



# **Financing Long-Term Care**

## ***A Framework for America***

**Prepared for the  
AAHSA Board of Directors**

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**American Association of Homes and Services for the Aging**

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# Executive Summary

The vision of the American Association of Homes and Services for the Aging is for all Americans to receive the care they need, when they need it, in a place they call home. However, the current system for financing long-term care presents serious financial barriers for the elderly and others to do so. As the baby boomers age into retirement, the need for long-term care will double over the next three decades, turning current problems into a far greater national crisis.

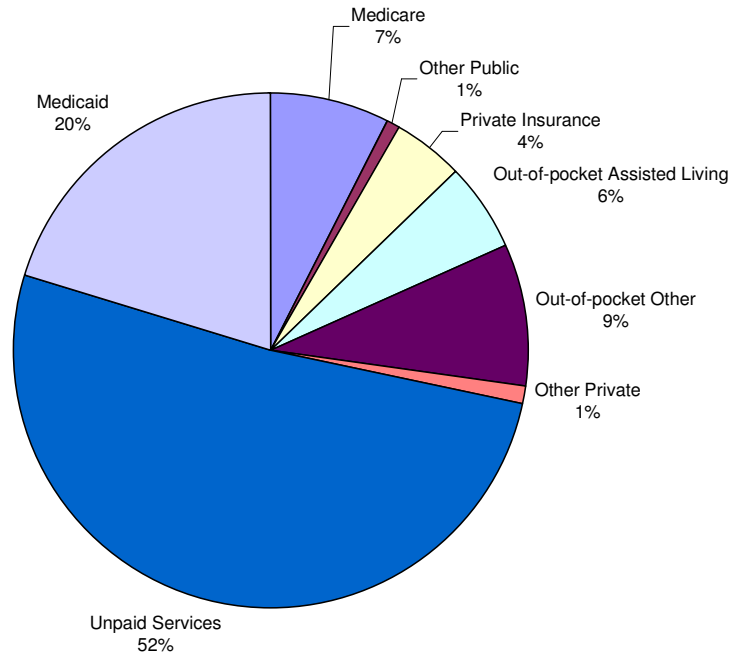
In 2004, AAHSA leaders convened a Finance Cabinet to recommend to the Board, after appropriate study, a position with respect to a model for future financing for long-term care. This document presents the Finance Cabinet's recommendations and the rationale for its decisions.

## The Challenge: Why Change is Needed

Ten million Americans today (40 percent under age 65) need long-term care, but our current financing system leaves many with unmet needs and catastrophic costs. Individuals and families shoulder the primary burden for providing help—both through payment for professional services in a variety of settings and through the substantial economic value of the donated services families and communities provide (Figure A).

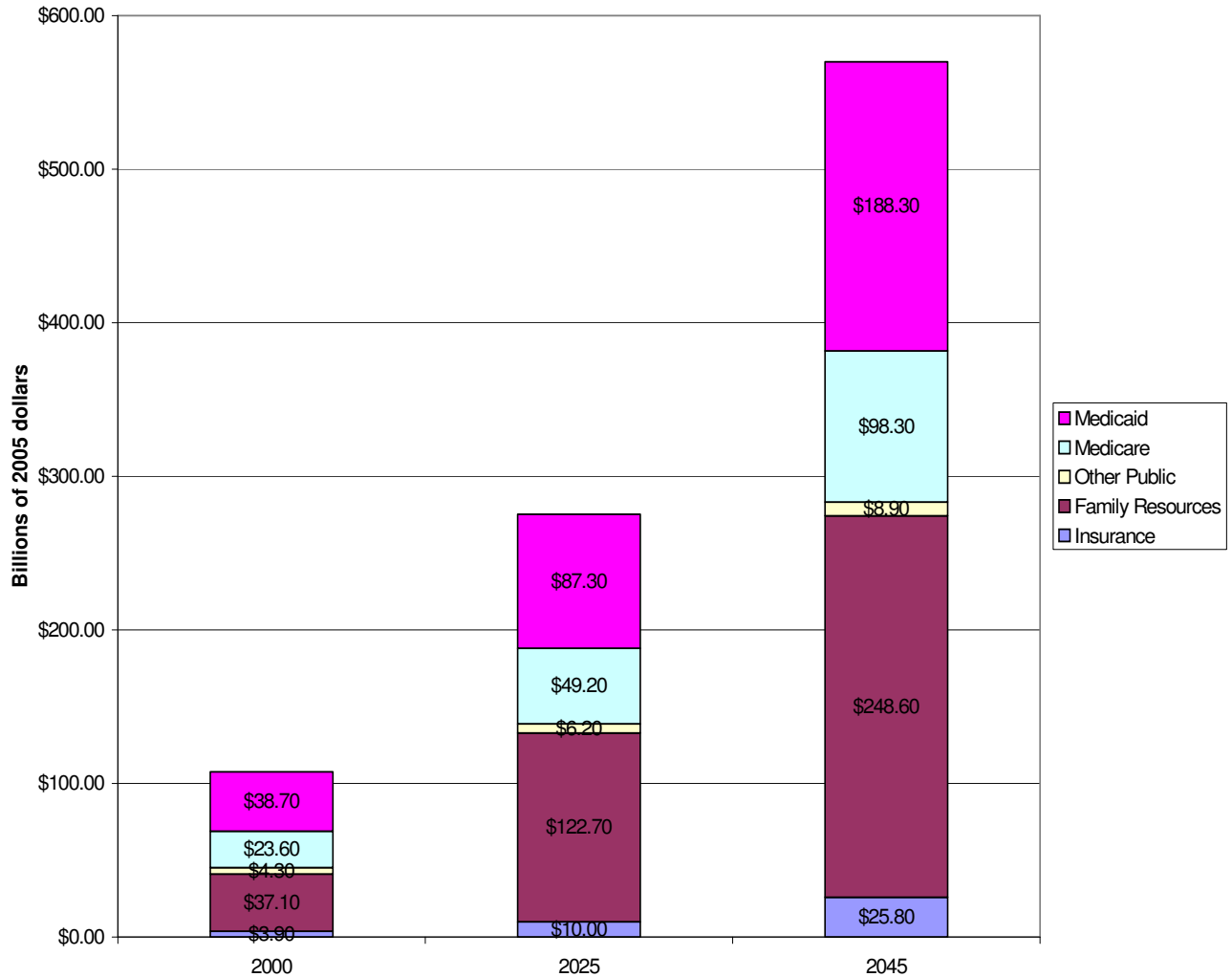
- **Needs are unmet** among the poorest of us, despite families' considerable efforts and substantial public expenditures. Over half of those covered by both Medicare and Medicaid who live in the community have unmet needs for long-term care with serious consequences such as going hungry, soiling themselves, or being unable to bathe or wear clean clothes.
- **Costs are catastrophic for those who need extensive or lengthy care.** In 2005, the average cost of a private room in a nursing home was \$203 per day; the cost of home health aides averaged \$19 per hour and a homemaker-companion cost \$17 per hour. Among those turning 65 today, 20 percent will need care for more than five years.

**Figure A: Funding Sources for Long-Term Care, Including the Economic Value of Services Provided Without Charge by Families (see text for sources)**



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- **The increasing burden on Medicaid is unsustainable.** Medicaid costs for long-term care will double (constant dollars) by 2025 and increase five-fold by 2045 (Figure B).
  - **More money will need to be spent; where will it come from?** Desirable policy choices such as expanding home and community-based services can only marginally improve the financial outlook; increasing labor costs and the sheer numbers of retiring baby boomers drive long-term care expenditures, overwhelming conventional policy options.

**Figure B: Growth in Expenditures for Long-Term Care, by Source of Payments**



## Recommendations

If the nation does nothing to change the current financing system, unsustainable pressure on state budgets and Medicaid will lead either to abandoning all other state responsibilities, such as education, or abandoning ever-larger proportions of those with long-term care needs. Merely federalizing long-term care would simply shift the costs to another locus, where growing Medicare costs compete for tax dollars. The Finance Cabinet concluded that additional money

would be needed but that a new system for raising it and paying for long-term care must be implemented to address both current and future problems in a manner that better shares the burden.

- **Insurance, not welfare**

The nation should adopt an insurance model for financing long-term care, rather than relying so heavily on Medicaid—a pay-as-you-go welfare model that leaves many with unmet needs and requires that people impoverish themselves before qualifying. The need for long-term care is a risk, not a certainty, with catastrophic financial consequences for the unlucky. An insurance model can spread the risk more equitably and, if implemented in sufficient time, pre-fund the baby boomers' coming explosive needs.

- **Universal participation**

A system should be developed to provide as close to universal coverage as possible because all Americans, to the extent feasible, should have access to long-term care without impoverishing themselves and their families and because substantially mitigating expected future Medicaid costs requires nearly universal insurance coverage with good protections.

The Cabinet does not envision an insurance system that will cover—as an entitlement—all long-term care costs for every American. Even if all or most Americans are enrolled in an insurance plan, there will be costs not covered by the plan. Germany, for example, expects those who participate in its national long-term care insurance to pay about 25 percent of the cost of nursing home care—roughly the room and board costs. Some may wish to purchase extra wrap-around insurance to cover full costs; some may pay with private funds; and some will have inadequate funds for either. Thus the Cabinet assumes that a residual Medicaid system will need to be retained to cover these costs as well as to cover people who fall through the cracks for one or another reason.

Universal participation could be achieved by a mandate, just as mortgage holders require home insurance and states require helmets or seatbelts. But it may also be possible to achieve nearly universal participation by automatically enrolling workers and requiring those who do not want to participate to actively “opt out.”

- **Public insurance, financed by premiums, as the foundation**

Given that the goal is universal (or nearly so) participation in an insurance system providing the greatest benefits for the lowest costs, what is the best way to get there? The Cabinet concluded that while private long-term care insurance should remain an important component of a national strategy, the foundation of that strategy should be a broad-based public insurance program with low overhead costs and an all-inclusive risk pool. The Cabinet concluded that even if private policies improved, insufficient numbers of people who otherwise might become Medicaid's responsibility could afford to and could be persuaded to buy private insurance, even if—as some suggest—Medicaid eligibility was tightened and/or tax incentives were increased. Getting close enough to universal coverage will require a mandate or near mandate; that in turn, the Finance Cabinet concluded, requires that an equitable, affordable public insurance program be available.

The public insurance program should be financed by premiums, not by general tax revenues. The premiums should be established in line with benefits to produce an actuarially sound program. People with very low incomes should receive financial assistance to purchase the insurance.

- **A disability insurance model, with cash at least one of the benefits; greater benefits paid to those with greater functional needs**

Long-term care is more suited to a disability (cash payments) model because long-term care services and supports are concerned with maintaining well-being in the face of disability. Consumers can better judge what's best for them in long-term care compared to a greater need for professional judgment in medical matters.

Workable models of cash payments exist in both the successful Cash and Counseling demonstrations operated in three states and the German system implemented a decade ago.

- **Administration by a federally chartered organization responsible for managing the premiums, investments and payments**

The goal is to have the finances managed outside of the federal treasury and budget, similar to the way funds are managed in a number of the European health and long-term care insurance systems. To maximize consistency, the disability assessment and appeals system should be a centralized function. New systems for providing help managing choices and accessing services could build on advanced state models and likely would be contracted to public or private organizations with expertise.

## **Introduction**

In 2004, leaders of the American Association of Homes and Services for the Aging convened a Finance Cabinet to recommend to the AAHSA board, after appropriate study, a position with respect to a model for the future financing of long-term care. This document is an interim discussion paper for the board. It presents the Finance Cabinet's current recommendations and the rationale for its decisions. In preparing this paper, the Finance Cabinet has considered comments and issues raised at the House of Delegates meeting on April 2, 2006, additional comments that House of Delegates members provided, and subsequent discussions with board members and others.

In fulfilling its commission, the Cabinet met eight times—frequently for two-day sessions—and further communicated extensively to refine its analyses and recommendations. The Cabinet considered literature on the American system, financing systems in other countries, and option papers concerned with changing the American system. Invited experts presented additional information and an opportunity for discussion at most of the meetings. For key

quantitative analyses, the Cabinet engaged Lisa Alexih of the Lewin Group to provide analyses using the Lewin Group Long-Term Care Financing micro simulation model.<sup>1</sup>

This paper continues with a discussion of the principles and values that guided the Finance Cabinet’s decisions, an explanation of challenges facing America in financing long-term care and why a new system is needed, and the Finance Cabinet’s recommendations and rationale for the decisions it made.

## **Principles and Values**

The Cabinet began its work discussing characteristics of an optimal long-term care system and how financing might relate to that goal. A financing system should:

- Promote and support informal caregivers
- Provide benefits equitably
- Promote consumer choice
- Promote quality of care and life; promote consumer-defined quality
- Promote access to technology and its integration into the continuum of care
- Support integration of medical and social models of care
- Promote and reward innovation, efficiency and competition
- Provide a safety net for those without resources
- Promote financial responsibility—personal and national

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<sup>1</sup> For a description of the structure of this model, see: <http://aspe.hhs.gov/daltcp/reports/modampes.htm>

## Core Principles

Continued discussion and consideration of the results of the House of Delegates' 2004 Survey of Principles and Values led the Cabinet to conclude that a financing system should embody three core principles:

- **Consumer choice:** Promote consumer choice in quality and services;
- **Financial responsibility:** Promote personal financial responsibility and stewardship of provider and public resources;
- **Equity:** Promote equitable availability of benefits

The Cabinet concluded that the current financing system substantially fails to promote and support an optimal long-term care system and falls short when measured against core principles and values held by AAHSA members.

