Policy Analysis

Cato Institute Policy Analysis No. 144: Long-Term Care: Why a New Entitlement Program Would Be Wrong

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Executive Summary

Despite all the talk of budget woes and runaway entitlement spending, some people in Washington are pressing for still another massive new entitlement program to pay for nursing home and home health care for everyone, regardless of wealth or income. A universal, comprehensive program to pay for such long-term care would probably add $60 billion to $80 billion in net new federal spending each year. Not only is such a new program financially infeasible, there is no sound policy rationale for it even if it were feasible. Lesser, incomplete versions of a universal long-term-care entitlement program represent incoherent policy and still involve infeasible new financial burdens for the federal government.

The federal and state governments already spend about $33 billion per year on long-term care. In general, individuals not covered by current government benefits can and should finance their own care through private insurance and other private-sector alternatives. Policy reforms can broaden the viability and attractiveness of private financing alternatives and even reduce future financial dependence on government for long-term care.

Nursing Home Care

Nursing home care breaks down into three categories. Custodial care involves providing shelter, food, and other basic necessities; structured activities and monitoring; and perhaps some minor assistance in daily functioning and moving around. Intermediate care includes more extensive assistance in the activities of daily living, such as eating, dressing, bathing, using the toilet, and moving around. Skilled nursing care involves assistance with those activities plus intensive medical treatment of an acute illness or injury.

The average cost of an intermediate nursing home is around $2,100 per month.(1) Skilled nursing facility care averages around one-third to one-half more, and custodial care averages about one-third less.(2)

About 5 percent of the elderly, or about 1.65 million retirees, reside in nursing homes at any one time.(3) Most nursing home stays are much shorter than is usually presumed:

* Fifty-two percent of those who enter a nursing home do not stay more than 90 days

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* Sixty-three percent do not stay more than six months;

* Seventy-five percent do not stay more than one year; and

* Only 16 percent stay more than two years.(4)

Skilled nursing facility care is generally short term, lasting a few weeks at most. The longest stays tend to involve custodial care.

The Government Pays for Those in Need

One key factor must be understood in order to soundly evaluate proposed reforms of long-term-care policy. In general, under current law, if an individual does not have the money to pay for necessary nursing home care, the government will pay for it. After a hospital stay of three or more days, Medicare will pay for up to 100 days of care in a skilled nursing facility, subject to a coinsurance fee of $74 per day after the first 20 days. Medicare spends close to $3 billion per day on such care.(5) In addition, Medicaid will generally pay for the nursing home expenses of individuals without the necessary funds. Medicaid expenditures for nursing home care currently come to approximately $23 billion per year, about 40 percent of the total spent for such care in the United States.(6)

Thirty states provide nursing home care under Medicaid through programs for the medically needy. In those states, single individuals without significant assets must contribute the funds from their own net income toward their nursing home expenses, except for a small personal needs allowance, and Medicaid picks up the remaining expenses. As noted above, a nursing home provides food, shelter, and other basic necessities for the residents, so they do not need additional funds to purchase those necessities. An individual can retain a home of any value, a car, and other person al belongings and household effects and still receive this Medicaid assistance.(7)

A major hardship used to occur under this system when one member of an elderly couple had to go into a nursing home and the other spouse remained in the community. So much of the couple's income and savings had to be contributed toward the nursing home expenses that the noninstitutionalized spouse was usually left with inadequate resources to finance his or her own basic necessities. However, under new provisions now being phased in, that spouse will be able to keep income of either spouse equal to 150 percent of the poverty line for a couple, which should total roughly $15,000 per year today, plus additional amounts to cover housing and utility costs in excess of 30 percent of income, up to a maximum of $18,000 per year. Further amounts of income can be reserved for the noninstitutionalized spouse upon a showing of financial duress. Income attributable directly to the noninstitutionalized spouse, including half of all income paid to the couple jointly, which in total exceeds the reserved income amount described above, can be retained by that spouse, but that spouse may not then retain any share of the income of the institutionalized spouse. The noninstitutionalized spouse will also be able to retain a minimum of $12,000 in savings, or 50 percent of savings if that amount is greater, up to a maximum of $60,000 in retained savings. States can choose to increase the $12,000 minimum retained savings to as much as $60,000, and both the $12,000 and the $60,000 limit are indexed to increase with inflation. The $12,000 to $60,000 in retained savings is in addition to the house, the car, and other household and personal belongings, which are also exempt.(8)

The other 20 states have a special income qualification limit for assistance to individuals in nursing homes. The limit is generally around $13,000 per year at present, though it is less in a few states. Individuals with incomes below the limit, whether single or part of a couple, receive nursing home assistance on the same basis as those in the other 30 states. Qualification of individuals who are part of a couple is determined only on the basis of income attributable directly to the nursing home resident.(9)

People with incomes above the limits, however, will not receive Medicaid nursing home assistance in these states even though nursing home costs may be in excess of their incomes. The system in these states nevertheless may, as a practical matter, effectively provide for people who are in need. Officials in these states may have found that those with incomes above the limits have resources in their families, perhaps their own savings or contributions from their children, that in combination with their incomes are generally sufficient to meet nursing home costs, particularly given the short duration of most nursing home stays. These states may also have special mechanisms to provide for people who still end up in need, such as special discretionary programs, block grant funds, or state nursing homes that accept individuals who cannot pay the usual nursing home fees in full.

These states should not be second-guessed without good reason. State officials may have effectively found a means of providing for people in need at less cost to taxpayers. Nevertheless, conceivably, some individuals in these states who need nursing home care could be left without the resources to pay for it. If that is indeed a real problem, the system used by the other states could be extended to these states. Reformers would be wise to focus their attention on this issue rather than on a costly and universal entitlement program.

An Estate-Planning Issue

Once the government has established a policy of paying for those who do not have the necessary funds, everyone is assured of access to nursing home care when needed. The only remaining problem involves those who do have the money to pay for their care, at least for a while. The concern here is how to prevent nursing home costs from consuming the significant life savings that a high proportion of the elderly have accumulated.

This is actually not a health policy issue at all; it is an estate-planning issue that can and should be addressed through the private sector. The government should not be using taxpayers' funds to preserve substantial private savings and estates.

