

## Reviving the Social Contract: Economic Strategies to Promote Health Insurance & Long-Term Care

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### Summary

The social contract that emerged, step by step, during the period stretching from the New Deal to the Great Society is slowly eroding in response to economic and demographic changes at home and abroad. Over the next three decades, American Presidents must choose between forging a new social contract and having none at all, and if we are to have a new contract, assuring that it both passes moral muster and gains bipartisan political support.

One important strand of the social contract that our new President should consider is a move to a range of economic policies that reflect a “real insurance” approach—that is, one that distinguishes between predictable events, for which savings must be encouraged, and rare, catastrophic events, for which insurance is appropriate. Such an approach is particularly needed in two key areas:

- making *small-group and individual health insurance* more affordable by creating a new, federal system of reinsurance that covers a substantial portion of catastrophic costs
- reducing the fiscal burden on Medicaid, Medicare, and state governments by mandating individual *long-term care insurance* and establishing federal mechanisms for regulating the market and financing individual purchases

The large number of uninsured Americans and the aging of the U.S. population, in a context of rapidly rising health care costs, suggest that the financial burden of health



care will become intolerable within our current system of government, private sector, and individual financing. The new President should support a rethinking of the structure of these programs now, in order to prevent this current shaky system from collapse, as well as to provide a basis for a variety of new social policies that would protect Americans' financial security.

## Context

Over the course of the 20th century, new social norms developed concerning acceptable levels of financial risk that individuals should be compelled to bear. Because many individuals could not reduce these risks on their own, even with the assistance of families, neighbors, and charitable organizations, a new social contract evolved that defined the appropriate role of the public and private sectors in reducing risks to individuals by taking on a share of those risks, by:

- expanding public programs
- increased private sector involvement in pensions and health coverage
- significant personal responsibility, through relatively high savings rates and increased purchase of private insurance

This social contract rested on important economic principles. Two are key. First, a certain amount of risk is essential for a dynamic, growing economy. The relationship between risk and growth is curvilinear: both too much and too little risk can lead to individual behavior that thwarts desirable social outcomes. For example, excessive risk reduction can dampen entrepreneurship and impose rigidity at the cost of mobility. Second, not all individuals have the same preference for risk (or capacity to endure it). A sound social contract will accommodate this psychological diversity, up to a point.

At present, all three legs of the economic security stool—public, private, and individual—are under intense and increasing pressure.

The *public sector* faces numerous problems, not the least of which is a structural budget deficit stretching far into the future. The long-term actuarial imbalance in

Social Security is on the order of 25 to 30 percent and increases with every year of inaction. Medicare and Medicaid are on course to triple as a share of GDP over the next quarter-century and, if not restructured, will consume nearly 12 percent of GDP by 2031. The federal Pension Benefit Guarantee Corporation is in the red by at least \$23 billion, and the agency estimates that overall, defined benefit pension plans are under-funded by \$450 billion. At the state and local level, unfunded liabilities for future retiree pensions and health care are estimated to be as high as \$1 trillion.

The *private sector* is struggling with two safety net issues—pensions and health care. Defined benefit retirement plans (pensions) proliferated after WWII and reached their peak in the late 1970s, when 62 percent of workers were covered solely by such plans, versus about 13 percent today. In 1979, only 16 percent of workers had defined contribution plans (401[k] or IRA plans) but no pensions, versus 62 percent today. Since 1980, the share of private sector jobs offering traditional pension plans has fallen to only 20 percent. Although nearly two-thirds of Fortune 1000 firms continue to have defined benefit plans, 11 percent had frozen them by 2004, up from 5 percent in 2001, and the trend is accelerating.