## The Challenge: Why Change is Needed

AAHSA's vision is for all Americans to be able to receive the care they need, when they need it, in a place they call home. However, the current system for financing long-term care presents serious financial barriers for the elderly and others to do so. With the doubling of the population needing long-term care over the next several decades, the current financial problems will get substantially worse. Because Medicaid pays for 40 percent of long-term care costs—excluding care donated by unpaid family, friends and charitable organizations—efforts to deal with Medicaid costs fundamentally must deal with the nation's system for long-term care financing. An advocate for the aged recently testified to Congress:

“The primary issue America must address regarding seniors needing Medicaid is simply: Who will pay for long-term care? Long-term care is expensive and those who need it most—persons 85 years and older—are the fastest growing segment of our population. The future is scary. The states do not want to pay

for it. The federal government does not want to pay for it. And seniors and their families cannot afford it.” (Bedlin, 2004)

The window of time in which to act to avert an even greater financing crisis over funding the baby boomers’ long-term care needs is beginning to narrow; the time to act is now

## **Current Financing Leaves Unmet Needs and Many With Catastrophic Costs**

The need for long-term care is measured in national surveys by asking people if they need help with one or more ADLs (activities of daily living, such as bathing, dressing, eating, going to the toilet) or help with one or more IADLs (instrumental activities of daily living, such as shopping, cleaning or managing a checkbook). In 2000, the most recent national data available, nearly 10 million Americans needed long-term care assistance, of which close to 40 percent were under age 65 (Georgetown, 2003). Most of those who need help live in the community, not in nursing homes: 83 percent of all those needing help and 96 percent of those under age 65 who need help live in the community. Those in nursing homes are more severely impaired—75 percent need help with three or more ADLs and 50 percent have some form of dementia. There are also 1.8 million adults in the community who need help with three or more ADLs; thus 22 percent of those needing long-term care and living in the community are severely impaired (Georgetown, 2003). Put differently, only 59 percent of the most severely impaired (those needing help with three or more ADLs) live in nursing homes.

### **Unmet Need**

Long-term care is expensive. In 2005, the average cost of a private room in a nursing home was \$203 per day; the cost of home health aides averaged \$19 per hour and a homemaker-companion cost \$17 per hour (Metlife Mature Market Institute, 2005). Those who need these services are disproportionately very old, live alone and have lower incomes than the general population. In sections to follow, we present data on who pays for long-term care. At the outset, it is important to recognize that many serious needs for help are not met at all.

Recent studies indicate not only that unmet need is a substantial problem but that the way we finance (or fail to finance) long-term care is a major contributing factor. A 1999 study of community-dwelling people (in six states) eligible for both Medicare and Medicaid found that over half (58 percent) of those needing help with activities of daily living did not get the help they needed. As a result, most of them experienced serious consequences, such as going hungry, falling, soiling or wetting themselves, or being unable to bathe or wear clean clothes (Komisar, et. al., 2005). Unmet needs were lowest in the states that provided more help through Medicaid with in-home care, suggesting that financing arrangements could make a difference.

Similarly, in the Cash and Counseling demonstrations, researchers found substantial unmet needs for personal care services, even among those who were enrolled in a Medicaid program that covered personal care, because agency personal care workers employed by the conventional Medicaid programs were not always available for as much time as needed or at the right times of the day. When the financing system was changed to provide cash to beneficiaries to hire their own workers, unmet needs were substantially reduced (Brown, 2006).

## **Catastrophic Costs**

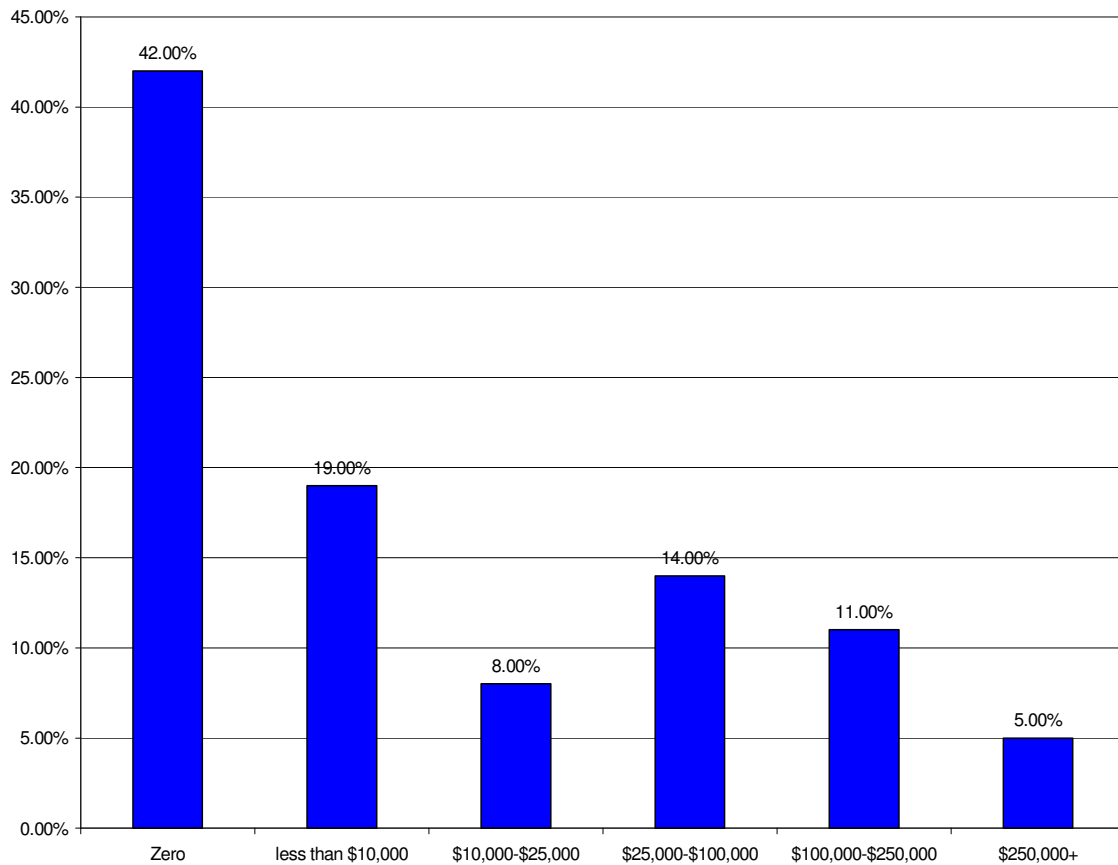
Among those turning 65 today:

- 31 percent will not use long-term care.
- 17 percent will use it for less than a year.
- 20 percent will need care for more than 5 years.

For those needing intensive or lengthy care, or for those with very modest resources, the costs can be catastrophic. Exhibit 1 shows the proportion of people turning 65 today who can expect various future lifetime expenditures on long-term care. The dollar amounts shown are present discounted values, meaning the amount of money a person would have to have tucked away at age 65 (and invested to earn a 3 percent real rate of return) to cover future long-term care expenses. As can be seen, 42 percent of those turning 65 today are likely to have zero long-term care expenses. But 16 percent have expenses so great they require a dedicated nest egg today of more than \$100,000. Five percent need a long-term care nest egg worth over \$250,000. At

younger ages, when private long-term care insurance is most affordable, no one knows (or is likely to imagine) his or her probability of being in the most-unlucky 5 percent. Nor can the modest-income 50-year-old predict if he or she will be among the 14 percent who will need \$25,000-\$100,000 socked away by age 65 to cover future long-term care expenses.

**Exhibit 1: Distribution of Present Discounted Value of Lifetime LTC Expenditures of People Turning 65 in 2005; Percentage of People with Various Levels of Expenditures**



**Source: Kemper, Komisar and Alecxih, 2006**

In the absence of public or private insurance, few individuals have sufficient resources to pay for extensive long-term care. In 2000 (the most recent year for a published analysis of this sort), 80 percent of the elderly had less than \$100,000 in liquid assets (cash, stocks, bonds) and nearly half (48 percent) had total assets (including home equity) less than \$100,000 (Knickman, et. al., 2003). Analysts estimated that in that year—2000—only 27 percent of the elderly had sufficient income and assets to cover 2.5 years of nursing home care. The proportion who could cover those costs was lower (18-19 percent) among those most likely to use nursing home care—the disabled elderly, those over age 75, and unmarried elderly (Knickman, et. al., 2003). Over half (53 percent) had incomes and assets so low the analysts termed them “Medicaid bound,” as they lacked the resources to cover extensive long-term care costs.

Given the high cost of care and the generally low income and assets of those needing it, it is hardly surprising that Medicaid—the nation’s long-term-care safety net—is the primary payer today for approximately 43 percent of those using the extensive services provided in assisted living facilities and nursing homes, as discussed below. Medicaid pays much less than it would were it not for the substantial contributions that families and communities make, helping provide long-term care services at no monetary cost—in the form of unpaid services.

## **Individuals and Families Provide the Greatest Share of Resources**

There is a common myth that Medicaid is the biggest funder of long-term care services. But the largest single source of long-term care financing is the donated care that family and friends provide; the monetary value of that largely unpaid help accounts for over half (52 percent) of total long-term care costs (Exhibit 2). After donated services, individuals and their families share second place with Medicaid, each paying the same proportion of the total—20 percent. Medicare and other public sources account for the remaining 8 percent.

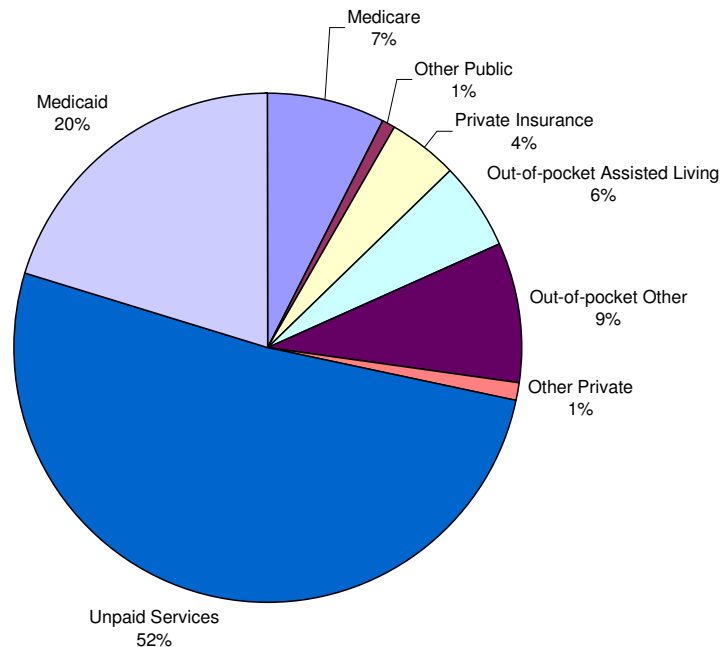
Donated care is the largest source of long-term care funding because most people with disabilities who need help live in the community where even those with severe impairments rely mainly on unpaid help from family, friends and the community. The economic value of this help is substantial. According to the Congressional Budget Office (CBO, 2004):

- “In 1998, the Department of Health and Human Services estimated that replacing donated LTC services for seniors with professional care would cost between \$50 billion and \$103 billion (in 2004 dollars).
- Another analysis, in 1997, estimated the value of donated care for people of all ages who had impairments—measuring it as the forgone wages of caregivers—at \$218 billion.”

Private expenditures (including those from private insurance) for nursing home, assisted living and home care are also a significant part of the financing picture, equaling Medicaid as a funding source. Many analyses of the sources of long-term care financing omit assisted living costs (because national data are less readily available for assisted living than for other types of care and because some may not understand its role) and thus understate the degree to which private and family resources cover even the paid costs of long-term care. We estimate that in

2002, individuals and their families paid 41 percent of the total paid costs of long-term care of which nearly one-third consisted of private payments for licensed assisted living. Medicaid similarly covered 41 percent of all paid care, with the remaining 18 percent covered by Medicare and other non-Medicaid public sources. Private long-term care insurance plays a growing but minor role in financing long-term care, as will be discussed in a following section.

**Exhibit 2: Sources of Funding for Long-Term Care Expenses, 2002**



**Sources: CBO, 2004 (unpaid services); AAHSA (Assisted Living); Georgetown LTC Financing Project, 2004 (all other categories).<sup>2</sup>**

Incomplete information about the sources of funding for long-term care has led to mistaken conclusions that confuse policy discussions. For example, one analyst (apparently unaware of the role of assisted living) states that proof “the middle class is taking advantage of

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<sup>2</sup> All assisted living was assumed to be privately paid, although Medicaid pays for a small amount. AAHSA estimated the cost of assisted living in 2002 by multiplying the number of licensed units (909,196) reported in the 2002 National Academy for State Health Policy survey by the average yearly base cost (\$25,908) reported by MetLife for 2002. “Unpaid services” is estimated by CBO as the cost of replacing care provided with professional services. We relied on the same study of donated costs that CBO used and converted the reported 1977 costs (\$196 billion) to 2002 costs (\$213.54 billion). “Other public” includes local and state-only public programs. “Other private” includes that portion of charity care included in the national health accounts, which is likely an underestimate.