The actual potential drain on the savings of the elderly due to nursing home care needs to be more carefully examined. Close to 90 percent of the elderly in nursing homes are single.(10) The income of these individuals generally can be used to cover part of their nursing home costs, since they do not have spouses who are dependent on that income for support. The current median income for elderly single retirees can be estimated as roughly $800 per month.(11) As noted above, 52 percent of nursing home stays currently last 90 days or less. Indeed, 34 percent last 30 days or less.(12) Intermediate care of 90 days or less, which costs around $2,100 per month, would require less than $5,000 from private savings, given at least partial contributions from income. The large number of stays of 30 days or less are mostly stays in skilled nursing facilities. A stay of that length covered by Medicare would cost the patient only $740 in total, for the Medicare coinsurance fee during the last 10 days. At least 75 to 80 percent of those who need skilled nursing home care meet the three-day prior hospitalization requirement for Medicare coverage.(13) For a 30-day stay not covered by Medicare, even assuming that income is not available to pay for the care because of the need to cover ongoing expenses during a short stay, the total required contribution from savings would be significantly less than $5,000. Consequently, the required contribution from private savings for about half of all nursing home stays for single retirees would be $5,000 or less.

A quarter of nursing home stays last between three months and a year, and half of those last less than six months. Intermediate care for six months can be financed for around $8,000, on average, from private savings, given feasible income contributions. Intermediate care for those staying a year can be financed for around $16,000, on average, from private savings, given income contributions. Custodial care for a year would require less than $10,000 from savings, given income contributions. Consequently, the great majority of nursing home stays of single retirees would require less than $20,000 from accumulated savings.

The family income of the small proportion of elderly nursing home residents with spouses in the community, about 12 percent, will be needed mostly to sustain the noninstitutionalized spouse and will not be available for the nursing home, except in the case of people whose incomes are well above average. But the Medicaid provisions discussed above protect substantial amounts of a couple's savings. A couple would have to have at least $40,000 in liquid savings before they would be expected to contribute $20,000 to the nursing home care of the institutionalized spouse.

Those who do have resources should use their own funds to finance their nursing home care before the taxpayers are asked to pay for it. It is not unreasonable to ask those who can to pay $10,000 to $20,000 for their own care, which would cover most nursing home stays. Indeed, those expenses are exactly what retirement savings are for. Public policy favors such savings in various ways precisely so they will be available to cover such costs. Single retired nursing home residents are usually quite elderly disabled persons; contributing to their own personal care in the last few months or years of life is surely a reasonable and sensible use of their savings. A substantial proportion of the savings of the small number of nursing home residents who have spouses in the community is sheltered for the noninstitutionalized spouse in any event.

Most important of all, however, those who want to prevent nursing home costs from consuming their life savings can do so by using part of their accumulated savings to pur chase private insurance to protect the rest. The elderly who need the insurance are those who do have substantial accumulated savings to protect, and by definition these individuals have sufficient funds to pay for the insurance. While private nursing home insurance is relatively new, close to 120 private companies offer such insurance today, and it is available across the country.(14) About 1.5 million elderly people already have such policies.(15)

People with enough resources to need protection from the costs of extended nursing home stays that may require more than $20,000 from savings can use the private insurance option. Moreover, newly developing insurance and financing products should be attractive and accessible even to those with relatively modest liquid savings to protect from the costs of shorter stays. Long-term-care riders can be added to life insurance policies to provide for the phase-out of paid-up death benefits at retirement and the phase-in of nursing home benefits in their place. Or the rider can allow the cash value of a life insurance policy to be used to finance necessary nursing home costs before death, instead of being paid to a beneficiary after death. Through these options, for a modest cost the frozen cash value of life insurance policies can be freed to finance nursing home expenses while existing liquid savings are kept intact. The total face value of life insurance policies accumulating cash value was a least $2.7 trillion in 1988,(16) which means the public is already accumulating vast reserves that can be used for nursing home care. About 60 percent of the elderly own life insurance policies today.(17)

Another frozen asset broadly held by the elderly is home equity.(18) About three-fourths of the elderly own their own homes, in which median equity is probably around $60,000 or more.(19) About 83 percent of elderly homeowners (62 percent of all the elderly) own their own homes free and clear of any mortgage.(20) Under a reverse annuity mortgage, the elderly homeowner would receive a payment each month in return for a mortgage on the home that would grow each year, reflecting the monthly payments, until the mortgage reached 80 percent of the home's value. The mortgage would be paid off when the home was sold. These reverse annuity payments could be used to pay for nursing home insurance, again keeping existing liquid savings intact.

Another alternative would allow retirees to retain access to their liquid savings while using those savings to obtain nursing home coverage. Individuals or couples can transfer current savings into a combined nursing home/life insurance policy that requires no further premium after the initial transfer. (This is known as a "single-premium" policy.) The funds transferred to the policy would earn competitive market interest that would accumulate in the policy tax free. The policy would provide the insureds with nursing home benefits equal to a multiple of the contributed earnings and interest, depending on the amount put into the policy, age at time of purchase, and length of participation in the plan. The unused amount of nursing home benefits would be paid at death as a life insurance benefit. Moreover, individuals could withdraw part or all of their contributed savings and accrued interest at any point, with a proportional adjustment in the nursing home and life insurance benefits.(21)

Under current law, about half of the nation's nursing home costs are paid through the private sector by those who do have the resources to finance their own care. There is no reason for the government to take over this expense. The sound role for government policy is to facilitate and promote further development of well-structured private insurance and other attractive and viable means for individuals with resources to finance their own care through the private sector. The government can help in particular by removing its own tax and regulatory barriers to such development. The government can also adopt policies to promote the development of additional resources that would be available in retirement to help cover nursing home expenses, thereby reducing dependence on government assistance.

Home Health Care

The phrase "home health care" covers a broad range of services provided in the home. Those services can include intensive medical treatment, skilled nursing care, and medically related therapy. They can also include simple assistance with or performance of basic daily living activities for those who can no longer engage in those activities unaided. Such activities include eating, dressing, bathing, grooming, using the toilet, moving about, cooking, cleaning, shopping, doing the laundry, and driving. Those "soft" services can be generally referred to as personal care.