Private sector employers also are retreating from employee health insurance. Only 66 percent of private full-time workers now have company-sponsored health insurance, down from 80 percent in 1989. Among companies with more than 200 workers, 66 percent had *retiree* health care plans in 1988, versus only 33 percent today. The table shows the recent, accelerating decline in the number of employers that offer health

**Table: Percentage of Employers That Offer Health Insurance Coverage**

2000	69%
2003	66%
2006	61%

insurance coverage. This trend has been driven principally by firms with fewer than 200 workers. Annual premiums have increased by 87 percent—more than four times as fast as workers' earnings, and the share of earnings consumed by premiums has

risen accordingly, pricing many workers out of the health insurance market. As a result, although the economy has 4 million more jobs today than in 2000, the number of workers with company-sponsored health insurance has not increased, the share of all workers covered has fallen from 63 to 59 percent, and the number of uninsured Americans rose from 39.8 million to 46.6 million between 2000 and 2005.

Finally, *individuals and families* are increasingly unwilling or unable to do their part in providing financial security for themselves. The personal savings rate, in double digits through much of the 1960s and 1970s, averaged 8 percent between 1980 and 1994 and then began a steep decline. By one standard measure, it has been in negative territory since March 2005. At precisely the time that individuals need to save more, in response to present and future declines in public and private sector security programs, they are doing the opposite. The result could be catastrophic when these individuals retire. Yet, the gap between perception and reality is sizable. One recent survey found that, among couples in which one or both spouses is working, only 41 percent actually participate in defined benefit pension plans, but 61 percent believe they will receive substantial retirement income from such a plan.

Clearly, the nation is in a period of rapid transition. In the larger context, global competitive pressures are forcing the private sector to eliminate defined-benefit pensions and retiree health care and to shift an increasing share of health care expenses to employees. At the same time, the fiscal pressures stemming principally from long-term security guarantees prevents the public sector from picking up the slack. We have become accustomed to a federal government that can fulfill its core responsibilities while commandeering no more than one-fifth of GDP. Over the next generation, we will face an historic choice: *We can have a federal government that plays a significantly smaller role in reducing insecurity and sharing risk, or we can have a government that consumes a significantly higher share of GDP.*

The first challenge is to identify new strategies for reducing individual risks to acceptable levels, while recognizing the special difficulties faced by low-income working families. The greater challenge may be to build broad-based support across partisan

and ideological lines for what is sure to be a difficult transition from a crumbling system to new social contract that reflects 21<sup>st</sup> century realities.

## **A New Social Contract<sup>1</sup>**

Government exists to achieve numerous economic ends: to help people do what they cannot do for themselves as individuals, as members of families and private associations, or as consumers; to treat as collective responsibilities misfortunes—natural disasters, birth defects—for which individuals cannot reasonably be held responsible; to use law to solve the coordination problems that can arise through disaggregated individual choices; to counterbalance individuals' tendency toward myopia and distorted estimates of risks; to correct for differences of income and wealth that affect individuals' capacities to provide for themselves; and to bolster, through various means, basic norms of individual behavior and of a decent society.

Consistent with these public goals, public programs should maximize economic growth, minimize moral hazard,<sup>2</sup> adverse selection,<sup>3</sup> and free-riding,<sup>4</sup> and respect the limits imposed by fiscal realities. And they should reflect both what we have learned about the circumstances under which markets work better than government (and vice-versa) and our shared social norms and understandings.

## **Specify Reasonable Elements of a New Social Contract**

Presidential candidate proposals to increase individuals' financial security first must *distinguish more clearly between savings and insurance*. Personal saving should be the social strategy for events that are likely to occur, such as spending a significant

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<sup>1</sup> This discussion assumes that Social Security will be restored to actuarial balance through a package of relatively modest benefit reductions and revenue increases that do not touch the basic structure of the program. The failure of efforts to convert a portion of current Social Security payroll taxes into private accounts suggests that public support for such moves is much weaker than now than during the stock market boom of the late 1990s.

<sup>2</sup> "Moral hazard" refers to how individuals might change their actions or behavior because the consequences of those actions are mitigated by insurance.

<sup>3</sup> "Adverse selection" refers to the problem that people who believe themselves at risk may be more likely to purchase insurance; thus insurers are not covering "average" individuals but a group likely to incur higher costs.