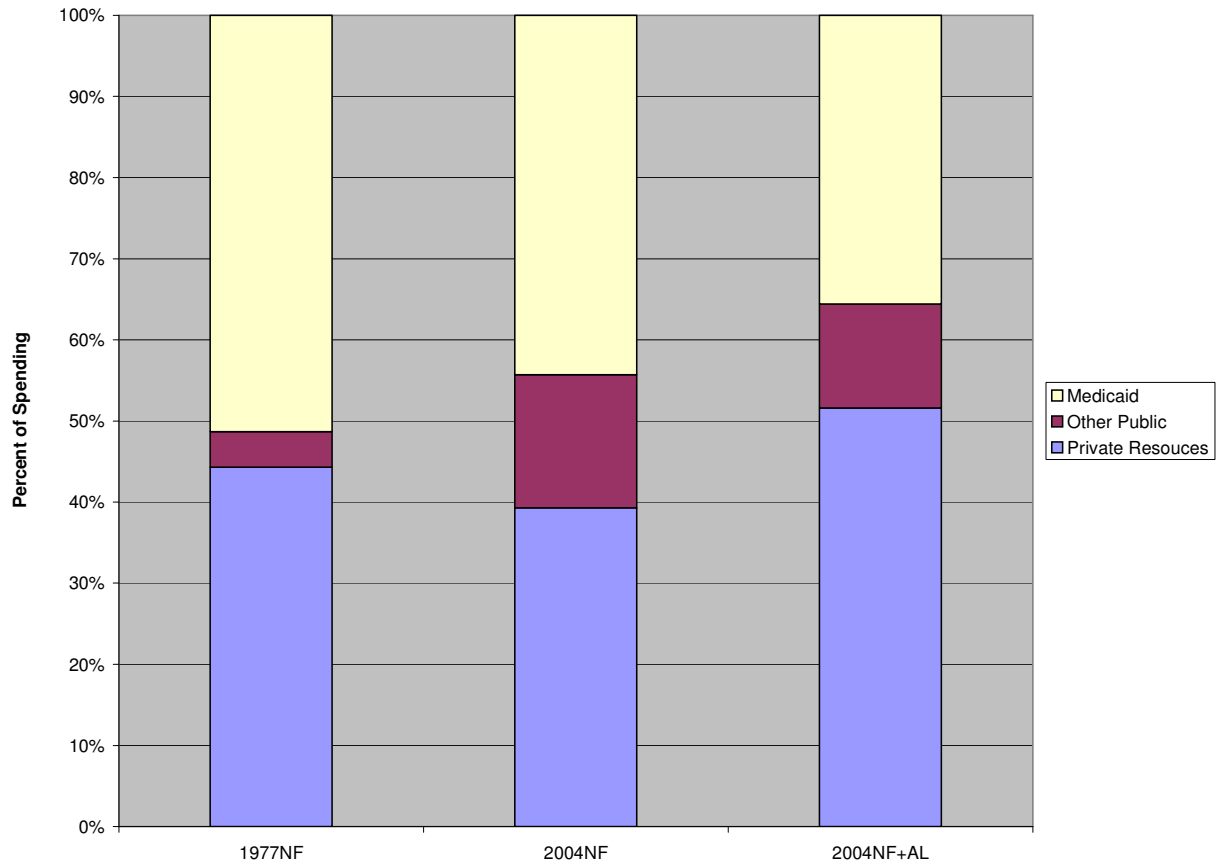
Medicaid for its long-term care ‘insurance’” can be found in a comparison of (1) private versus public spending for total health care costs and (2) private versus public spending for *nursing home care* (Teske, 2000). The analyst notes that public sources such as Medicare and Medicaid pay 47 percent of all health care expenditures, but 62 percent of nursing home expenditures. He concludes from this: “This massive shift in public spending explains who isn’t pulling their fair share of the load,” i.e., the individuals with long-term care needs and their families. But Medicaid’s share of *nursing home* costs has increased primarily because those who have sufficient resources are increasingly choosing assisted living. Exhibit 3, below, shows the distribution of payments for these two related types of care together. As can be seen, in 2004 public resources paid for just 48 percent of residential long-term care, nearly identical to the 47 percent cited for all health care expenditures.

Ignoring the fact that assisted living increasingly serves as an alternative to nursing homes also leads to inaccurate statements about the proportion of people relying on Medicaid to help provide for their long-term care needs. For example, Stephen Moses asserts “Medicaid is not primarily a long-term care safety net for people who have spent down into impoverishment. Rather, Medicaid is the principal payer of long-term care for nearly everyone,” stating that Medicaid covers two-thirds of nursing home residents’ stays (Moses, 2005). But in 2004, while Medicaid was the primary payer for 66 percent of nursing home residents, Medicaid was the primary payer for only about 11 percent of residents in licensed assisted living facilities (National Center for State Health Policy, 2004). Individuals and their families paying privately were the primary payers for more than half (57 percent) of the 2.43 million people receiving care in nursing homes and licensed assisted living facilities.

Medicaid’s share of nursing home cost has actually declined from 51 percent in 1977 to 44 percent in 2004 as Medicare’s share has increased (Exhibit 3) and people with money and lighter care needs are cared for in community settings. Most Medicaid expenditures for non-institutional long-term care are incurred as part of services provided under a waiver of ordinary federal Medicaid rules. Medicaid spending on these waived services has “increased substantially over

the past decade, from 5 percent [of Medicaid costs] in fiscal year 1991 to 22 percent in fiscal year 2003” (Georgetown LTC Financing Project, 2004).

**Exhibit 3: Proportion of Expenditures for Nursing Facilities and Nursing Facilities Plus Assisted Living Paid from Private and Public Resources: 1977 + 2004**



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**ources and Notes: “NF” refers to data on expenditures for nursing facilities; “NF+AL” refers to data on expenditures for nursing facilities and assisted living combined. Data on nursing facility expenditures from CMS, 2006; expenditures for assisted living calculated by AAHSA.<sup>3</sup>**

Despite the struggles of families and individuals shouldering the heaviest share of long-term care costs, public programs are also strained. All face substantially increasing problems in

<sup>3</sup> We estimated expenditures on assisted living by multiplying an estimate of the number of licensed assisted living units for 2004 (Mollica, 2006) by the average yearly base cost for 2004 (MetLife, 2004). We assumed that all assisted living is paid privately, although Medicaid covers a small amount.

the future. A spokesperson for the federal Government Accountability Office recently testified to Congress: “Current problems with the provision and financing of long-term care will be exacerbated by the swelling numbers of the baby-boom generation needing care. These problems include whether people with disabilities receive adequate services, the potential for families to face catastrophic long-term care costs, and the burdens and social costs that heavy reliance on unpaid caregivers create[s] coupled with possibly fewer caregivers available in coming generations” (GAO, 2005). GAO further noted: “Taken together, Medicare, Medicaid, and Social Security represent an unsustainable burden on future generations.” Medicaid—discussed below—is the system most affected by increasing long-term care needs. The AAHSA Finance Cabinet agreed that the projected growth in Medicaid costs is unsustainable.

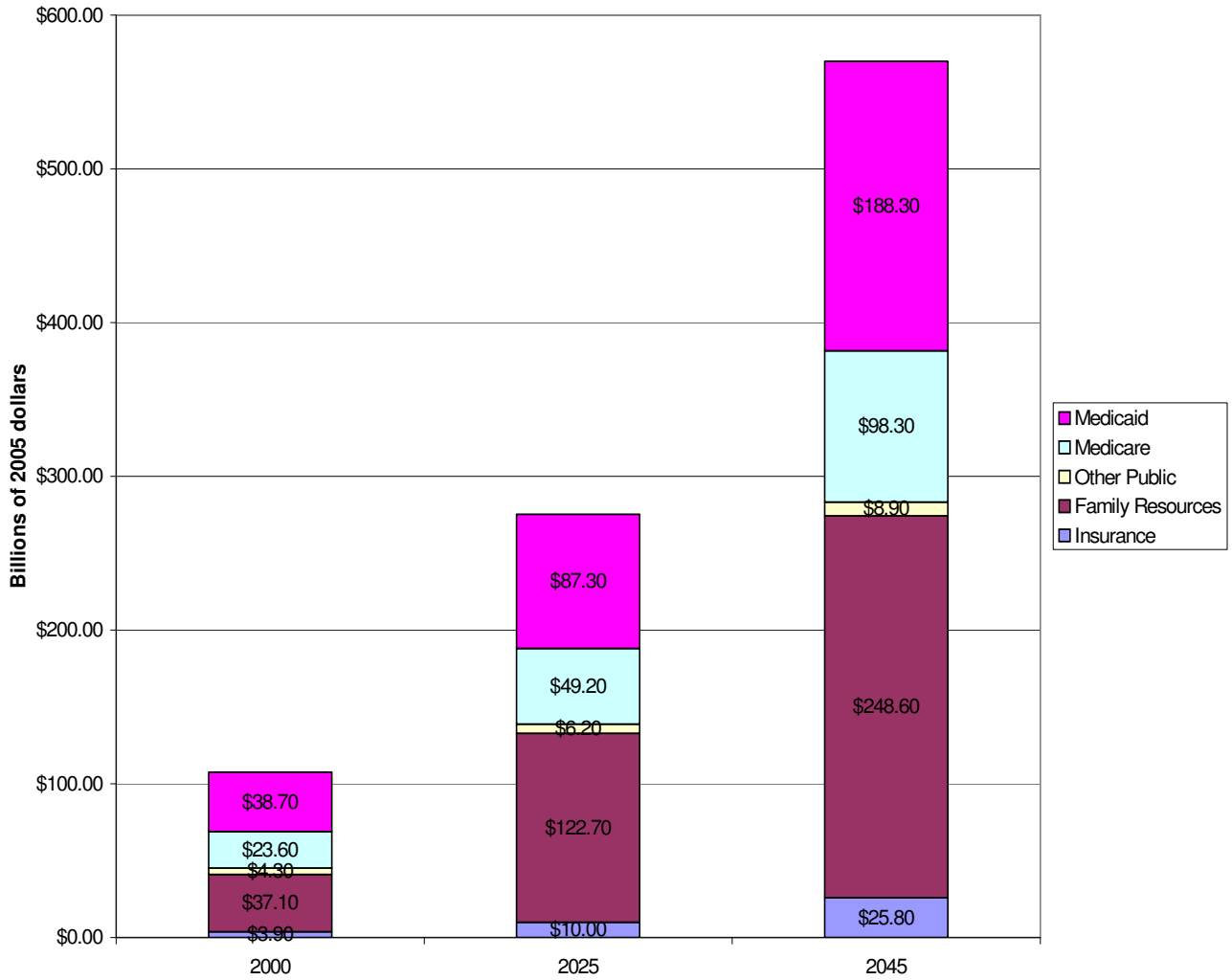
## **Growth in Medicaid Costs Is Unsustainable**

Total long-term care costs are projected to increase more than five-fold in constant dollars by mid-century (2045), as shown in Exhibit 4, driving Medicaid costs beyond sustainable levels. State budgets are already—in 2006—severely stressed by Medicaid costs. To the nation’s governors, continued increases are unsustainable. The National Governors Association has told Congress:

“As this Committee well knows, the state Medicaid programs bear most costs of long term care for our seniors and adults with disabilities, through nursing home care, Medicaid Waiver programs and various state plan Medicaid services. These costs are increasing dramatically. Our current model of long term care is unsustainable for the future.” (NGA, 2002)

Without a change in the financing system, Medicaid costs will double by 2025 and increase five-fold (constant dollars) by 2045.

**Exhibit 4: Growth in Expenditures for Long-Term Care by Source of Payments**



While policy choices such as increasing the use of home and community-based care or reverse mortgages may improve the picture marginally, the sheer number of those with long-term care needs in the future, and increasing labor costs for this field, drive these likely expenditures, as discussed below.