Medicare and Medicaid

Medicare already pays for medical services provided in the home for the elderly. Physicians' services or any other medical treatment normally covered by Medicare is covered just as well if it is provided in the home by a qualified professional. In addition, Medicare will pay for an unlimited number of visits to the home to provide the medically oriented forms of home health care that supplement a physician's treatment of illness or injury. Such services may include skilled nursing care, physical therapy, speech therapy, and occupational therapy. The program will also pay for medical supplies used to provide such care and 80 percent of the cost of durable medical equipment used in the home. Medicare spends close to $3 billion per year on these home health care services.(22)

In every state Medicaid also covers such medically oriented home heath care for those who qualify for the program.(23) In addition, Medicaid covers the softer personal care services to varying degrees in 26 states.(24) However, New York State's liberal personal care program accounts for around 80 percent of Medicaid personal care expenditures nationwide, and about three-fourths of that money is spent in New York City.(25) Federal and state Medicaid expenditures for personal care in New York currently total close to $1.5 billion per year,(26) about $1 billion of which is spent in New York City. In addition, 27 states provide Medicaid home health coverage to those who would otherwise be in nursing homes at the program's expense. This coverage, on average, is to cost no more than nursing home care for the same individuals. Just about any service may be provided under this coverage--personal care, housekeeping, transportation, and even home modification--to enable the individual to remain at home.(27) Overall, federal and state Medicaid expenditures for home health care services total close to $4 billion per year.(28)

A Family Affair

Close to 5.5 million elderly people outside nursing homes need regular home health care involving the softer personal care and housekeeping services.(29) The overwhelming majority of that care is provided free of charge by family members and acquaintances. Even counting government-funded assistance, over 70 percent of the elderly who require such care receive it exclusively from these unpaid sources.(30) Only 5 percent receive all their care from paid professionals.(31) The rest receive assistance from a combination of paid and unpaid help.

The government's role in providing these personal care and housekeeping services should be limited to paying the costs for retirees who would otherwise be in a nursing home at government expense and for whom, on an individual basis, the cost of providing care in the home is less than that of nursing home care.(32) This role would ensure that the government would provide assistance whenever it was absolutely needed--when an individual could not do without the services, could not pay for them directly, could not find someone to provide them for free, and, therefore, was headed into a nursing home at government expense. At the same time, it would limit assistance to those in true need and actually reduce net government expenditures by substituting home health care when it would be less expensive to the government than nursing home care.

Otherwise, personal care and housekeeping services can and should be provided by family members and others, as they are today. Such care is a family responsibility, and there is no reason why it should be shifted to paid professionals financed by the taxpayers.

Elderly Couples. The healthy spouse in an elderly couple can, and generally does, provide personal assistance to the disabled spouse. For occasional relief, adult children, other relatives, friends, church groups, and other local organizations can help to provide care. Hiring someone to attend to the disabled spouse once in awhile is also feasible, just as young parents sometimes hire sitters to tend their children. If the healthy spouse is unable to provide the needed care, the couple lacks sufficient funds to pay for the care directly,(33) no one else is available to provide the care for free, and the disabled retiree cannot function in the community without assistance, then the retiree would be eligible for Medicaid nursing home benefits under the new spousal impoverishment rules, which would protect substantial income and savings for the noninstitutionalized spouse. Under the government home health care role discussed above, the disabled spouse would also qualify for government-financed personal care assistance in the home as long as that care cost less than nursing home care.

For those couples with more substantial resources, private nursing home coverage would protect their resources if one spouse had to go into a nursing home because neither the other spouse nor anyone else could provide the needed care at home. In addition, the couple can purchase private home health care coverage to preserve the option of staying at

home with paid home health care while protecting their resources from the cost of such care. Coverage for home health care is generally available along with nursing home coverage, usually at one package price or at relatively little additional cost. Riders on life insurance policies, reverse annuity mortgages, and joint long-term-care/life insurance policies with withdrawal options, discussed above, can all be used to provide resources for home health care while protecting liquid savings.

Single Elderly Retirees Living with Their Children. Most of the single elderly who need personal care live with the families of their adult children, who provide the needed care themselves.(34) Substantial resources are available to the family to help with such care. The retiree's income is completely available to the family, which is providing for all of the retiree's needs. As noted above, the median income of single retirees is around $800 per month, or close to $10,000 per year. Since the elderly parent is living in the adult child's home, any equity in the parent's former home is available to the family as well. Such equity has a median value of around $60,000 or more, as also noted above. The liquid savings of the elderly parent are also available to the family. These resources more than compensate for the cost of food, clothing, and shelter within the family's home and other necessities for the elderly parent, which would not be a substantial burden in any event, leaving funds to pay for some hired assistance as well, if desired.

Providing personal care directly may be more difficult for two-earner couples. But those families have at least three incomes, including the resources brought to the family by the elderly parent, and substantially above-average total income and resources. Such families should not be looking to the taxpayers to pay for their needs. Rather, they can and should purchase personal care services to cover times when both spouses are at work and no one else is available to assist with care. These families can also purchase private insurance coverage to protect their liquid resources.

Nevertheless, if the adult children, for whatever reason, cannot provide the needed care directly and others are not available to do so, then the elderly parent living with an adult child's family can still seek government assistance based on the parent's resources alone. If the parent lacks sufficient resources to pay for the care directly(35) and without the care would have to go into a nursing home at government expense, then, again under the government home health care role discussed above, the elderly parent would qualify for government-financed personal care within the adult child's home, assuming that such care cost less than nursing home care. But substantial contributions to the cost of this care from the parent's income should be required, since the adult child's family can provide shelter, food, and other basic necessities at little additional net cost to the family budget. This would be only fair to taxpayers, since families should provide for their own needs when they can. Contributions from the parent's income would also provide a major incentive for the children to make every effort to provide the care themselves and avoid the loss of the parent's income to the family

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If the elderly parent does have sufficient resources to pay for his or her own care, at least for a while, then the parent would not immediately qualify for government assistance. With the adult child's family providing shelter, food, and other necessities, many parents may well be able to finance the care they need out of their own incomes and other resources indefinitely, depending on the amount of care needed. Otherwise, private nursing home coverage can protect the savings of the parent, and home health coverage can preserve the option of staying at home while shielding resources from home health care costs. Parents with modest savings may also pay for home health care directly until the taxpayers pick up the burden. The children would again have a major incentive to make every effort to provide care themselves to avoid loss of the parent's income and savings to the family. The entire analysis of single elderly retirees living with their children applies as well to such retirees living with the families of other relatives who are still working.

Elderly Retirees Living Alone. About 10 percent of single retirees who need assistance with personal care live alone.(36) Those individuals can and do receive needed care without charge from their children, other relatives, friends, church groups, and others. When necessary, single retirees can move closer to such potential volunteer providers to facilitate care. They can also hook up with other elderly retirees as roommates who can help provide regular care, if they cannot move in with adult children or other relatives.