<sup>4</sup> "Free-riding" refers to the problem that occurs when people reap the full benefit of a good or service (for example, public television) without paying for it (responding to pledge week).

number of years in retirement, whereas insurance should be reserved for relatively low probability, high negative-impact events, like unemployment, catastrophic illnesses or injuries, or the early death of a spouse.

Second: to avoid free-riding, security-oriented programs *should mandate both savings and the purchase of insurance against risk.*

Third: the programs should *offer subsidies to mitigate the burdens of saving and insurance premiums on low-wage workers and their families*, in the form of progressive matching for savings, income-sensitive support for insurance premiums to cover catastrophic events, and income-sensitive payments for non-catastrophic costs above some percentage of income.

Fourth: the programs should *disseminate information and facilitate individual choice*, much as some current federal health programs do. For example, public programs should offer a range of self-financed, actuarially balanced choices above mandatory minimum coverage levels. And, they should be responsible for ensuring that information about choices is accurate and enables average citizens to easily compare their options with respect to costs, benefits, and other plan provisions.

Finally, the programs should *require all individuals to pay risk-based prices for insurance against self-incurred risks.* This would imply substantial changes in many programs, such as federal flood insurance.

### **The “Real Insurance” Model: Two Examples**

Working out the implications of this new social contract model would take years and many volumes. This discussion focuses on a single dimension—the increased use of programs structured as “real insurance”—and offers two policy proposals illustrating how this might work.

## Address adverse selection and catastrophic costs through reinsurance

While the lack of health insurance affects individuals in most subgroups of the U.S. population, the epicenter of the problem is now among those who are neither poor nor well-to-do, neither young nor old, and who are either self-employed or work in small firms. Only for firms with more than 100 workers have insurance plans become near-universal. And, because premiums under small-firm plans are significantly more expensive on average, fewer employees in such firms accept the coverage even when it is offered.

Most health economists agree that three factors principally drive the substantial price differences between large-group plans and small-group or individual plans. Per-capita administrative costs are lower in larger plans; the risk of adverse selection declines; and underwriting results are less likely to be skewed by a small number of high-cost enrollees.

Given the voluntary nature of health insurance purchases and the information asymmetry between buyers and sellers, insurers seek in various ways to protect themselves against costly customers. They use the limited amount of information they receive as a basis for restricting or denying coverage, and they build a substantial risk and uncertainty surcharge into plans for individuals and small groups. Political realities usually limit state governments' efforts to force insurers to offer policies on more nearly equal terms.

While states have experimented with a number of strategies to aid individual and small group purchasers, *the strategy that seems most likely to succeed tackles the problem of information asymmetry head-on*. This approach builds on the model of "reinsurance"—insurance for insurers—used extensively in the private sector. Although the details of possible program design are mind-numbingly complex, the basic idea is straightforward: the federal government agrees to pay a substantial fraction (75 to 90 percent) of individual expenses above, say, \$50,000 in today's dollars. If this

guarantee were limited to the people in the individual and small-group markets, the most plausible estimates place public sector costs at no more than \$20 billion annually.

In return, by eliminating the incentives for insurers to impose risk and uncertainty premiums on individuals and small groups, the reinsurance program would permit them to reduce their reliance on risk selection and to reduce premiums, which not only would make coverage more affordable for uninsured individuals, but also would enhance the overall efficiency of the insurance market. (This follows from the premise that information asymmetry and adverse selection create a kind of market failure.) By some estimates, premiums would fall enough to *bring insurance within the financial reach of between one-third and one-half of the individuals currently priced out of the market*. In addition, the shared public-private responsibility for very high-cost individuals would probably produce increased oversight of these cases, offering the possibility of further savings through improvements in care. Assuming that these estimates are within hailing distance of reality, this program illustrates how selective public investment could reduce overall societal costs—a type of public expenditure worth making whenever possible.