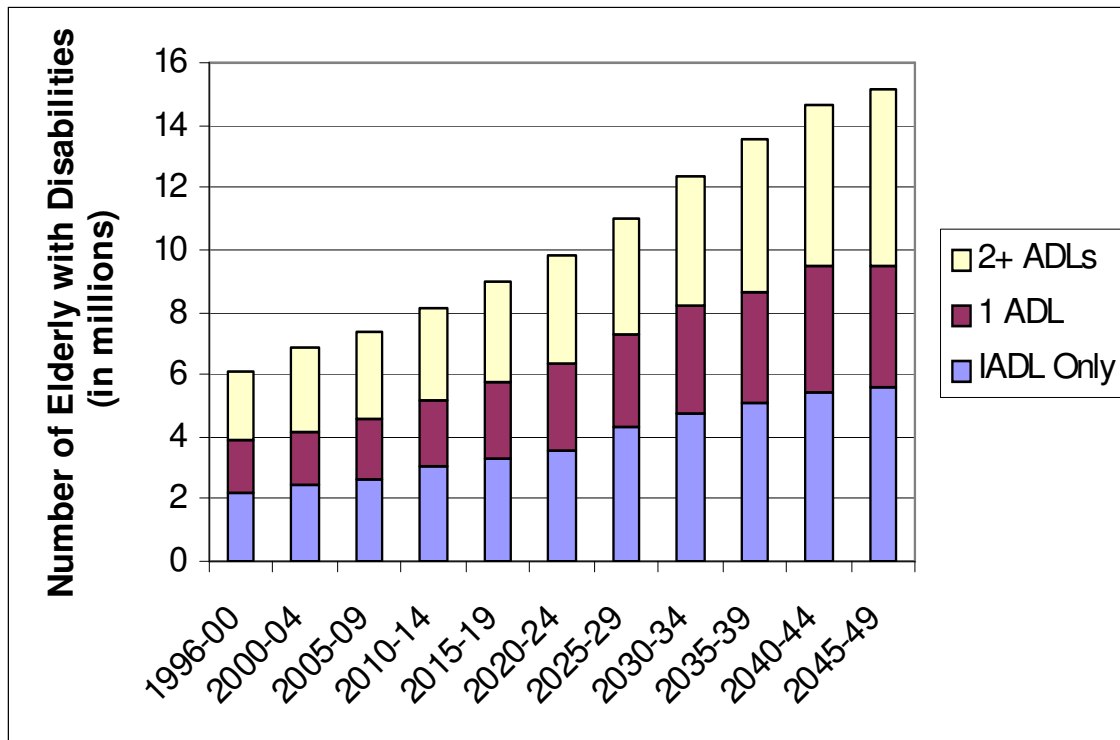
## **Increasing Labor Costs and Numbers of Elderly Drive Costs**

Long-term care costs and hence expected Medicaid expenditures grow more rapidly than the general cost of living, in part because long-term care is labor-intensive. To date, technology has yet to substantially increase productivity in the field, though AAHSA is working hard to change that with the work of CAST, the Center for Aging Services Technologies.

Reflecting the labor-intensive nature of long-term care, the Lewin model uses the projected real wage growth (1.5 percent greater than inflation) in making the projections discussed in this paper. The growing shortage of nurses and other caregivers may lead to even more rapid growth in long-term care labor costs. Those increases might, on the other hand, be offset by increasing improvement in the health of the elderly beyond that already built into the model.

The key factor driving costs' explosive growth is the sheer number of people aging and developing long-term care needs (Exhibit 5). Over the next three decades, the number of elderly people with disabilities will double. Some policy choices, discussed below, may marginally improve the financing outlook, but the sheer numbers of people who will need long-term care in the future overwhelm the effect of policy choices.

**Exhibit 5: Growth in the Number of Elderly with Disabilities by Level of Disability**



Source: Lisa Alexih, Lewin Long-Term Care Financing Model

### Some Policy Choices May Marginally Improve the Picture

Four of the most commonly suggested policy options to reduce future Medicaid long-term care costs are: substituting home and community-based services for nursing home care, encouraging elderly homeowners to tap into home equity through reverse mortgages to pay for care, encouraging the purchase of long-term care insurance with education and tax incentives, and tightening up Medicaid eligibility standards to ensure that only the truly poor qualify. The first two ideas are discussed in the sections immediately to follow. Private long-term care insurance and Medicaid eligibility are discussed under a section below explaining the Finance Cabinet’s recommendation with regard to public and private insurance for long-term care.

## Home and Community-Based Services

Nearly all people prefer to live independently rather than in a nursing home unless the care in that setting is absolutely essential. For the past 25 years, the nation has successfully increased the availability of non-institutional settings for long-term care and continues to seek improvements in that area. While satisfaction with the type of care available now has doubtless increased immeasurably, savings have been elusive and, where documented, relatively modest.

In 1981, the U.S. Department of Health and Human Services convened a high-level task force, chaired by the under secretary, to assess the nation's care delivery and financing system for long-term care. The under secretary's task force concluded:

“The Congress, government officials at all levels, consumers, and providers generally agree that the present programs often fail to promote desired objectives:

- the maximum feasible independence of the individual in making decisions and in performing everyday activities;
- the provision of services in the least restrictive environment, preferably at home or in other community settings;
- the provision of appropriate, cost-effective, accessible, and humane care to all individuals who need it; and
- the encouragement and support of the care provided by family and friends.”

(U.S. Department of Health and Human Services, 1981)

At that time, analysts were concerned that too many people who needed a limited amount of help were prematurely going to nursing homes because alternatives at affordable prices were not available. It was also hoped that by developing community-based alternatives, money could be saved. A frequently cited report of the era prepared by the U.S. General Accounting Office (now, the Government Accountability Office) found that for all but the heaviest care residents, care in the community could be less expensive than nursing home care (GAO, 1977). Since that time, considerable effort has been made at the state and federal levels to promote the development of home and community-based services, funded in part by Medicaid. The success of these efforts

and the development of a new alternative—assisted living (funded primarily by private money)—have, in fact, greatly reduced the nation’s reliance on nursing homes.

In 1981, analysts for the Under Secretary’s Task Force on Long-Term Care projected that by 2003, there would be between 2.07 million (assuming a constant mortality rate) and 2.8 million (assuming a declining mortality rate) people of all ages in nursing homes (U.S. Dept of HHS, 1981). The projections assumed that use rates by age observed in the 1977 National Nursing Home Survey would continue into the future.<sup>4</sup> But by 2005, there were actually only 1.44 million nursing home residents, according to the federal government.<sup>5</sup> Thus, the actual number turned out to be 30-49 percent lower than the projected number. But this dramatic reduction in nursing home use did not bring hoped-for savings as the cost of nursing home care increased roughly two-fold (constant dollars) during the same period, while expanded community care added new sources of spending.<sup>6</sup> Adding the number of people in licensed assisted living facilities –estimated to be 985,000 in 2004—to those in nursing homes brings the total in these types of residential care settings to 2.43 million which is squarely within the 1981 projections, based on nursing home use rates in 1977.<sup>7</sup>

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<sup>4</sup> Analysts noted, however, that while use rates for any type of residential care setting for the elderly had remained relatively constant for at least a century, the types of residential settings used had changed dramatically over time from privately financed “homes for the aged,” mental hospitals and public almshouses to nursing homes. The availability of public funding for various settings was a key driver in how the elderly were cared for.

<sup>5</sup> Data from the December, 2005 OSCAR report. This system counts only residents of nursing homes that are certified for Medicare and/or Medicaid, omitting the relatively small number that are in private-pay-only facilities. The 1999 National Nursing Home Survey, which counts residents of all types of nursing homes, found that 2 percent were in homes that were certified for neither Medicare nor Medicaid. Grossing up the 1.44 million residents of certified homes to add an estimate for those in non-certified homes results in a total estimate for 2005 of 1.47 million.

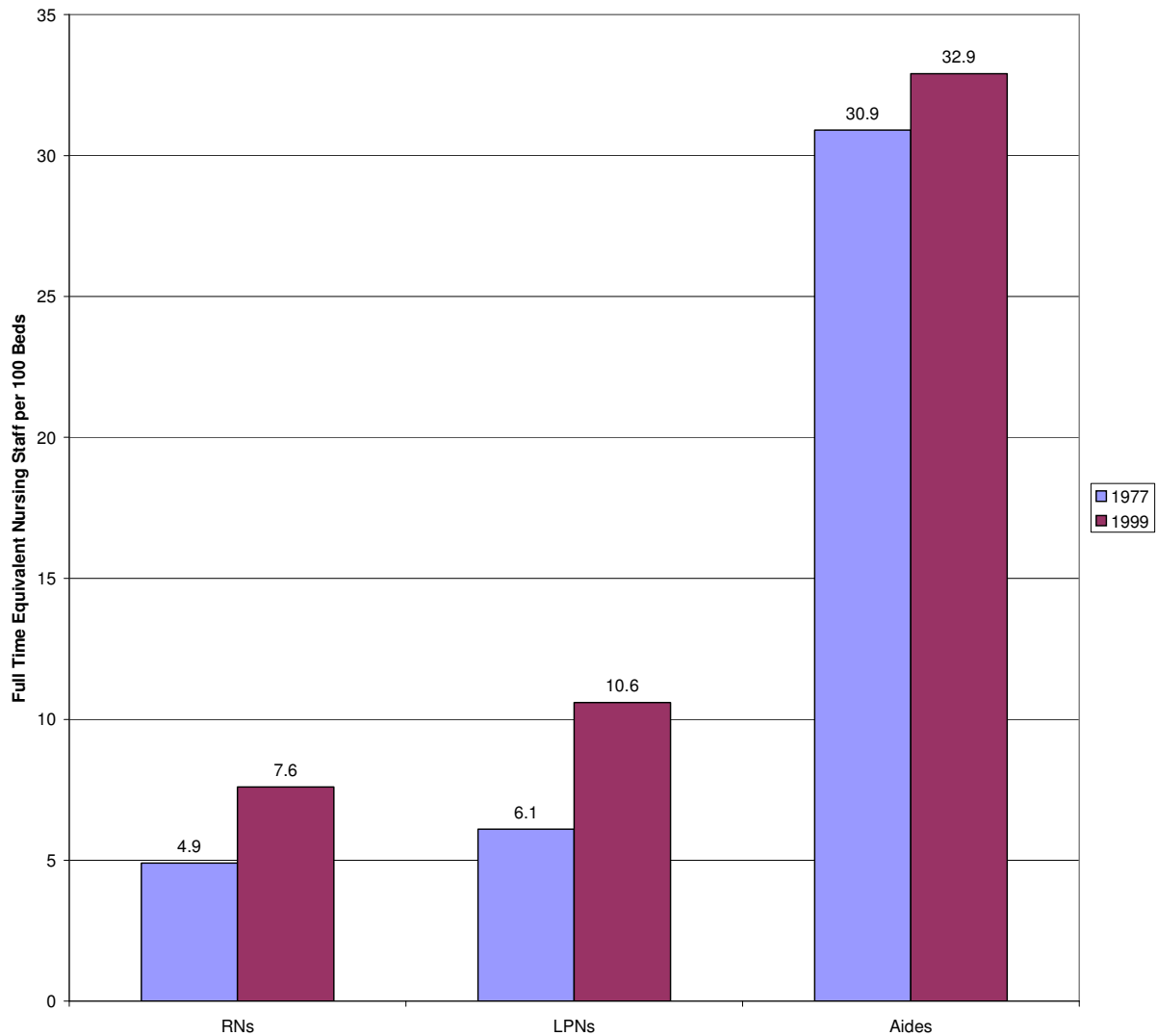
<sup>6</sup> The two-fold increase in nursing home costs was estimated in the following manner. The 1977 National Nursing Home Survey reported that total revenues per day from all sources for nursing homes were \$23.89/day; that amount translates to \$75.74/day (\$27,645/year) in 2005 dollars. By comparison, a private room in a nursing home costs an average of \$203/day or \$74,095/year (MetLife, 2005). In 2002—the latest data available-- Medicaid paid an average of \$124.09/day or \$45,293/year (BDO Seidman, 2005). Medicare paid for about 10 percent of the patients at a rate slightly higher than the private-pay average. Thus, for a conservative estimate of current total annual costs for patients (i.e., revenues to the home, not their “costs”), we weighted the yearly Medicaid payments by the proportion (66 percent) of patients covered by Medicaid and the remainder (34 percent) by the private-pay rate. The result is an estimate of \$55,086/year.

<sup>7</sup> Estimate of 2004 population of licensed assisted living facilities from Robert Mollica, National Center for State Health Policy, personal communication, April 4, 2006.

Nursing home costs more than doubled in real terms over the last decades due in part to a change in the types of people being cared for and changed expectations for staffing. As those with lighter care needs were diverted to assisted living and other community settings, those sicker patients remaining in nursing homes needed more care. These trends were exacerbated by the implementation in the mid 1980's of a system of hospital payments (diagnosis related groups, or DRGs) that provided strong incentives for hospitals to discharge patients “quicker and sicker,” intensifying the care needs of those who went to nursing homes. Further, in 1987, federal law required additional skilled nursing staff, as a lower level of care was discontinued. The result of these combined changes has been a sharp increase in the ratio of nursing staff to nursing home residents, particularly with respect to professional nursing staff—registered nurses and licensed practical nurses, as shown in Exhibit 6.

Despite this increased staffing, federal reports indicate some homes today lack sufficient nurse staffing for quality care. Increased nurse staffing need not always entail extra public spending, depending on how payment methods are targeted, but increased staffing does increase providers' costs. Cost increases stemming from additional investments to improve quality of care are not built into the assumptions about future spending on long-term care in this report. If those desirable investments are to be made, more resources will be needed—in addition to a continuous effort to increase the value of invested resources.

### Exhibit 6: Increase in Nursing Staff per 100 Nursing Home Beds: 1977-1999



**Source: 1977 and 1999 National Nursing Home Surveys**

Today, as in 1981, many hope that by continuing to increase access to home and community services and further reducing reliance on nursing homes (where such care is not absolutely necessary), money can be saved. For example, the National Governors Association told Congress in 2002 that two things that should be done to avert a state Medicaid funding crisis in long-term care would be to increase the use of home and community-based services and shift long-term care from a state to a federal responsibility (NGA, 2002). Similarly, a detailed analysis

in the respected on-line resource for states and localities produced by the staff of *Congressional Quarterly* recently called long-term care a “ticking bomb that threatens to bankrupt Medicaid and the states that pay for it.” The headline further proclaims, “The best hope for a cure lies in cutting down on the need for institutional care” (Governing.Com, 2004). Substantial research, however, clarifies that however desirable home and community-based services are for many reasons, expanding these alternatives is unlikely to be a cure for the nation’s long-term care financing ills.