If volunteer sources ultimately fail to provide essential care and the retiree does not have the resources to pay for such

care, necessitating nursing home institutionalization at government expense, then again the government's role would be to pay for the essential home health care as long as it cost less than a nursing home. Contributions to the cost of such care from the retiree's income should be required when feasible, but the retiree should be allowed to retain enough income to meet the expenses of living in the community in a viable manner. This would be necessary for the home health care option to be a practical alternative, and as long as the total net cost to the government for home health care still remained less than the cost of nursing home care, costs to the government would still be effectively reduced. Single retirees with more substantial resources could protect those resources through private insurance mechanisms or by paying for their care with modest savings until eligible for government assistance.

The Entitlement Fiasco

A new entitlement program for long-term care would take the government beyond providing for those in need to paying for the nursing home and home health care costs of everyone, regardless of wealth or income, including millionaires. Such a program would be enormously costly. Total nursing home expenditures in the United States this year are likely to be at least $55 billion,(37) and total home health care expenditures are likely to be at least $15 billion.(38)

But that is only the beginning. Less than one-fourth of those who need long-term care are in nursing homes. The remaining three-fourths are in the community receiving care from their families and others.(39) If the government were to start picking up nursing home costs across the board, many more people would enter nursing homes, sharply increasing the program's costs. With three-fourths of those who need assistance still outside nursing homes, the potential for a sharp increase in nursing home utilization once the government starts paying all the bills is enormous.

Moreover, the problem for home health care is even worse. As noted above, in-home medical care and related supplemental services to aid recovery from acute illnesses and injuries are already covered for all of the elderly by Medicare. What is at issue is whether the government should provide the softer personal care services for everyone as well. As noted above, around three-fourths of the elderly who need personal care receive it entirely from family members and others without charge, and most of the rest receive at least part of their care in that way; only 5 percent rely entirely on paid care.

If the government offered paid professional personal care to everyone, such care would massively displace the current voluntary care. This is especially so since the volunteers find providing the care burdensome, while the elderly and their families find home health personal care, unlike nursing home residence, quite attractive. People do not want to go into nursing homes. But as discussed above, the personal care services at issue here involve professionals coming into the home to provide cooking, cleaning, laundry services, bathing, dressing, grooming, feeding, shopping, and other similar services--the equivalent of the services of a battery of free maids and cooks. All of the elderly who can qualify for such service will want it, and their families will want them to have it. Indeed, the energy of family members that formerly went into caring for an elderly person will go into lobbying the bureaucracy for government-funded professional care.

In addition, because the home health personal care services are so attractive, many of the elderly who do not receive such assistance now will try to qualify for the government-provided personal care, and many will succeed. The history of the Social Security disability program, which includes a relatively objective, strict requirement that beneficiaries not be able to work at all, shows that the government is unable to prevent many ineligible people from receiving assistance even with such a clear and stringent test. The question of whether an elderly retiree needs personal care assistance is far more murky and subjective.

Taking the abuse even further, many family members who formerly provided free care will instead arrange to receive free services themselves when the government is paying the bill. For example, a home health aide who is cooking for an elderly recipient will often end up cooking for the whole family. Or when a home health aide is doing housecleaning or laundry or shopping for an elderly recipient, the aide will often end up doing those chores for the whole family. This is natural when the elderly recipient lives with a spouse, but it will also happen often when the elderly recipient lives with the family of an adult child. It happens today with Medicaid-financed home health care. Because home health care is provided in the privacy of the home, controlling such abuses would be impossible. All

this abuse and unnecessary utilization of home health care would again sharply increase the costs of the program.

An entitlement program would also produce a massive increase in demand for nursing home and home health care services, which would sharply increase the fees charged for such services, as has been the case with other government programs--from health, to education, to defense. It would also eliminate incentives for consumers to shop for the lowest cost care alternatives and to avoid unnecessary care. Instead, they would demand any care or service whose benefits were greater than zero regardless of cost without even considering whether the charges were competitive or reasonable. Given the open-ended, attractive nature of personal care services in the home, the entitlement incentive structure would be likely to lead to a ballooning demand for services that are neither necessary nor cost-effective.

With consumers relieved of cost concerns, providers will have no incentive to attempt to keep costs down either. They will instead have every incentive to try to pile on as many services as they can get each consumer to accept. Advocacy and political pressure groups for the elderly will lobby for the delivery of the broadest possible range of services to each elderly recipient as well. All of those factors would further increase the costs of the program. The government would naturally try to counter such cost pressures through various regulatory and bureaucratic controls, but it would not be sufficiently successful to avoid a major increase in costs.

Some argue that an entitlement program offering home health care to all would actually save government funds on net by allowing more of the elderly to be cared for at home instead of in high-cost nursing homes at government expense. Several research and demonstration projects have been con ducted to test that contention. They have found that expanded home health care programs increase government costs by increasing the use of government-paid professional care by elderly people at home, while not significantly reducing nursing home use.(40) The potential for home health care to reduce costs even if it resulted in reduced institutionalization is also too easily exaggerated. Any paid home health care involving more than 12 hours of service per day is going to cost more than nursing home care, given any reasonable hourly rate for home health care. Yet the elderly who might turn to home health care in place of a nursing home will often need that much care and more. Seventeen percent of the elderly served by the New York State personal care program receive 24-hour care, 7 days a week,(41) which could not possibly cost less than a nursing home.

Finally, any government nursing home program, means tested or otherwise, that provided for home health care when it was less costly than nursing home care at government expense would realize all the savings for the government that home health care could possibly provide. An entitlement program for home health care could not possibly add to that savings.

$60 Billion to $80 Billion per Year

Considering all these factors, a nursing home and home health care entitlement program for every one could easily cost $60 billion to $80 billion per year in net new federal spending. If the percentage of the disabled elderly using nursing homes increased by just 8 points, from 25 to 33 percent, under a new entitlement program, the result would be $18 billion in additional spending on nursing home care, besides the current $55 billion or more, for a total of $73 billion. Subtracting the $26 billion the government already spends leaves $47 billion in new spending.