At present these estimates are theory-driven and model-based. However, there is an intriguing reference point at the state level. New York recently instituted a reinsurance program for low-income individuals and small firms that employ substantial numbers of low-wage workers. Based on a public guarantee to pay 90 percent of an individual's annual health care expenses between \$5,000 and \$75,000, premiums for program participants are only half of those in the traditional market. To be sure, these results have been obtained in a state with a highly regulated insurance sector. Starting in 1993, insurers participating in the individual and small-group market were required to issue policies to all comers and to use community rating. The result was a classic vicious circle—very high prices that drove younger and healthier customers out of the market, leaving a pool of increasingly sicker, costlier beneficiaries. The effect of instituting reinsurance in less regulated states would probably be less dramatic.



## Develop Real Insurance for Long-Term Care

Long-term care is already a big-ticket item in national health care spending. In 2003, long-term care spending from all sources totaled \$183 billion, or about 13 percent of all health care expenditures, and public programs—principally Medicaid and Medicare—financed nearly 70 percent of it. Medicaid’s share was \$87 billion (48 percent), and Medicare provided an additional \$33 billion (18 percent), which mainly covered up to 100 days of rehabilitation after an acute event. By contrast, private insurance of all kinds accounted for only 9 percent of the total, and long-term care insurance less than 5 percent. More than 70 percent of Medicaid’s long-term care outlays went to nursing homes, while Medicare’s spending was divided almost evenly between nursing facilities and home health care services.

There is every reason to believe that these figures will climb substantially—in constant dollars and as a share of GDP—over the next two generations, as the number of Americans over age 65—and especially the number over 85—rises. Depending on assumptions about medical advances and lifestyle changes, population projections suggest that the number of disabled elderly needing long-term care in 2040 will be between 2 and 4 times the current number.

Most elderly Americans never require extended stays in nursing homes or lengthy periods of dependence on professional home health services. The average (mean) nursing home stay is 2.4 years—higher for women, lower for men. Only 9 percent of stays last longer than 5 years. For home health services, the average involvement is less than a year. While private savings can help with these costs at the margin, relatively few families are able to save enough to protect themselves against the worst case, particularly since resources may have been depleted by a family member’s lengthy illness prior to the need for more costly, professional services. *Long-term care, then, is a classic insurable event.*

For various reasons, the private market for long-term care insurance has been slow to develop. Many people mistakenly believe that Medicare or their medigap supplemental

insurance policies will cover long stays in nursing homes. Medicaid provides no-cost default insurance for low- and moderate-income elderly without substantial assets and for whom the program's "spend-down"<sup>5</sup> requirement has less relevance. By the time most middle-income adults begin to consider purchasing long-term care insurance, they have reached the age at which annual premiums are very high, pricing many of them out of the market. (The average purchaser is 67 years old!) Adverse selection also may be pushing premiums up. (Some analysts believe that the percentage of risk-averse individuals purchasing long-term care insurance may very likely be high enough to offset buyers who have good reason to believe that they will need long-term care.) And insurers have difficulty estimating future price increases for long-term services and maintaining actuarial balance in the long run, in part because the fundamental service mix of "long-term care" is a moving target, due to technological advances and the movement from institution-based to home-based care.

Long-term care policy should shift dramatically toward private insurance as the principal funding source for many reasons. Increased reliance on private insurance would reduce fiscal pressures on the public purse, especially for states. It would mitigate harsh tradeoffs states now face between health care and other programs and would blunt powerful pressure to shrink Medicaid programs serving poor children. While the impact on overall health care costs is difficult to estimate, shifting to private insurance would certainly reduce the baseline costs of public entitlement programs and would be a step toward addressing our nation's largest future fiscal challenge. And it would reflect a morally as well as fiscally sustainable balance between individual and social responsibility that a savvy candidate could use to bridge some of the gap between liberal and conservative philosophy.

