, 1998 for a forceful argument of this point.

¹⁷ S. Lutzky et al., "Preliminary Data from a Survey of Employers Offering Group Long-Term Care Insurance to Their Employees," Office of Disability, Aging, and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Contract #HHS-100-97-0011, June 23, 1999.

Exhibit 1**Medicaid spending as a percent of GDP^(a)**

<i>Scenario</i>	<i>2000</i>	<i>2025</i>	<i>2050</i>	<i>Ave. 2000-2050</i>
Current law: baseline settings	1.9%	2.3%	3.0%	2.5%
Current law: reduced medical inflation	1.8%	1.9%	2.1%	1.9%
Current law: reduced disability rate ^(b)	1.9%	2.2%	2.8%	2.3%

(a) The model begins in 1996 using results from the 1996 Medicare Current Beneficiary Survey and the 1996 Medical Expenditure Panel Survey for initialization. The relatively small differences in 2000 across scenarios reflect the implications of different input assumptions over the years 1996-2000.

(b) Exhibit 2 lists the disability rates.

Sources: AHCA LTC microsimulation model.

Exhibit 2**Assumed Disability rates by age in 2025**

<i>Age</i>	<i>Proportion of population disabled</i>	
	<i>Baseline disability rate^(a)</i>	<i>Reduced disability rate</i>
0-17	1.0%	0.7%
18-64	1.2%	1.0%
65 and up	9.9%	8.8%

(a) Baseline disability rates were estimated from the 1996 Medical Expenditure Panel Survey, the 1995 and 1996 Medicare Current Beneficiary Survey, and the 1995 and 1996 Health and Retirement Survey.

Sources: AHCA LTC microsimulation model

Exhibit 3
Total government (federal + state) spending on LTC and acute and primary care as a percent of GDP

Scenario	2000		2025		2050		Ave. 2000-2050	
	LTC	A&P ^(c)	LTC	A&P ^(c)	LTC	A&P ^(c)	LTC	A&P ^(a,c)
Current law: baseline settings	0.9%	3.2%	1.0%	4.6%	1.7%	5.9%	1.2%	4.8%
Medicare expansion: baseline settings	0.9%	3.2%	1.4%	4.6%	2.8%	5.9%	1.8%	4.7%
Medicare expansion: increased insurance inducement ^(b)	0.9%	3.2%	1.7%	4.6%	3.3%	5.8%	2.0%	4.7%

(a) The 50-year average A&P values are slightly lower under Medicare expansion as compared to current law due to the substitution effect discussed in endnote 5.

(b) The baseline insurance inducement assumption is that 25% of non-institutionalized individuals who are eligible for insurance benefits will use home health services and 25% will use assisted living services. Under the increased insurance inducement assumption each of these values is raised to 35%.

(c) A&P spending includes inpatient hospitalizations, physician visits, skilled nursing facility stays, and prescription drugs. It does not include non-SNF long-term care services, dental services, supplies, durable medical equipment, non-durable medical equipment, or other professional services.

Sources: AHCA LTC microsimulation model.

Exhibit 4**Refundable tax credit rates and resulting financial burden by income level^(a)**

<i>Income^(b) as percent of federal poverty level^(c)</i>	<i>Refundable tax credit as percent of premium</i>	<i>Premium net credit as percent of income^(b)</i>
Less than 100%	100%	0%
100% to 200%	50%	3.1%
200% to 300%	25%	3.6%
300% to 400%	0%	3.6%
Greater than 400%	0%	1.6%

- (a) Results in this table were generated assuming that 4.1% of individuals purchase private LTC insurance in 2000 and 27% do so in 2050.
- (b) To account for the fact that some wealthy individuals have low incomes, income is the sum of family income and 10% of assets.
- (c) See endnote 10.

Sources: AHCA LTC microsimulation model

Exhibit 5**Loss in federal tax revenue, Medicaid savings, total formal LTC, and percentage financed privately under a refundable tax-credit policy (in billions of 1996 dollars)**

Scenario	Annual Average 2000-2050				
	Fed. Tax Loss	Medicaid Saving ^(a)	Medicare Saving ^(a)	Total Formal LTC	Percentage Financed Privately ^(b)
Current law:					
4.1% market penetration in 2000 and 10% in 2050	\$0	\$0	\$0	\$232.56	15%
Refundable tax credits:					
4.1% market penetration in 2000 and 27% in 2050	\$20.84	\$5.27	\$5.72	\$243.78	22%
Refundable tax credits:					
4.1% market penetration in 2000 and 41% in 2050	\$27.64	\$13.33	\$7.27	\$245.38	25%

(a) Medicaid and Medicare saving are relative to baseline current law simulation. Medicaid saving would be shared among the state and federal governments in proportion to the federal matching percentage, which varies by state. Medicare saving is generated by the substitution effect discussed in endnote 5.

(b) Percentage financed privately is the percent of total formal LTC spending financed by a LTC insurance policy benefit. Note that rapid growth in market penetration does not generate as rapid growth in the percentage financed privately because individuals who purchase insurance generally do not use services until many years later.

Sources: AHCA LTC microsimulation model.

Exhibit 6**Medicaid spending as a percent of GDP**

Scenario	2000	2025	2050	Ave. 2000-2050
Current law, baseline settings	1.9%	2.3%	3.0%	2.5%
Medicaid restructuring ^(a)	1.9%	1.9%	2.2%	2.0%

(a) Uses the same subsidy rates presented in Exhibit 4.

Sources: AHCA LTC microsimulation model.