If the percentage of the disabled elderly who rely entirely on paid home health care increased from 5 to 17.5 percent, the percentage utilizing some professional care increased from 20 to 40 percent, and a small number of elderly sought care for the first time because of the new program and received it in part from that source, the result would be about $25 billion in new home health care spending, which would increase the total from $15 billion to $40 billion. Remember New York City alone in its liberal Medicaid program already spends $1 billion per year on personal care alone, and that program is not an entitlement for everyone. Subtracting the $7 billion in current government home health spending from the $40 billion total leaves $33 billion in net new spending. Adding the $47 billion in new nursing home spending brings total net new spending for the entitlement program to $80 billion.

Perhaps the new program would require substantial contributions from the incomes of single nursing home residents and single home health care recipients living with their children. Considering the median income of the elderly and the proportions of the disabled elderly utilizing nursing home and home health care, one may assume that a strict contribution requirement might raise as much as $20 billion. But that would still leave net program costs at $60 billion.

Rising prices for care resulting from increased demand, more intensive service utilization by those receiving care, and other effects of the new entitlement incentive structure as well as greater new utilization than assumed above, which seems likely particularly in home health care, could easily add another $20 billion to program costs, which would bring the total back to $80 billion.

Adopting such a huge new entitlement obligation to the elderly in the face of already large budget deficits, and the pending retirement of the baby-boom generation, would be foolhardy. Medicare itself is already projected to run deeply into the red, requiring increases in the program's payroll tax rates of as much as 475 percent by the time today's young workers retire, according to the latest official government reports.(42) The required Medicare payroll tax rates alone could be higher by then than payroll tax rates for all of Social Security are today. We need to focus on bringing the fiscal obligations we already have for Medicare under manageable control instead of looking at new unmanageable obligations.

Moreover, there is no sound rationale for adopting such a huge new long-term-care entitlement obligation. Once the government adopts a policy of providing for those who do not have the resources to pay for their care, the rest can and should finance their own care through private savings and insurance. To go further and pay for the care of everyone regardless of need would impose an unfair, unnecessary, and heavy burden on taxpayers. Indeed, the huge new tax burden to finance this additional spending would undoubtedly be regressive, falling mostly on working people with less in resources to preserve the resources of those who have more, including many who have quite substantial accumulated estates. Such a heavy new tax burden would also substantially harm the economy, slashing economic growth and stifling job opportunities, which would again most hurt those with less in resources.

Recognizing that a full-blown entitlement program is infeasible, some have proposed more limited entitlement benefits. One proposal would pay nursing home expenses after the first two years in an institution. But that proposal would benefit only the richest of the elderly who would still have significant assets to preserve after two years of paying nursing home costs totaling around $50,000 out-of-pocket. Those with less in resources would have used them all up before the initial two-year period ran out and would already be receiving government aid under current law. Even staunch entitlement advocate Robert Ball has strongly criticized this proposal on these grounds. The people the proposal would help are clearly able to purchase private insurance to protect their extensive resources and therefore should not be looking to the taxpayers to pay their bills. Imposing a burden on taxpayers to benefit these individuals would be most unfair.

The Pepper Commission Proposal

Another, somewhat slimmed down alternative was offered recently by the majority of the Pepper Commission, composed of members of Congress appointed to develop recommendations on long-term care.(43) This proposal has three major components. The first would pay for the first three months of nursing home care for everyone; individuals with incomes over 200 percent of the poverty line would pay a daily coinsurance fee equal to 20 percent of the average nursing home charge. But the first three months of care do not threaten life savings. As discussed above, such a stay would generally cost single retirees less than $5,000 of accumulated savings, given some reasonable contribution from income, and couples would bear a similar burden only after substantial savings and income were protected. There is no reason why those who have the resources to pay this expense should not do so, which indeed would leave most of the elderly with still significant savings. Moreover, mostly free three-month nursing home stays would encourage a sharp and unnecessary increase in utilization, as many disabled retirees and their families would be able to use a short nursing home stay for a little rest and relaxation and a chance to get away, particularly, for example, during months the rest of the family might go on vacation. Nursing home providers would design services to make this attractive, and little basis would exist for denying disabled retirees entry to a home if that were their choice.

The second component of the plan would substantially lessen the current means-tested requirements for assistance with longer nursing home stays. For example, when one spouse has to go into a nursing home, the income the other spouse could retain exempt from nursing home expenses would increase from 150 percent of poverty, or about $15,000 today, to 200 percent of poverty, or about $20,000. The non- institutionalized spouse could also retain $60,000 in sav ings exempt from the expenses, rather than 50 percent of savings with a minimum of $12,000 and a maximum of $60,000, as under current law. This dramatic expansion of spending obligations is unwarranted, as current protections for

couples are ample. Sharply expanding the government's responsibility to protect more and more savings and income would simply displace the private means of protecting resources, at unnecessary expense to the taxpayers.

For elderly singles, the majority of the Pepper Com- mission would exempt $30,000 in savings from nursing home expenses, while requiring incomes to be mostly contributed toward expenses after the first three months of a nursing home stay. The $30,000 savings exemption is again unwarranted. The elderly with modest savings can still use the single-premium nursing home/life insurance policies that keep savings accessible, life insurance riders, and reverse annuity mortgages to protect their savings. Moreover, if individuals do not obtain such private coverage, it is again not too much to ask that those who do have some modest savings contribute those funds to the cost of their own care before the taxpayers are asked to pick up the bill. Those who stay in a nursing more than a few months are unlikely to return to the community, except in the care of adult children or others who would be providing basic needs, and their savings are therefore no longer needed for their support. Shorter stays would consume only a few thousand dollars of savings, which would not be a significant source of support in any event. Again, such expenses are exactly what retirement savings are for. What could be a more reasonable or acceptable use for the last modest savings of a single, disabled, quite elderly nursing home resident? The alternative policy is to tax working people to ensure that such residents never spend their savings and die with those funds in the bank, which would make no sense.

The third component of the majority plan is a full- blown entitlement program for the complete range of home health care services, including all the personal care services from personal assistance to cooking, housekeeping, doing the laundry, grocery shopping, and providing transportation. Individuals with incomes greater than 200 percent of poverty would pay only a coinsurance fee equal to 20 percent of the average cost of such care. This part of the plan is subject to all of the criticisms and analysis of government-financed home health care discussed earlier. The government already provides truly medically oriented services in the home to the elderly, and the personal care services can and should be provided by family members and other relations, as they are in the overwhelming majority of cases today. In the few cases in which volunteer assistance is unavailable and personal care services are absolutely needed or institutionalization will result, the government may pay for those without sufficient resources who would otherwise be publicly supported in a nursing home at greater expense, and private insurance can protect the savings of those with more substantial resources. The Pepper Commission's home health care entitlement plan would again massively displace the current voluntary care from family and others, encourage the elderly to seek more personal care services, expose the government to wide abuse, eliminate most incentives to control costs, and send the price of home personal care services soaring.