This report's specific proposal builds on, while substantially modifying, two existing programs. In 2000, Congress passed the Long-Term Care Security Act, which required the federal government to offer long-term care insurance to its employees and their families. The Office of Personnel Management conducted a competitive bidding

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<sup>5</sup> "Spend-down" refers to the depletion of family finances to the point where an individual is impoverished, in order to become eligible for, in this case, Medicaid.

process and contracted with large carriers selling long-term care insurance in the private market to offer an array of insurance products. The contract ensured not only a wide range of choices but also that information about each option would be reliable and standardized, in order to permit easy comparison among options. Under this initiative, annual premiums averaged 46 percent lower for single people and 19 percent lower for married couples than premiums for comparable policies in the private market. More than 200,000 individuals have purchased long-term care insurance under the program since its inception in 2002.

The second program, the Long-Term Care Partnership Program, was sponsored by the Robert Wood Johnson Foundation in the early 1990s. The basic idea was that individuals would be able to combine private insurance with Medicare by buying private coverage for a certain number of years (or for a certain level of expenditures), after which Medicaid would take over. Private insurance would reduce Medicaid outlays, while the presence of the Medicaid backstop would reduce premiums. Four states—California, Connecticut, Indiana, and New York—implemented Partnership programs before Congress, fearing that high-income individuals would use the program to abuse the Medicaid system, acted in 1993 to prevent new states from participating. Nearly 150,000 individual policies are in force, but only 2000 individuals are claiming benefits under the program, so far. We are thus some years away from being able to conduct a full evaluation of the financial performance of the program.

The proposal would work as follows:

- Every adult reaching age 40 would be required to purchase a long-term care insurance policy with certain specified features: five-year term, a benefit of at least \$150/day, automatic inflation adjustment, and low deductible.
- Individuals in households with incomes between 150 and 300 percent of poverty would receive income-related premium subsidies; those below 150 percent would be enrolled for free.
- The federal government would create a competitive bidding process along the lines of, but broader than, the current system for federal employees, with the aim of creating a large menu of carefully vetted, readily comparable choices.

- After the expiration of the five-year benefit period, Medicaid would assume full financial responsibility for individuals' subsequent long-term care costs, and they would not be required to spend down their remaining assets.

The choice of age 40 to mandate the purchase of insurance rests on a judgment as to when it is reasonable to expect adults to begin providing for events that may occur in later life. It also reflects a key fact about the long-term care market: while premium costs for 40-year-olds are not significantly higher than for young adults in their 20s and 30s, they accelerate more rapidly thereafter. Premiums for 60-year-olds are more than twice as high; for 70-year-olds, more than three times as high.

Insurers in the current federal program offer the policy to 40-year-olds for \$950 a year. With mandatory individual participation and more competition among insurers, premiums under this proposal should be significantly lower. As in the federal program, regulations would permit premium increases in only a narrow range of circumstances that companies would be required to document and subject to stringent review.

Under this plan, Medicare expenditures would be reduced somewhat as private insurance financed a portion of the 100-day rehabilitation period that Medicare now covers. The impact on Medicaid would be far larger in fiscal terms and much more significant structurally. The program's revised role in long-term care would be to: (1) create, through a competitive process, the plan options among which individuals could choose and provide information to assist them in making that choice; (2) ensure appropriate standards and safeguards; (3) subsidize premiums for low- and moderate-income individuals; and (4) serve as insurer of last resort after the five-year private benefit period.

## **Concluding Observations**

During the coming decades, an aging population will interact with advancing medical technology to generate both enhanced well-being and unprecedented fiscal challenges. If our thinking remains confined within current assumptions, we face an excruciating

choice between dramatically lower levels of personal financial security and tax increases large enough to inhibit economic growth. But, we can avoid the worst aspects of that choice and act more productively by updating the terms of the social contract—defining new roles for individuals and families, the private sector, and government that are consistent with emerging realities. The two policies sketched out here show how a new contract among individuals and families, government, and the private sector might be structured.

Under a new social contract, to the greatest extent possible, *individuals and families would be expected to take the lead in providing for their own futures*. Two factors will limit their contribution—financial resources and socio-economic changes that prevent family members from playing roles previously taken for granted. The geographic dispersal of extended families and increased workforce participation by women are two prime trends limiting the availability of family caregivers.