Federal policy analysts conducted an exhaustive review of available research on the cost-effectiveness of home and community-based services in 2000 and came to the following conclusions:<sup>8</sup>

- **“The "woodwork" effect seriously impedes the cost-effectiveness of home and community-based services.**
  - Research and demonstration projects that used controlled experimental or quasi-experimental designs to evaluate the cost-effectiveness of home and community-based services under the above programs and demonstrations found that expanding access to these services did not succeed in reducing—and indeed most often increased—aggregate long-term care expenditures (that is, total long-term care spending, including spending for nursing home and home and community-based services combined).
  
  - [For example], in one randomized design demonstration (Georgia AHS) it was determined that of every five participants who received home and community-based services as an alternative to nursing home care, two would not have actually entered nursing homes in the absence of the experimental intervention.
  
- **Narrow targeting, low average benefit levels (taking into account availability of informal supports), and a strong emphasis on services provided in alternative residential facilities can increase the chances that home and community-based services programs will achieve budget neutrality, [if not actual savings].**

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<sup>8</sup> For the sake of brevity, only the major findings are highlighted. The document offers additional insight into ways that policies might somewhat improve the cost savings attributable to developing home and community-based services.

- **It is difficult—indeed it is virtually impossible—to design and conduct research that truly measures cost-effectiveness as distinct from "cost-shifting" from one program to another, from state to Federal funds, and from formal to informal care.**

Cost-effectiveness of home and community-based services is almost always measured in terms of Medicaid expenditures only. However, from the earliest studies..., analysts have repeatedly observed that, in a broader conceptual framework, "cost-effectiveness" estimates would also consider the impact on other public programs such as Medicare, SSI, and Food Stamps. These studies have not been done because it is too difficult and costly to obtain the necessary data. Some analysts also insist that research on the cost-effectiveness of alternatives to institutionalization ought to take into account the role of informal caregivers in subsidizing the costs of services in "at home" settings. That is, a true comparison of costs on either side of the home and community services/nursing home ledger should assign a dollar value to the hours of unpaid care provided by informal caregivers." (Doty, 2000)

At the time the analysis quoted above was completed, results from evaluations of the Cash and Counseling demonstration and of newer programs, such as Wisconsin's Family Care, were not yet available. These provide evidence that some savings may be achieved in some well-designed systems. Even so, the reported savings are relatively modest in light of the expected five-fold increase expected in Medicaid long-term care costs, driven by demographics.

## **Reverse Mortgages**

More than 80 percent of the elderly own their homes and three-quarters of them have paid off the mortgage (U.S. Census Bureau, 2005 and 2003). The more than \$2 trillion in assets represents half of the elderly's wealth and one potential source of financing for their long-term care needs (NCOA, 2005).

Reverse mortgages are specialized loans that enable a person who is 62 or older to remain in his or her home (for the rest of life, if desired) while tapping into the value of home equity. The National Council on Aging (NCOA) recently completed a study in which it found "[a]lmost half of older households are candidates for using a reverse mortgage to pay for long-term care at home....By liquidating a portion of their housing wealth through a reverse mortgage, impaired older homeowners could access a significant amount of cash [on average, \$72,128] to pay for immediate assistance and to help prevent premature institutionalization. This average

encompasses a wide range of potential benefits, depending on the worth of the property and—importantly—on the age of the person securing the loan. In reverse mortgages, the amount one can receive increases with the age of the homeowner, so that younger elderly may have quite limited benefits.

It is also unclear how much of the elderly’s home equity is already earmarked for necessary expenses and not actually “extra money” for long-term care that otherwise wouldn’t be spent. Researchers have found, for example, that many elderly do sell their homes, mostly to cover health-care related expenses. One study found that 44 percent of those owning a house at age 70 will have sold it by age 85 (Porter, 2006). Even if home equity is available for long-term care costs, the NCOA found that promoting reverse mortgages would have a very limited effect on future Medicaid costs, principally because those most likely to spend down to Medicaid have less home equity on average than others. Simulations using the Lewin long-term care financing model revealed that if 4 percent of the elderly could be persuaded to get a reverse mortgage and all of the proceeds were spent on long-term care, Medicaid could save 6 percent in 2010 and the same annual amount by 2020. Even pushing the assumed “take up rate” (percentage of elderly taking out a reverse mortgage) to 25 percent only reduced projected Medicaid savings in 2020 by 8 percent.

Improvements in protections for those who want to use reverse mortgages and education of seniors to their pros and cons are clearly worthy activities that very likely will help some pay for long-term care costs while remaining at home. But the potentially increased use of these financial instruments is unlikely to affect future Medicaid long-term care costs substantially.

# Finance Cabinet's Recommendations

The Finance Cabinet concluded that tinkering around the edges of the current system is an insufficient way to address the challenges outlined above and that a new approach to financing is needed. Further, the Cabinet concluded that while every effort must be made to improve the value of long-term care services and reduce costs where possible (e.g., by substituting technology for labor), new money will absolutely need to be spent to care for the growing numbers of those needing care. The real question is this: where will the needed revenues come from? If the nation does nothing to change the current financing system, the unsustainable pressure on state budgets and Medicaid will lead either to abandoning other state responsibilities, such as education, or abandoning an ever-larger proportion of those with long-term care needs. Neither is acceptable. The Cabinet concluded that new revenues would be needed and that a new system for raising this revenue and paying for long-term care must be implemented to address both current and future problems.

After studying options for changing the financing system, the Finance Cabinet recommends the following:

- The nation should move from a welfare system (Medicaid) to an insurance system.
- As nearly as possible, everyone should be covered by the insurance system.
- Broad-based public insurance, financed by premiums, should be the foundation for achieving universal participation (or nearly so) in an insurance system providing the greatest benefits for the lowest cost.
- Cash should be one (if not the only) benefit, providing consumers optimal flexibility to address needs for long-term care; consumer protections and access to help organizing care must be available to all.<sup>9</sup>
- Benefits should be tied to a simple level-of-need determination with higher benefits for those with greater need for care.

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<sup>9</sup> The cash might go directly to the beneficiary or instead to a fiscal intermediary. If the cash went to a fiscal intermediary *and* there were limitations on the types of things that could be bought, the “cash benefit” could be called a voucher. There are a number of different ways to do a “cash” benefit, as discussed in the following sections.

- The system should be administered by a publicly chartered entity with responsibility for investing and managing the insurance funds, which are not to be part of the federal budget.

These recommendations and the rationale for choices made by the Finance Cabinet are detailed below.

## **Insurance, Not Welfare**

The Cabinet concluded that the nation should adopt an insurance model for financing long-term care, rather than relying so heavily on Medicaid—a pay-as-you-go welfare model. An insurance model can spread the risk of catastrophic costs more equitably and—if implemented in sufficient time—pre-fund the baby boomers’ coming explosive needs.

The need for long-term care is a risk, not a certainty, with catastrophic financial consequences for the unlucky. Thus, insurance is the appropriate vehicle for dealing with the risk. Our current system, with heavy reliance on Medicaid, leaves substantial unmet needs and requires that people impoverish themselves before qualifying for financial help. As a nation, we can do better.

## **Universal Coverage**

The Financing Cabinet concluded that a system should be developed to provide as close to universal coverage as possible because all Americans, to the extent feasible, should have access to long-term care without impoverishing themselves and their families, and because substantially mitigating expected future Medicaid costs requires nearly universal insurance coverage with good protections.

As discussed in a subsequent section on benefits, the Cabinet does not envision an insurance system that will cover—as an entitlement—all long-term care costs for every American. Even if all or most Americans are enrolled in an insurance plan, there will be costs not covered by the plan. Some may wish to purchase extra wrap-around insurance; some may pay with private funds; and some will have inadequate funds for either. Thus the Cabinet assumes that a residual Medicaid system will need to be retained to cover these costs as well as to cover people who fall

through the cracks for one or another reason. The exact nature of that residual Medicaid system was not a focus for the Cabinet.<sup>10</sup>

## **Substantially Mitigating Medicaid Costs Requires Near Universal Coverage by Insurance**

One of the Finance Cabinet’s greatest concerns from the outset has been the pressure on Medicaid to provide increasing sums for long-term care, in the absence of an alternative. Thus a critical question is this: what does it take in terms of insurance coverage to mitigate future Medicaid costs substantially? Analyses from the Lewin model indicate that substantially mitigating Medicaid costs requires near universal coverage with better policies than private long-term care insurance holders have today.

Lewin researcher Lisa Alexih presented analyses to the Finance Cabinet comparing future spending on long-term care under two different assumptions about private long-term care insurance. The base case is the best estimate of future expenditures given current policies and trends. The second scenario (the “affordability” model) assumes that everyone who can afford long-term care insurance purchases the best policy they can afford.<sup>11</sup>

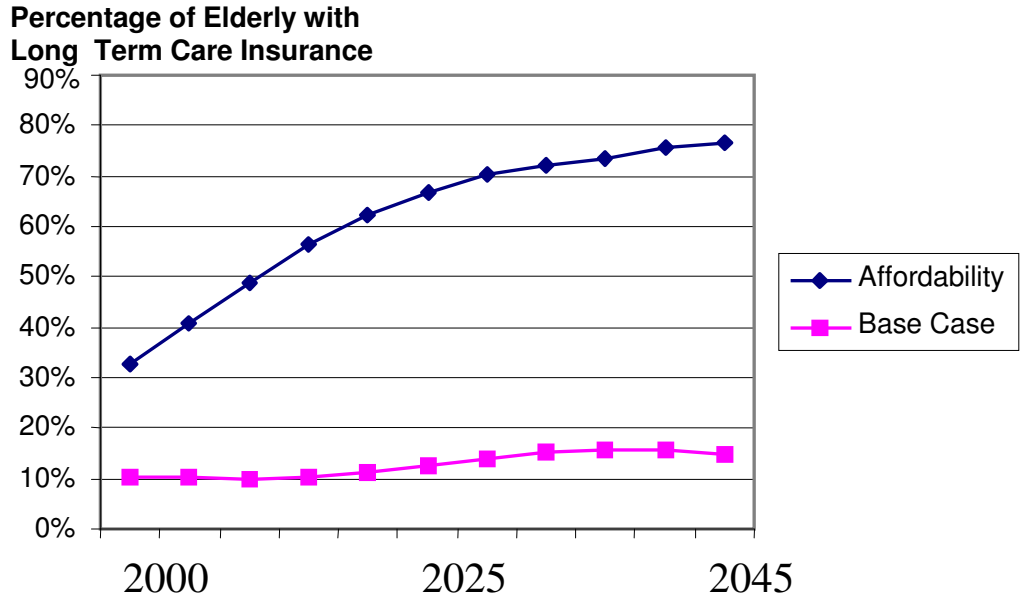
Under the first scenario—reflecting the current trend of somewhat increasing purchases of long-term care insurance—only about 15 percent of the elderly would be covered by private long-term care insurance by 2045, not much more than today (Exhibit 7). But if everyone who could afford the insurance bought it, almost 80 percent of the elderly would be covered by 2045, primarily because they purchased the insurance when they were young and the insurance was relatively inexpensive.

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<sup>10</sup> Proposals have been put forward by many, including the National Governors Association, to federalize the long-term care portions of Medicaid. Others have proposed establishing a national floor of income and asset protections for Medicaid to improve the safety net (National Academy for Social Insurance, 2005). These and other proposals for the residual Medicaid system envisioned by the Cabinet could be considered at a future time.

<sup>11</sup> Affordability was defined as those age 65+ spending no more than 4 percent of their income on insurance and younger people spending no more than 2 percent of their income.