Individuals would qualify for assistance under this entitlement if they needed assistance in three of five activities of daily living--eating, dressing, bathing, using the toilet, and moving about. The Pepper Commission majority treated this requirement as limiting assistance to only severely disabled individuals, but that is an exaggeration. The extremely liberal proposal advanced by the late Rep. Claude Pepper (D-Fla.) in 1988 required that assistance be needed in two of those five activities. Moreover, determining whether an elderly individual needs assistance in any of those activities is at least somewhat amorphous and subjective. The requirement, therefore, does not provide a strict, bright-line limit, and it does not obviate the above-noted criticisms. Moreover, individuals could also qualify for home health care assistance on the basis of one of two other even more vague standards--a need for constant supervision because of cognitive impairment that impedes the ability to function, or a need for constant supervision because of behavior that is dangerous, disruptive, or difficult to manage.

The commission majority touted case managers, who would determine need and authorize services for each case, as effective means of controlling costs and abuse. But case managers would not be able to control the problems noted above. Family members and others who would have formerly provided care can too easily disclaim ability to fill the need responsibly once government-financed professional care is available. And officials have again been unable to keep ineligible people off the roles even for the far stricter disability program with its much more concrete eligibility test. Case managers would also have no means to counter the abuses of the system within the privacy of the home, as discussed above.

The Pepper Commission itself estimated that its long-term-care proposal would increase net federal spending by $43 billion per year. But even this huge sum is surely an underestimate. While some resulting increase in nursing home utilization was admitted, the likely dramatic increase in professional home health care utilization was ignored.

Moreover, no effort was made to account for the program's effects on incentives and prices. Given the track record of official estimates of costs for new government programs, if the promoters are already projecting $43 billion in net new costs, the actual cost is likely to be staggering. A more realistic estimate of the cost of the Pepper Commission's long-term-care proposal, given the number of people potentially eligible and all the other factors, is over $60 billion. As noted above, adopting such a huge new entitlement obligation now would be unwarranted and foolhardy.

The Politics of Long-Term Care

Entitlement advocates insist that the public is overwhelmingly in favor of a massive new long-term-care obligation for the government. But the politics of the issue do not compel support for such a new program. Quite the contrary, a new long-term-care entitlement program is politically infeasible.

The elderly are not nearly as worked up in support of such a new program as the advocates suggest. This is clearly revealed by comparing the grassroots pressure for such a program with the grassroots response to the catastrophic health insurance income tax surcharge. The volume of opposition from the elderly to the catastrophic tax dwarfed what is heard from the elderly about long-term care. The catastrophic tax episode showed what the elderly are capable of when they are really concerned about something.

Another example is the experience of the much vaunted Long Term Care 88 project, which was a massive, lavishly financed, highly organized effort by the American Association of Retired Persons and several other advocacy groups to make their demand for a new long-term-care entitlement program the central issue of the 1988 campaign. The effort failed badly. The issue never arose in the presidential campaign, despite its champions' best efforts. It surfaced significantly in a few congressional races but never took hold nationally. If several candidates had been defeated by this highly sophisticated lobbying effort, the groups would have touted those defeats as establishing deep public suport for the program and a political imperative for adopting it. By the same token, the failure of the project to surface as a significant issue during the campaign shows, once again, that the public is not nearly as exercised in favor of the program as its advocates contend.

The elderly in fact are not enthusiastic about a government nursing home program because they do not want to go into nursing homes. Each of them plans to do what he or she can to avoid it, and consequently many do not see such a program as really helping them directly. Many surely surmise that such a program would increase the likelihood that their families would end up putting them in nursing homes. The home health personal care benefits, by contrast, are quite attractive and therefore have much more grassroots political support. As the preceding analysis shows, however, a universal entitlement to personal care would create intractable problems of displacement of private care, unnecessary utilization, and uncontrollable abuse. Such care ultimately must remain primarily a family responsibility.

Moreover, the most important political factor by far is that the taxpayers will not accept the massive new tax increases needed to finance a universal long-term-care entitlement. Congress could not find $7 billion or $8 billion per year in new taxes to finance the catastrophic health care program, let alone $60 billion to $80 billion for longterm care. The Pepper Commission could not come up with any new revenue to fund its proposal either. There are just no new tax lambs waiting to be sheared for so much wool. That is why a long-term-care entitlement program is politically infeasible and will not be adopted.

One source of tax revenue often touted by entitlement advocates is to remove the current cap of $51,300 on wages subject to the Medicare payroll tax of 2.9 percent and to apply that tax to all wages. But this tax would be woefully inadequate, raising only about $7 billion per year, assuming no effect on behavior. The tax would raise the top marginal rate in the federal tax system from 28 to 30.9 percent,(44) a 10 percent jump, reneging on the tax reform compromise of reduced rates in return for reduced deductions. The tax would also fall entirely on just 5 percent of workers, which means it would not follow the principle of social insurance, whereby workers are supposed to contribute to their own future benefits. Rather, it would rapaciously place the entire burden of the $7 billion tax on just one small group of taxpayers who would be forced to pay for benefits for everyone. Our democracy will have been totally perverted if it sinks to the low of imposing steep tax burdens on small groups to fund freebies for everyone. The public has never supported such a policy because they recognize it as grossly unfair and because they can see that if one small group can be targeted today, anyone could be similarly targeted tomorrow.

Advocates of this tax contend that allowing workers who earn more than the cap to avoid the Medicare tax on their wages above the ceiling is unfair. But just the reverse is true. The current system is unfair to workers at and above the cap; they pay more in Medicare taxes than everyone else yet receive no more in medicare benefits. Workers at and above the current $51,300 wage cap pay more than three times the tax paid by workers who receive $15,000 in wages, and more than twice the tax paid by workers who receive $25,000 in wages, yet receive exactly the same Medicare benefits. Eliminating the cap on taxable income would sharply increase the unfairness for these workers.