*Government* would step in to do for us collectively what we cannot easily do for ourselves as individuals. This is hardly a new principle, but its practical meaning would change. In the new social contract, government would assess and publicize information; employ laws and regulations to shape competitive markets for social ends; use incentives and, when necessary, mandates to counter myopia and free-riding; transfer resources to individuals who otherwise could not afford to participate in public programs; and act as insurer of last resort in case of unmanageable personal catastrophes.

The role of the *private sector* also would change significantly, recognizing that businesses are increasingly less likely than they were in the post-WWII era to provide security for their workers through pensions and low-cost health insurance. In return for being relieved of direct responsibility for these benefits, businesses would be called upon to participate in social markets and to bargain in good faith with the public sector concerning the terms of their participation. Publicly created markets would generate large revenue flows and economies of scale from which all citizens are entitled to

benefit, a principle that was conspicuously ignored in constructing the Medicare prescription drug benefit.

These broad principles generate policy templates with applications far beyond the two policies proposed. They suggest, for example, that the health insurance market should move toward a system of differential premiums reflecting the real costs of risky behavior, such as smoking. (A fair system would have to distinguish between risks to which individuals voluntarily expose themselves and the results of simple bad luck.) These principles also suggest a possible strategy for Medicare reform based on choice among insurance plans, subsidies for premiums, and an emphasis on expensive events rather than routine medical care. (This new system, however, would have to be carefully designed to avoid discouraging cost-effective preventive care.)

### **Political Feasibility**

Revising the post-WWII social contract in a manner that promotes important public purposes while sustaining broad-based public support will require a grand bargain between the center-left and the center-right. The center-left will have to acknowledge that individuals must assume greater responsibility for their own security, that the public sector cannot afford to discharge its core responsibilities without increased reliance on means-testing and other progressive cost-sharing strategies, and that government should make greater use of choice and market mechanisms to enhance efficiency and allow for individual variations in tolerance for risk and desire for security. For its part, the center-right will have to acknowledge that individuals cannot be expected to bear the full burdens of health insurance and retirement without substantial public sector involvement, that 20 percent of GDP is not a feasible size limit for the federal government in coming generations, and that, whatever size we agree government should reach over the next generation, we must pay for it.

To implement the grand bargain, the federal government by 2030 will have to be substantially larger as a share of GDP, fully funded, more market-oriented, more inclined to use its power to mandate rather than tax, more sensitive to the impact of

income differences on personal security, and more rigorous about expecting individuals and families, in proportion to their means, to share the risks and burdens of greater financial security.

Is it realistic to expect that our political system is capable of carrying out such wrenching changes? Up to now, neither political party has really tried to prepare the American people for the hard choices that lie ahead. In the private sector, however, some corporate and labor leaders are rethinking the model of employer-provided health insurance. And recent pension reform legislation has moved some distance down the road to mandatory savings. One thing is clear: over the next generation, U.S. domestic politics will increasingly revolve around the need for both qualitative and quantitative changes in the programs that provide financial security and concretely express our sense of mutual obligation.

Hammering out the terms of a new social contract will take a generation. No doubt the process will be messy. Nonetheless, we must begin the difficult task of reconciling our moral commitments with stubborn new realities. While clinging to the past may seem the safest and easiest course, in the long run it puts at risk everything we hold dear. The alternative to a new contract is *no* contract and a society in which the strong take what they can and the weak endure what they must.

## **About the Author and the Project**

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William A. Galston, a senior fellow at Brookings, is an expert in domestic policy, political campaigns, and elections. He served as deputy assistant for domestic policy to President Clinton, and directed national efforts on civic renewal led by Sen. Sam Nunn and Secretary William Bennett. Galston also served as an advisor to presidential candidates Walter Mondale and Al Gore.

Opportunity 08 aims to help 2008 presidential candidates and the public focus on critical issues facing the nation, presenting policy ideas on a wide array of domestic

and foreign policy questions. The project is committed to providing both independent policy solutions and background material on issues of concern to voters.

## **Additional Resources**

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