**Exhibit 7: Long-Term Care Insurance Purchase- Base Case (best estimate given current trends) v. Affordability (everyone who can afford private insurance buys it)**

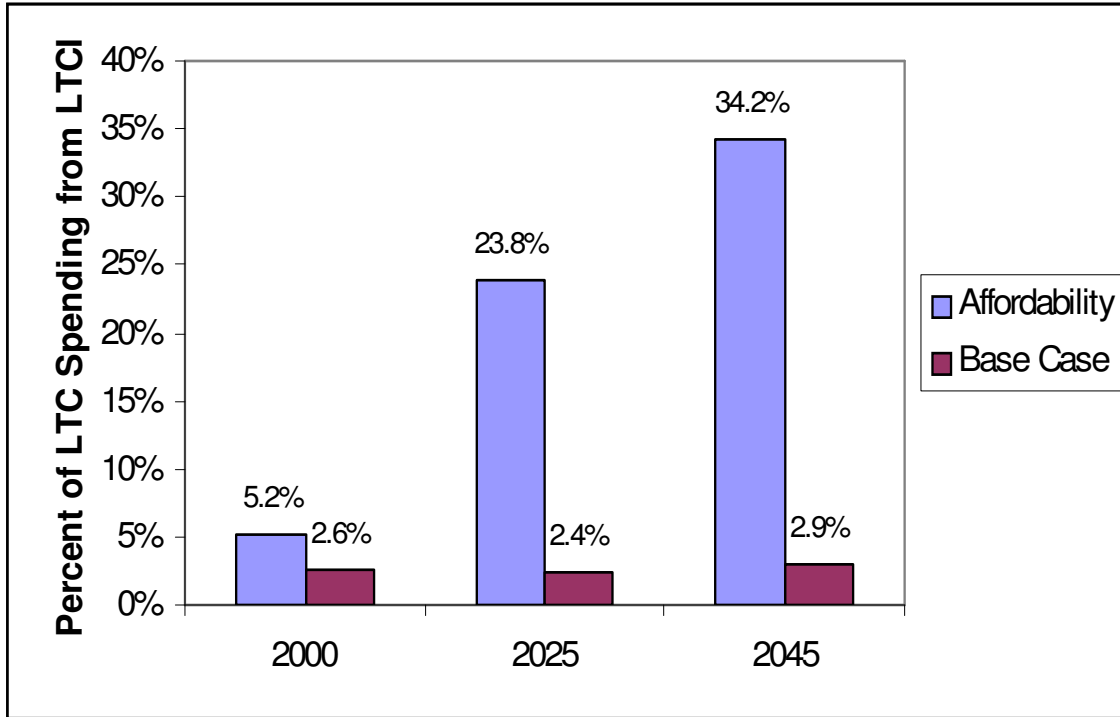


**Source: Lisa Alexih, Lewin Long-Term Care Financing Model**

By 2045, with 80 percent of the elderly covered by the best private long-term care insurance they could afford, insurance would be paying for 34.2 percent of long-term care costs—10 times the percentage that insurance would cover if current trends persist (Exhibit 8). The percentage covered by insurance under the “affordability” scenario is lower than it would be if more people could afford at least some insurance protection and the protection afforded by the insurance were better—increasing the numbers with inflation protection, for example. In terms of Medicaid spending, if current trends regarding private long-term care insurance persist, Medicaid costs increase five-fold (in constant dollars) by 2045 (Exhibit 9). But if everyone purchases the best long-term care policy he or she can afford, by 2045 Medicaid costs “only” triple.

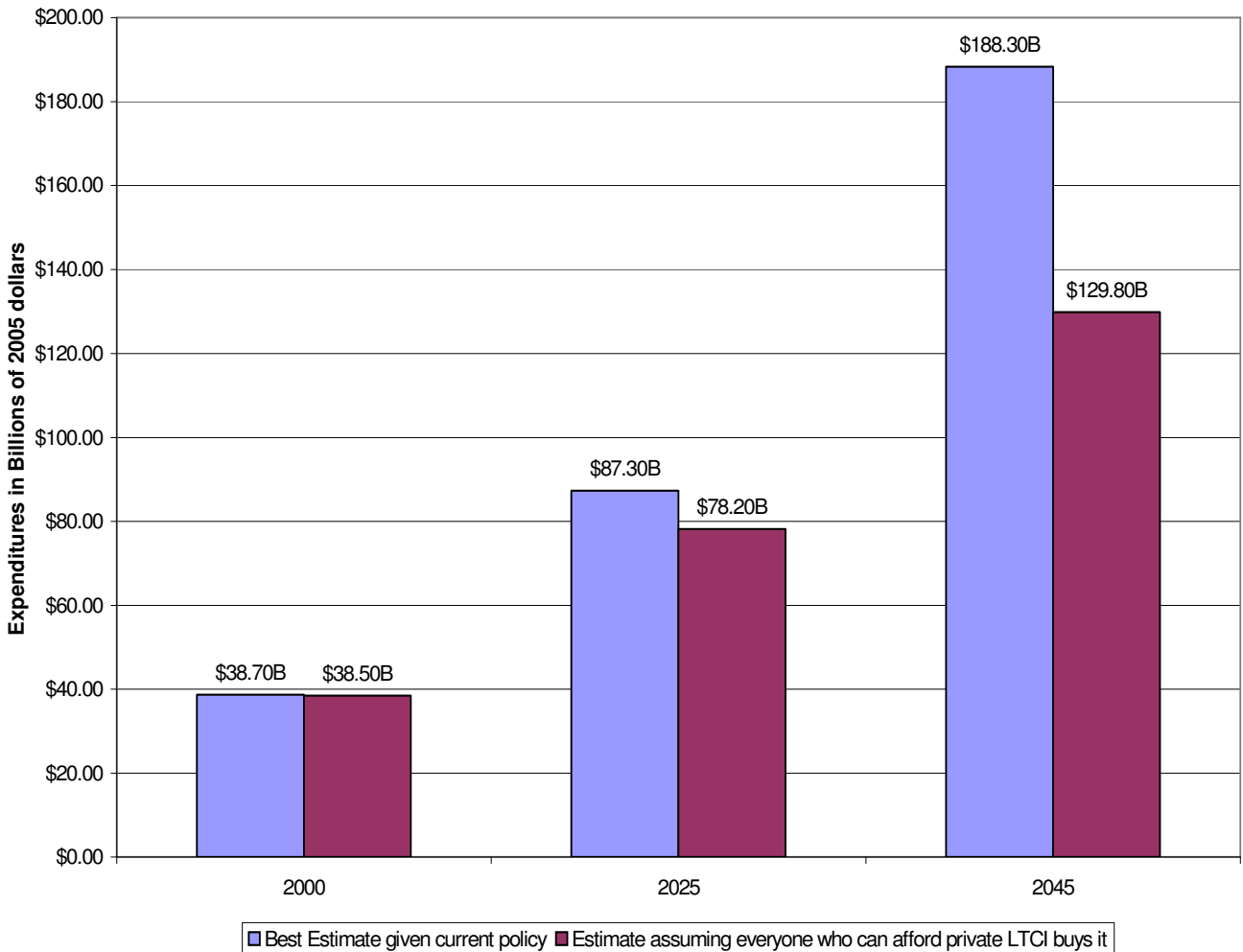
To reduce Medicaid costs even more would require nearly universal coverage with better protections. These analyses demonstrate that to mitigate future Medicaid costs substantially in the future requires dramatic policy changes—not just marginal increases in private long-term care purchases.

**Exhibit 8: Percentage of Spending on Long-Term Care Paid by Private Long-Term Care Insurance: Two Scenarios**



**Source and Notes: Lisa Alexih, Lewin Long-Term Care Financing Model.**  
“Affordability” means that everyone who can afford private LTC insurance buys it.  
“Base Case” represents the expected result, assuming current trends.

**Exhibit 9: Change in Medicaid Expenditures (in Billions of 2005 Dollars) Under Different Assumptions About Purchase of Long-Term Care Insurance**



**Source: AAHSA chart based on data from Lisa Alexih, Lewin Long-Term Care Financing model**

**Mandates and Voluntary Opt-Out Strategies**

As discussed above, nearly universal coverage is required to mitigate future Medicaid costs substantially. How can this be achieved? Universal participation can be achieved by a mandate, just as mortgage holders require home insurance and states require helmets or seatbelts. It also may be possible to achieve nearly universal participation with a voluntary participation

strategy. Under this approach, workers could be automatically enrolled in the insurance plan. Those who did not want to participate would be required to opt out. Research on opt-out programs with retirement accounts suggests fewer than 10 percent actually do take the steps to opt out (Choi, et. al., 2002). It is likely that a larger proportion would opt out of a long-term care insurance program because receiving an actual pay-out of benefits is not assured as it is with a retirement fund. But only real world experience—perhaps through a pilot program—will provide information on how a voluntary opt out program would actually work with long term care insurance.

## **Broad-based Public Insurance, Financed by Premiums, as a Foundation**

Given that the goal is universal (or nearly so) participation in an insurance system providing the greatest benefits for the lowest costs, what is the best way to get there? The Cabinet concluded that while private long-term care insurance should remain an important component of a national strategy, the foundation of that strategy should be a broad-based public insurance program with low overhead costs and an all-inclusive risk pool. The Cabinet concluded that even if private policies improved, insufficient numbers of people who otherwise might become Medicaid’s responsibility could afford and be persuaded to buy private insurance, even if, as some suggest, Medicaid eligibility were tightened and/or tax incentives were increased. Getting close enough to universal coverage will require a mandate or near mandate; that, in turn, requires that an equitable, affordable public insurance program be available, the Finance Cabinet concluded.

The public insurance program should be financed by premiums, not by general tax revenues. Premiums should be established in line with benefits to produce an actuarially sound program. People with very low incomes should receive financial assistance to purchase the insurance.

## **Encouraging or Mandating the Purchase of Private Long Term Care Insurance is Unlikely to Work**

The Cabinet concluded that encouraging or mandating purchase of private insurance is not a workable strategy for addressing the nation's long-term care needs. Non-buyers correctly perceive that private long-term care insurance is generally not a good value (researchers find that on average it costs about twice the actuarially fair price), and the weight of the evidence indicates that neither tax incentives nor plausible changes to Medicaid are likely to induce sufficient new buyers (who might have ended up on Medicaid) to save Medicaid much money at all. Given that, the Cabinet concluded that an equitable, affordable public insurance plan is a better approach. The logic and evidence supporting the Cabinet's decisions are detailed below.

### **Why Has Long-Term Care Insurance Remained a Minor Part of Long-Term Care Financing?**

Private long-term care insurance currently pays for less than 5 percent of long-term care costs, despite a three-fold growth in the number of policies sold each year between 1988 and 2002 (Desonia, 2004). The proportion of people who are eligible to buy is narrowed by underwriting procedures that exclude as much as 15-40 percent of the population for pre-existing health conditions. Among eligible individuals, only a small proportion actually purchases policies. Most policies (over 80 percent) are sold by brokers to individuals whose target market has been older adults. About 6-10 percent of persons over age 65 have purchased policies; the average age of buyers is 67 in this predominantly individual market. The group market (policies sold principally in the workplace) has been growing about 30 percent per year but is still very small—generally only about 5-6 percent of those eligible for employer-sponsored plans actually participate (Strum and Zuiker, 2002). In 2002 the federal government began offering (but not subsidizing) long-term care insurance for some 20 million employees, retirees and family members. Underwriting criteria are said to be somewhat less restrictive than for most individual market plans, and approximately 81 percent of those who applied in the first year were expected to qualify (Georgetown LTC Financing Project, 2003). But even with massive advertising and

education, the enrollment rate in the federal program has been only about 6 percent—the same as that in the general group market (Desonia, 2004).

Despite some increasing participation, most analysts predict a very limited role for private long-term care insurance in the future, given current trends and policies (i.e., no mandate to purchase it). Why has private long-term care insurance remained a small part of financing long-term care? Surveys of people who bought and did not buy the product consistently find some key factors. First, buyers have substantially greater wealth than non-buyers, leading one researcher to conclude, “The ...effects of high assets and income far outweigh the effects of most demographic variables, such as education, race, and age” (Mellor, 1998). Buyers also tend, not surprisingly, to be more risk-averse (Finkelstein and McGarry) and—surprisingly—more likely to be an elderly person with a daughter, at least among elderly males (Mellor, 1998). Non-buyers disproportionately have lower income and assets. Some people don’t buy because they incorrectly believe they are already covered; some are concerned that policies will become obsolete or the insurance companies will not be there 30 years later when care is needed. Many think the policies are too expensive given their other obligations; many say the policies are “not a good value.” In one study conducted by the insurance industry, 65 percent said they were concerned the policies were not a good value; in another conducted by university researchers, 63 percent of non-buyers had similar concerns ( Stum and Zuiker, 2002).