Some have even ludicrously suggested eliminating the $51,300 cap for the Social Security payroll tax as well and applying the entire 15.3 percent payroll tax rate to all wages in order to fund a long-term-care commitment. This would raise $36 billion per year assuming no change in behavior, but vigorous effort to avoid this heavy new tax would probably lead to substantially less new revenue. The revenue would still be grossly insufficient to fund a universal long-term-care entitlement in any event. This tax increase would raise the top marginal tax rate by 55 percent to 43.3 percent,(45) shattering tax reform. Moreover, imposing this entire massive tax increase on just 5 percent of workers goes far beyond what most would consider reasonable or acceptable tax policy worthy of serious consideration. Income above the cap today is not counted in calculating Social Security benefits, so exempting the income from the payroll tax as well is a fair policy.

Proposals for Reform

Instead of the outdated and unjustified big-spending and big-taxing entitlement approach, with wasteful and counterproductive effects, an alternative package of reforms can meaningfully help people meet long-term-care expenses efficiently through private markets.

Encourage Development of Appropriate Private-Sector Coverage

Policymakers are applying too much pressure to insurers to offer only comprehensive policies that cover almost all long-term-care expenses, effectively discouraging lower cost insurance. Instead, policymakers and insurers need to realize that the elderly who do not qualify for Medicaid do have substantial resources that could be applied to long-term- care expenses and that a policy with lower premiums that simply covers a major part of the costs may be adequate to meet their needs and protect the bulk of their resources. For example, for most single elderly people who are in nursing homes or live with their children and need some personal care, a policy paying $50 a day for nursing homes and $30 a day for home health care with some inflation adjustment over time may be sufficient, given that these individuals can contribute their incomes to the cost of their care and that the families of their adult children can help with personal care as well as provide basic necessities.

Moreover, policymakers need to recognize that some other newer, less traditional products have highly attractive policy features and should be strongly encouraged. The single-premium long-term-care/life insurance polices that pay interest on the up-front premium and allow the funds to be withdrawn if needed are highly desirable. Any elderly person with significant savings can afford such a policy since the funds remain available for withdrawal if needed for other, higher priority purposes. Nursing home benefits equal to a multiple of such savings provide adequate coverage. Most important, the insured would still have every financial incentive to avoid using unnecessary nursing home or home health care services and thereby avoid depletion of the funds available for withdrawal or as a legacy to children or other heirs through the life insurance component. The children or other heirs would also have every incentive to help out and avoid unnecessary utilization, thereby preserving the life insurance benefits available to them. The same positive features are provided by long-term-care riders on life insurance policies. Reverse annuity mortgages to fund long-term-care expenses directly would also maintain incentives to avoid unnecessary utilization.

Remove Regulatory Barriers

Insurance regulators in may states have yet to approve long-term-care riders on life insurance policies or the single-premium long-term-care/life insurance policies noted above for sale in their states. Removing such regulatory barriers would broaden the availability of these feasible and attractive private long-term-care coverage alternatives.

Remove Tax Barriers

Several tax barriers need to be removed to broaden the availability of private long-term-care coverage.

* Extend the tax treatment accorded life insurance policies to long-term-care polices. The same tax exemption that applies to life insurance reserves should be firmly established for returns on long-term-care insurance reserves. Long-term-care insurance benefits should also be tax-exempt, as are life insurance benefits. This would mean that long-term-care benefits paid through riders to life insurance policies, which basically accelerate the life insurance benefits, would be tax-exempt, just as life insurance benefits paid to heirs would have been. Similarly, the long-term-care benefits paid as an alternative to life insurance benefits in the joint long-term-care/life insurance policies discussed above should be tax-exempt as well.

* Allow long-term-care insurance as an employee benefit. Employers should be able to deduct contributions to reserves for long-term-care benefits as a business expense for employee compensation. The returns on these reserves would also need to be tax-exempt. Employers should also be allowed to offer workers long-term-care insurance as an option under cafeteria plans.

* Allow a deduction for long-term-care expenses and insurance premiums. The government should not be taxing the income the elderly are trying to use to pay for long-term care. A deduction for insurance premiums would extend the coverage of private insurance in place of public benefits paid out of tax funds. Similarly, vested pension funds, or IRA or 401(K) funds, that are used to purchase long-term-care insurance or to pay for such care directly should be tax-exempt. This principle could be extended further to allow taxpayers deductions for the long-term-care insurance premiums or direct expenses they may pay for others, to encourage more voluntary assistance from family and others.

Enact Health Care Savings Accounts

Perhaps the most revolutionary impact would result from Health Care Savings Accounts, as proposed by Rep. D. French Slaughter (R-Va.) and others in H.R. 1080. These accounts would permit the development of additional resources by retirement to help finance long-term-care insurance and expenses, in a highly attractive overall vehicle that would provide funds for medical and other retirement needs as well and address the deep problems of Medicare. Through these accounts, average workers could develop sufficient funds to buy long-term-care insurance and substantially better their retirement finances overall.(46)

Conclusion

A new nursing home and home health care entitlement program would cost $60 billion to $80 billion a year in net new federal spending, a massive burden that taxpayers will not support. Such a program would cause substantial unnecessary utilization, produce massive displacement of private care givers, eliminate incentives to control costs, send prices for long-term care soaring, and expose the government to uncontrollable abuse. Adopting such a huge new entitlement obligation to the elderly in the face of the pending retirement of the baby-boom generation, and the immense short- and long-term fiscal problems that already exist, would be foolhardy.

With the government providing for those who do not have the resources to pay for their own care, there is no sound rationale for a long-term-care entitlement program for everyone. Those who want to protect their substantial life savings from the costs of long-term care can and should do so by using part of their accumulated savings to purchase private insurance to protect the rest. Newly developing private coverage alternatives should be attractive and accessible even to those with more modest savings. With respect to single elderly individuals who do not obtain such private coverage, it is not too much to ask of those who do have some modest savings to contribute the funds to the cost of their own care before the taxpayers are asked to pay the bill. With respect to couples, substantial resources will now be protected for the noninstitutionalized spouse in any event.

The sound role for government policy is to facilitate the development of private coverage mechanisms, primarily by removing its own unnecessary tax and regulatory barriers. Ultimately, policy reforms can promote the development of additional retirement resources that would be available to take advantage of private coverage mechanisms and sharply reduce dependence on government.

Notes

(1) Task Force on Long Term Health Care Policies, Health Care Financing Administration, and National Center for Health Statistics, U.S. Department of Health and Human Services, Report to Congress and the Secretary (Washington, D.C.: HHS, September 21, 1987), p. 69.

(2) Ibid.

(3) National Center for Health Statistics, U.S. Department of Health and Human Services, "Use of Nursing Homes by the Elderly: Preliminary Data from the 1985 National Nursing Home Survey," Advance Data, no. 135 (May 14, 1987); 1990 Annual Report of the Board of Trustees of Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds (Washington, D.C., April 19, 1990), Table A1, p. 88 (hereafter cited as 1990 OASDI Trustees' Report).

(4) Task Force on Long Term Health Care Policies, pp. 84-91.

(5) Office of Management and Budget.

(6) Based on data from the Health Care Financing Administration of HHS and the Congressional Research Service.

(7) For further discussion, see Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives, Medicaid Source Book: Background Data and Analysis, 100th Cong., 2d sess., 1988, Committee Print 100-AA, especially Appendix C, "Medicaid, the Elderly, and Long Term Care" (hereafter cited as Medicare Source Book).

(8) For further discussion, see Medicaid Source Book, especially pp. 84-86, 360-63.

(9) For further discussion, see Medicaid Source Book, especially pp. 358-60.

(10) Task Force on Long Term Health Care Policies, p. 67.

(11) Extrapolation based on U.S. Bureau of the Census, Current Population Report, Series P-60, no. 162 (Washington, D.C.: U.S. Government Printing Office, 1987). The $800 figure may be an underestimate. IRS data show that average income for single retirees was $16,700 in 1986. Statistics Division, Internal Revenue Service.

(12) Task Force on Long Term Health Care Policies, pp. 84-91.

(13) Ibid., p. 67.

(14) Health Insurance Association of America.

(15) Ibid.

(16) American Council of Life Insurance, 1988 Life Insurance Fact Book (Washington, D.C.: ACLI, 1988), p. 27; American Council of Life Insurance, 1989 Life Insurance Fact Book Update (Washington, D.C.: ACLI, 1989), p. 10.

(17) U.S. Bureau of the Census, Statistical Abstract of the United States, 1989 (Washington, D.C.: U.S. Government Printing Office, 1989), Table 839, p. 509.

(18) Task Force on Long Term Health Care Policies, p. 66.

(19) The median home equity of person 65 and older in 1984 was $46,200. U.S. Bureau of the Census, Household Wealth and Asset Ownership (Washington, D.C.: U.S. Government Printing Office, 1986), Table 5. With 5 percent appreciation per year since then, the median equity would be over $60,000 today.

(20) Task Force on Long Term Health Care Policies, p. 66.

(21) For example, the Golden Rule Life Insurance Company in Indianapolis, Indiana, offers such a policy natio

nwide.

(22) Committee on Ways and Means, U.S. House of Representatives, Overview of Entitlement Programs, 1990 Green Book-- Background Material and Data on Programs within the Juris diction of the Committee on Ways and Means, 101st Cong., 2d sess., 1990, Committee Print WMCP:101-29, Table 10, p. 145 (hereafter cited as 1990 Green Book).

(23) Medicaid Source Book, pp. 95-96.

(24) Ibid., pp. 96-97.

(25) New York State Department of Social Services, New York City Human Resources Administration, and New York State Council on Home Care Services, Annual Report to the Governor and the Legislature (1989), p. 6; New York State Council on Home Care Services, An Overview of Home Care Services (1989), p. 11.

(26) Ibid.

(27) Medicaid Source Book, pp. 156-62, 366-71.

(28) Office of Management and Budget.

(29) U.S. Bipartisan Commission on Comprehensive Health Care, A Call for Action (Washington, D.C.: U.S. Government Print ing Office, 1990), Executive Summary, p. 11.

(30) Ibid.; 1990 Green Book, p. 248; Robert Maxwell, state ment on behalf of the American Association of Retired Persons on long-term-care financing before the Senate Finance Committee on Health, Washington, D.C., 100th Cong., 1st sess., June 12, 1987, p. 1; Task Force on Long Term Health Care Policies, pp. 67-68.

(31) Maxwell, p. 1.

(32) The current Medicaid program simply requires an estimate that on average home health care for recipients who would otherwise be in nursing homes costs less than institutional ization. But the rules should require that the cost of home health care for each individual be no higher than nursing home care for that individual, with the nursing home costs serving as an annual cap on home health expenses for the individual.

(33) If the 20 states that do not have medically needy pro grams for nursing home care under Medicaid in practice leave without assistance some people who lack the funds for nursing home care, then reforms would be needed to ensure that those without the necessary funds have access to essential nursing home care.

(34) Task Force on Long Term Health Care Policies, pp. 62-68.

(35) The points made in note 33 also apply here.

(36) Task Force on Long Term Care Health Policies, pp. 67-68.

(37) Total nursing home expenditures were $48 billion in 1988. General Accounting Office, Long Term Care Insurance Coverage Varies Widely in a Developing Market (Washington, D.C.: U.S. Government Printing Office, 1986), p. 10. In recent years, Medicaid nursing home expenditures have equaled 40 percent of total nursing home expenditures. With Medicaid nursing home expenditures in 1990 close to $23 billion, total nursing home expenditures would be about $57 billion.

(38) Home health care expenditures excluding privately paid personal care totaled $9 billion in 1985, with about half of that paid by government programs. 1990 Green Book, p. 253. With government home health care expenditures totaling more than $7 billion in 1990, total home health care spending in cluding privately paid personal care would be likely to be over $15 billion.

(39) Since about 1.65 million retirees are in nursing homes, and about 5.6 million in the community need personal care assistance, this means about 23 percent of those who need assistance are in nursing homes and three-fourths are out side nursing homes. See also Task Force on Long Term Health Care Policies, p. 66.

(40) 1990 Green Book, pp. 257-59; Peter Kemper, Robert Apple baum, and Margaret Harrigan, A Systematic Comparison of Community Care Demonstrations (Madison, Wis.: Institute for Research on Poverty, June 1987).

(41) United Hospital Fund of New York, Home Care in New York City: Providers, Payers and Clients, March 1987, p. 28.

(42) 1990 Annual Report of the Board of Trustees of the Fed eral Hospital Insurance Trust Fund (Washington, D.C.: April 18, 1990); 1990 OASDI Trustees' Report.

(43) U.S. Bipartisan Commission, pp. 15-18.

(44) While the tax rate is putatively split between employer and employee, effectively the entire tax comes out of employees' wages, because employers will pay in total no more than the marginal productivity of each worker.

(45) The points made in note 44 also apply here.

(46) That proposal and how it would work will be analyzed intensively in a forthcoming Cato publication.