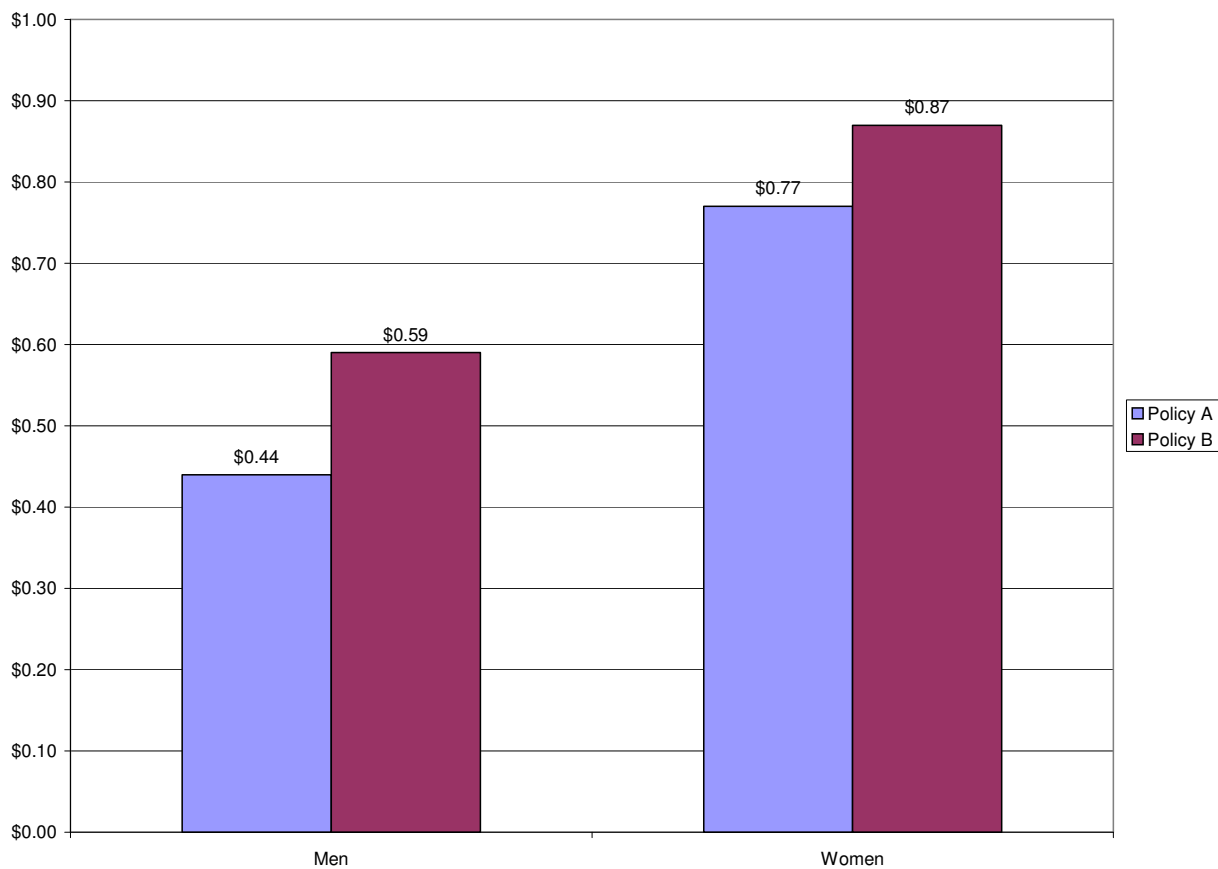
Research has recently confirmed that private long-term care policies on average are not a good value. Economists from Harvard and the University of Illinois, in work they believe provides “the first estimates of the money’s worth of long term care insurance,” compared what policy-holders would pay in premiums to the benefits they would receive (Brown and Finklestein, 2003).<sup>12</sup> They found that men received poorer value for their premiums than women but that, when average lapse rates were taken into account, neither men nor women got actuarially fair returns for their premiums. Exhibit 10 shows the results of their analysis of two of the many types of policies and scenarios they studied. Men, for example, get just 44 cents in benefits for every \$1.00 in premiums for a policy that covers all types of care (home, assisted living and nursing

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<sup>12</sup> “Money’s worth” was defined as the ratio of the expected present value of benefits to the expected present value of premiums. The researchers used “comprehensive data on the structure of insurance policies and their premiums” and “detailed actuarial data on transitions across different types of care by age and gender” in developing their model.

facility) for four years with a 60-day waiting period before coverage starts. With the same policy, women get 59 cents of benefits for every \$1.00 in premiums. The difference between men and women occurs because women live longer than men, receiving more benefits, but policies generally cost the same for women as for men, all else being equal.

**Exhibit 10: Lack of Money’s Worth from Private Long-Term Care Insurance: Present Value of Benefits for Every \$1.00 (present value) of Premium Costs**



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Source: Brown and Finklestein, 2003. “Policy A”=covers all types of care, 60-day waiting period, four-year benefit period. “Policy B”= covers nursing facility only, 90-day waiting period, two-year benefit period. Assumes average lapse rates.

These same researchers considered whether changes in tax policy, which would lower the cost to the purchaser, might induce more people to buy private long-term care insurance policies and considered the role of Medicaid in potentially discouraging such purchases.

### **Could Tax Incentives or Changes to Medicaid Sufficiently Increase Purchases?**

The weight of the available evidence indicates that tax incentives are costly and unlikely to stimulate sufficiently the purchase of long-term care insurance by people who otherwise would become Medicaid's responsibility. Neither do analysts—including the Congressional Budget Office—believe that more than very small amounts can be saved directly by Medicaid strategies such as tightening the spend-down and asset protection rules. Economists do find that Medicaid *in theory* could deter all but the wealthiest from buying private long-term care insurance, but, they acknowledge, so would any safety-net policy that provided quality care to those who needed it but had no money to pay. Further, researchers find little evidence that long-term care insurance decisions are in fact—as opposed to theory—affected by Medicaid policies to any substantial degree. Thus, neither tax incentives nor plausible changes to Medicaid are likely to be effective strategies for substantially increasing private long-term care purchases.

#### **Tax Incentives**

Focusing on cost as a factor discouraging purchase, some advocate lowering the cost to buyers of long-term care insurance through tax incentives, thus shifting the cost to the treasury. At the federal level, the cost of qualified long-term care insurance policies is deductible, but only if the cost of the insurance and other medical expenses exceeds 7.5 percent of adjusted gross income, canceling the value of the deduction for most people. Approximately 30 states also provide various levels and types of tax deductibility for long-term care insurance. There are numerous proposals at the state and federal level to expand these deductions, including making the cost of qualified plans an “above the line” federal deduction available to people who do not itemize or do not have sufficient medical expenditures to qualify for the “below the line” deduction.

Tax deductions are costly, are more valuable to people with higher incomes, and produce (according to the available evidence) little in the way of Medicaid savings. Proponents of tax

deductions argue that the deductions will pay for themselves in reduced Medicaid expenditures. The foregone taxes occur immediately, but the Medicaid savings are speculative and far in the future. Evidence from financial modeling by various analysts indicates a very modest net payoff, if any, principally because those who benefit most from tax deductions are those with the highest incomes—people who are unlikely to go on Medicaid even without insurance:

- Researchers using the Lewin long-term care financing model investigated multiple tax deduction scenarios in 1994 and found only one that approached breaking even after 25 years.<sup>13</sup>
- Researchers using a different model, in work prepared for the American Health Care Association, found the tax deduction policy they studied saved Medicaid 8 percent of projected costs by 2050 but cost more in forgone taxes than the Medicaid savings (Frakt and Pizer, 2001).
- Researchers in a work commissioned for the Health Insurance Association of America concluded from their analysis that a 100 percent above-the-line tax deduction for long-term care insurance would reduce future Medicaid expenditures \$3.5 to \$3.8 billion annually. By comparison, Lewin estimates Medicaid spending for long-term care in 2025 to be \$87.3 billion. The HIAA analysts did conclude that the tax deduction would cost less than the Medicaid savings such that Medicaid would save \$1.06 for each federal tax dollar foregone (Cohen and Weinrobe, 2000).

Refundable tax credits, if they work as intended to induce demand for private long-term care insurance, would be more likely to save Medicaid money because they can be targeted to people with lower incomes. A refundable tax credit does not require one's tax liability to be higher than the credit; that is, people can qualify for the credit even if they end up with no tax liability. In other cases, a tax credit is deducted from one's tax liability. One set of researchers, using a sophisticated simulation model, have reported that the refundable tax credit they studied could save Medicaid considerably more than the tax deduction studied and that the tax deduction would also cost less in foregone tax revenues than the savings. While the tax credit approach was more successful than a tax deduction strategy, the tax credit approach yielded, at best, 25 percent

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<sup>13</sup> Research by Weiner, Illston and Hanely (1994) cited in Merlis (1999). Merlis reports, "The most successful option assumed an employer-based program with employer contributions of 50 percent of premiums."

of projected Medicaid savings, or a net of 20 percent after the cost of the foregone tax was included (Frakt and Pizer, 2001).

Estimates of Medicaid savings from tax incentives depend on the researchers' assumptions about how much induced demand such incentives will generate. A number of researchers question whether tax incentives can have much effect at all on people with lower incomes. First, there is a timing problem in that cash to purchase the insurance must be spent before the value of a tax deduction or tax credit is received, creating a potential cash flow problem. Second, there is an issue, particularly with tax deductions, of the modest savings possible, compared to the huge step of committing oneself to a long-term care insurance policy, which especially concerns younger people. Mark Merlis gives this example:

“In 1995, the average federal taxpayer paid at a marginal rate of 14.7 percent. An above the line deduction for the purchase of long-term care insurance in that year would have reduced a \$500 annual premium for a 40-year old to \$427. Allowing purchase through flexible spending arrangements would also reduce the tax-payer's liability for Social Security and Medicare payroll taxes—a \$500 policy would then cost \$388. It is not clear whether such price reductions would be sufficient to induce many more middle-income persons to buy coverage during their working years” (Merlis, 1999).

Economists Jeffrey Brown and Amy Finkelstein, reviewing the results of analyses conducted using their sophisticated model of long-term care insurance costs and benefits, have recently concluded “...The results suggest that tax subsidies are unlikely to be an effective way to induce demand for a large fraction of the population” (Brown and Finkelstein, 2003). Their analyses are principally concerned with the question of the degree to which Medicaid's availability “crowds out” or deters the purchase of private long-term care insurance.

### **Changes to Medicaid**

Some critics of Medicaid claim that it has become a middle-class entitlement and an asset shelter for the rich, who use it to avoid paying for their own long-term care. If this were true to a large degree, Medicaid costs could be cut substantially simply by closing the loopholes. But empirical research, exhaustively reviewed by Ellen O'Brien, finds little support for substantial misuse (even legally) of Medicaid, and federal analysts predict only very small savings from

tightening the asset transfer rules (O'Brien, 2005). For example, the Medicaid Commission, charged with finding savings for the program for 2006, recommended changing the penalty date for transferring assets (projected five-year savings of \$1.4 billion), and increasing the look-back period for asset transfers (projected five-year savings less than \$100 million). But these combined are less than one-half percent of Medicaid's projected costs over the same five-year period (\$328.9 billion).

. Some economists do find that Medicaid *in theory* could deter all but the wealthiest from buying private long-term care insurance, but, they acknowledge, so would any safety-net policy that provided quality care to those who needed it but had no money to pay.<sup>14</sup> Even if these theoretical studies reflected how people actually behave, the policies that would correct the problem—providing no safety net at all or cutting Medicaid recipients' quality of care in half—are not policies that AAHSA could support. But researchers actually find little evidence that long-term care insurance decisions are in fact—as opposed to theory—affected by Medicaid policies to any substantial degree. For example, one careful analysis of people's decisions about long-term care insurance purchases found Medicaid policies had no effect on purchases for those aged 51 to 61 and only a small effect on the decisions of those over age 70 (Sloan, et. al, 1996)

## **Why Not Mandate Purchase of Private Insurance?**

If universal (or nearly so) coverage cannot be achieved by encouraging people to purchase private long-term care insurance, why not mandate it? The principal reasons for rejecting this approach were the following:

- Private plans have high overhead costs, smaller risk pools, a need for investor returns, and hence higher premiums than a public program could have.
- It would be hard to mandate a product that can't sell itself in the market, particularly when distrust of the stability of private insurers is part of the deterrent to purchase.

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<sup>14</sup> Economists Brown and Finklestein (2003) concluded “the very presence of Medicaid crowds out private insurance for over half the households, and significantly reduces the value of private insurance among the rest.” Theirs is not a study of what people actually do in real life, but what people might do if they made decisions based on obtaining an “optimal consumption pattern.” A comparison was made, in essence, between what individuals with various incomes and life histories might be able to consume (the measure of “utility”) with and without an insurance policy. For all but the wealthiest part of the income distribution, long-term care insurance—by this measure—was not a rational purchase.

- One could, more likely, mandate public insurance, and public insurance also allows the possibility of getting to nearly universal participation with a voluntary opt-out approach.
  - What's more, it would be unethical to auto-enroll people in private plans with very different costs and benefits.<sup>15</sup>
  - If one tried to solve the ethical dilemma by requiring all private plans to have an identical “basic plan” for auto-enrollees, what would be the point of competition?

Finally, the Finance Cabinet considered the new national experiment in competing private plans—Medicare Part D. The Cabinet was concerned about increased consumer confusion, with no clear benefit for the long-term care insurance currently envisioned. The results of Medicare Part D so far indicate that competition among private plans *has worked* to produce benefit designs more preferred by consumers than the one Congress originally designed. While Congress designed a “target” model plan with a doughnut hole, set deductibles and determined co-pay amounts as a percentage of drug costs; Part D consumers are more commonly selecting plans with different benefit designs, such as flat co-pays.<sup>16</sup>

The relevance of that one clear advantage in Part D from competition among private plans to a disability long-term care insurance plan (as the Cabinet envisions) and how that might outweigh the disadvantages of competing private plans is not entirely clear. But given current information, the Cabinet concluded that mandating insurance purchased from competing private plans would be less optimal than a broad-based public insurance plan as the foundation of the new financing system.

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<sup>15</sup> Medicare Part D does auto-enroll dual eligibles in private plans that differ somewhat in the drugs they cover. But dual eligibles pay the same price, regardless of the plan, so long as they use formulary drugs or obtain an exception. Therefore, the same level of ethical concerns is not raised by Medicare Part D.

<sup>16</sup> The jury is still out with regard to whether the design saved money compared to alternative designs that have been proposed. While the cost of premiums has turned out to be lower than had been predicted, that only means that predictions were faulty, as they commonly are.

## **Premiums to Pay for a Workable Publicly Offered Insurance Plan**

The goal is to devise a plan that is actuarially sound and sustainable from the premiums paid by individuals joining the plan. The details of this need to be worked out in concert with decisions about benefit levels and will require substantial modeling. The range of possible levels of premiums is suggested by considering the difference between the plan passed by both Houses in Hawaii (though vetoed by the governor) and the German plan. The Hawaii plan matched universal premiums of \$10/month with a \$75/day benefit for one year. The German plan relies on premiums pegged at 1.7 percent of payroll, split evenly between business and individuals, with the top 10 percent of earners allowed to buy private insurance with comparable coverage instead. Benefits, described in the following section, are substantial and extend for a lifetime.

The Cabinet admired the simplicity of the Hawaii plan's flat rate and the approach to equity in the German plan's progressive percentage rate. The Cabinet recommends a plan that balances the two competing objectives. This might be achieved by setting a flat rate for most people, but tying premiums somewhat to income level for those with low incomes. If universal participation is mandated, then the lower premiums paid by those with low incomes could be subsidized by higher premiums of others. If the plan is implemented using the voluntary opt-out approach, low-income premiums would likely need to be subsidized from general revenues for equity's sake.

## **Benefits**

The Cabinet recommends the following key features for benefits associated with the new insurance plan:

- One, if not the only, choice of benefits should be cash to be used at the beneficiary's discretion.
- Benefits should be tied to a relatively simple level-of-need determination based on functional status; age should not be a criterion.

- Benefit levels should optimally provide for a foundational level of services for people in the community and in residential settings, consistent with keeping the program actuarially sound.
- Systems to ensure that beneficiaries have access to appropriate help selecting and securing needed services must be available; vulnerable adult protections must be enforced and exploitation potentially associated with cash benefits guarded against.

Each of these features is discussed below.

## **Cash Benefits: At Least One of the Options**

The Cabinet recommends that the new insurance plan more closely follow a disability insurance model than a medical insurance model. Disability insurance typically provides a cash benefit for people to use however they like. Medical insurance, by contrast, pays for a defined set of “medically necessary” services. The latter typically are accompanied by various systems of utilization review and control, including set schedules of maximum reimbursable amounts for particular services (e.g., a maximum \$500/year for drug coverage) or lifetime use of any service. While a disability model, with cash benefits, is generally more appropriate for long-term care in the Cabinet’s view, a cash benefit raises some difficult issues, including consumer protections and cost control.

Some consumer protection issues can be addressed through a model developed in the successful Cash and Counseling experiments. In those experiments, consumers’ monetary benefits were deposited with a fiscal intermediary who paid bills as directed by the consumer; counselors provided assistance in purchasing decisions. Another approach, which addresses both consumer protection and cost control issues, is a model used in the German system. For every level of need, beneficiaries are given three choices: cash, specified services in the community (up to a dollar limit), or institutional care. At each level of care, the cash benefit—always the most popular—is less than the benefit for defined services or institutional care. The German model, however, introduces some challenges of its own (e.g., a tendency to perpetuate an institutional bias).

In sum, there are a number of different ways to design benefits in which cash is at least one of the options. Variations include such issues as who gets the cash—the individual or a fiscal

intermediary? How much control does the beneficiary have over what may be bought with the cash—is this completely unrestricted? What other choices might a beneficiary have to choose from at the point of qualification? If there are choices among types of benefits, is the value of each the same or different?

Ultimately decisions about how best to balance the pros and cons of various options need to take into account financial realities—how much people are willing to pay for choices—and other details of system design (the effectiveness of administrative systems to control fraud and protect consumers, for example).

Political realities are also a factor: What design features do consumers and their representatives want? What is critical to garner support from important constituencies? Weighing the pros and cons also is better informed by computer modeling of the likely costs of various options so trade-offs can be quantified. The Cabinet thus recommends that multiple, detailed options remain on the table for future resolution, consistent with the principle that cash be one, if not the only, benefit option.

## **A Disability Model with Cash Benefits Is More Appropriate for LTC Insurance**

The disability model, with cash as the basic benefit, is more appropriate to a long-term care insurance plan than a medical model, in the Cabinet's view.

First, cash benefits provide consumers maximum choice in meeting their needs, including such things as home modifications, employing relatives to provide personal care services, or purchasing services from an agency or residential care provider. Consumer choice and maximum flexibility are particularly important in long-term care because the primary goal of long-term care is to help people maintain maximum functioning. The best way to support individual functioning in any community can be very idiosyncratic. Reflecting this, studies show that professionals, asked to outline an optimal care plan for identical cases, prescribe wildly varying amounts and types of supports.

Second, cash benefits address one of the major concerns about long-term care insurance—service obsolescence. People are concerned that the services provided in the benefit package

purchased at age 50 (e.g., today's typical choice of specified home care, assisted living or nursing home services) will be obsolete when help is needed 30 years later (Stone, 2001). New technologies (e.g., robots) or ways of packaging or purchasing services (e.g., paying a flat monthly fee to an organization that provides a whole array of services from home fix-ups to grocery shopping) are likely to replace what we know today.

Third, available evidence indicates that long-term care consumers are more satisfied with plans that allow them to control how funds for long-term care are spent. Disability model plans make up only 10 percent of the long-term care private insurance plans that are sold. Experts attribute this both to the higher cost of disability plans and to the fact that fewer companies offer such policies. Yet a recent study of thousands of people with private long-term care insurance who had actually used it (filed a claim) found that 95 percent of those with disability plans were satisfied compared to 60 percent of those with traditional plans (Cohen, 2001). Strong evidence of consumer preferences also comes from a recently completed evaluation of the Cash and Counseling demonstration. More than 6,000 Medicaid beneficiaries (elderly and children) who used personal care services were randomly assigned to either traditional agency services or to a plan in which they received cash (up to a budgeted amount) to purchase services and goods they wanted—from home modifications to hiring relatives as care-givers. Researchers found that those in the cash benefit group were significantly more satisfied with services, by wide margins, than those in the traditional plan (Brown, 2006).

Fourth, there is evidence of a preference for cash benefits from the one state (Hawaii), which publicly debated and designed a universal long-term care insurance plan for citizens that was passed by both houses of the legislature, though ultimately vetoed by a new governor who took office shortly after the plan passed. The Hawaii plan, being reconsidered by the current legislature, was to be financed principally by mandatory \$10/month premiums and was to pay—when fully phased in—\$70/day (for one year) for those meeting disability criteria (two or more ADLs or a defined cognitive impairment). A key selling point was the full choice provided by the cash benefit.

Fifth, a disability model that makes it possible for beneficiaries to hire people—neighbors and relatives—who would not otherwise have done personal care services work has the potential

to expand the supply of needed long-term care workers. As researcher Robyn Stone points out, “A recent study of the In-Home Supportive Services Program in California, which allows participants to hire relatives, friends, and neighbors as caregivers, underscores the potential of [the disability model] for developing untapped sources of labor. The researchers found that approximately one-fifth of the family and friends hired as paid caregivers had not previously been providing long-term care assistance, either paid or unpaid” (Stone, 2001).

Lastly, the Cabinet is proposing a financing system that wraps around and extends, rather than replaces, existing Medicare benefits, which will continue to provide for more intensely medical and shorter-term rehabilitation needs. The proposed insurance program is not meant to cover everything that is today sometimes included in lists of “long-term care services.” Medicare’s skilled nursing, outpatient therapy and home health benefits all require strengthening, but the Cabinet envisions them continuing. The more medical the service need, the more appropriate is an insurance model priced to provide for all “medically necessary” services. Consumers are far less able to determine how many of what kinds of medical tests they need than they are to determine how many hours of personal care assistance they need and want. Thus, in the Cabinet’s view, a system that combines both types of insurance—an indemnity model for highly medical needs and a disability model for basic long-term care needs—is optimal.

### **Concerns Raised by a Purely Cash Benefit**

Despite the notable advantages of a pure disability model with only cash benefits, the model raises concerns about consumer protections, cost control, and even fundamental social cohesion as services formally provided for love and duty are “monetized.” Some are concerned that long-term care consumers, particularly the frail elderly with few supports, would be subject to abuse from people who prey on the vulnerable; relatives might keep elders at home with inadequate care to garner the disability cash payments. For some, the concern increases with the size of the cash payment. Private long-term care insurance policies typically offer a choice of \$50/day or \$100/day for those in a nursing home. Suppose that a universal disability insurance plan paid those benefits directly to a beneficiary who qualified for benefits by reason of disability, but did not choose to go to a nursing home, and could instead spend the cash in any way. The

beneficiary would be getting monthly checks of \$1,500 to \$3,000, which for many would exceed all other forms of monthly income—current or achieved during working years. Would this amount of “new money” make otherwise low-income elderly or disabled persons more vulnerable to scam artists and unscrupulous care givers than they are now?

Additional consumer protection concerns raised by a cash benefit include matters such as how beneficiaries, particularly those with cognitive impairments, might find quality services at a fair price or manage to coordinate an array of service workers. Lessons from the Cash and Counseling experiment suggest some of the ways these and other consumer protection concerns might be addressed, while maintaining what is fundamentally a disability benefits model.

Cash benefits also raise the issue of potentially greater “moral hazard” associated with the insurance plan than a pay-for-services model. Moral hazard refers to the tendency of insurance (which reduces the price to the consumer of a good or service) to induce greater use of that service or good. Policy-makers more typically talk about this issue under the rubric “woodwork effect” (although the term “moral hazard” sometimes has overtones of fraudulent use of a benefit). Since most people would prefer not to enter a nursing home unless it is really needed, an insurance product paying for nursing home care risks minimal moral hazard. But since free cash is infinitely popular, some analysts argue it carries a high risk of moral hazard or bringing people “out of the woodwork” to use the benefit. Some further see that there will be an extreme temptation to push the limits of legitimate eligibility: “If people can make money from insurance and do not have to do anything that healthy people would not do, there will be very substantial (and very clever) excess claims” (Pauly, 2001).

At a minimum, a disability insurance model will require attention to the potential for fraud and malingering and a well-designed system for eligibility determinations (assessments). But even if fraud and malingering were eliminated, cash benefits are still substantially more likely to be used than a service benefit (particularly a nursing home) for any level of disability. Private sector long-term care insurance plans deal with this by charging higher premiums for disability (cash) plans than for other types. One expert reports that disability long-term care insurance plans

cost 30-50 percent more than roughly equivalent service plans (LTCQ.com, 2005).<sup>17</sup> The German system effectively mirrors this differential pricing; while premiums do not differ by the benefit ultimately chosen, the value of the benefit paid out is less when cash is chosen. The notion built into this model is that even if cash is so popular that benefits are always used when qualification by reason of disability is at all possible, system costs can be controlled by offering a much reduced benefit when cash is chosen. However, that approach to cost control raises additional issues, discussed in the section below specifically dealing with the German system.

Finally, some people are concerned that cash benefits will mean that services that many families previously provided out of love or duty will become paid services leading to withdrawal of family supports, diminished exercise of familial responsibility, and ultimately lower social cohesion. Researchers have studied the topic of the relationship between provision of formal and informal services for over a quarter of a century. In brief, the research shows either no relationship between increased availability of either public or private coverage for community-based long-term care services or modest reductions in informal services, consistent with reductions in care-giver stress (Brown, 2006; Christianson, 1988; Hanley, et al, 1991; Kemper, 1992; Penning, et. al., 2000; Penning, 2002; Shanas, 1979; Tennstedt, 1996). Two recent studies are particularly relevant to the type of insurance plan with cash benefits discussed in the paper. A large-scale study, for example, was conducted between 1997 and 1999, to examine the difference in long-term care use for a large sample of people with and without private long-term care insurance (RWJ, 2005). That study found:

- **Long-term care insurance finances more formal care, but its benefits do not replace informal care.** The presence of insurance increases weekly care for people with long-term care insurance by 10 to 13 hours, with the increase coming from paid care financed by the insurance. The additional care financed by insurance does not lead to a reduction in total care received. Roughly, two in three informal caregivers had not reduced the level of care they provided, and half of the informal caregivers provided the same level of care.
- **About half of all claimants and informal caregivers indicated that without private insurance, they would have to seek institutional alternatives, i.e., nursing home care or assisted living facilities.**

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<sup>17</sup> All of the price differential is not necessarily due to higher cost to the insurer of more claims against the disability plans. Some (perhaps much) of the difference may simply reflect market conditions—people who want the choice afforded by cash benefits are willing to pay substantially more for that.

- About **two in three informal caregivers indicated that the presence of private insurance benefits reduced their stress level.**

A second particularly relevant study –an evaluation of the Cash and Counseling experiment discussed in detail below—looked at cash benefits and the effect on informal care-giving, rather than the type of formal service benefit discussed above. In this second study, researchers found that informal care-givers *did* reduce their hours of care-giving modestly, resulting in considerable reductions in stress and lowered depression for the care-givers. But informal care-givers did not by any means “abandon” the people with disabilities for whom they cared and the combination of newly purchased personal care services and continued (though reduced) informal unpaid care resulted in delayed and avoided nursing home use (Brown, 2006).

The sections that follow describe two programs in which cash has been at least one of the options in real world, successful approaches to financing long-term care services.

### **Cash and Counseling: A Successful Experiment Pioneers Ways to Help Consumers Manage Choices**

Beginning in 1998, the federal government and the Robert Wood Johnson Foundation have collaborated on funding a large scale demonstration in three states (New Jersey, Arkansas and Florida) that tests newly designed systems for giving cash to qualifying Medicaid beneficiaries who need help to live with disabilities against the traditional system in which Medicaid pays professional agencies to provide services. The cash may be used to hire personal care workers (including family or friends) or may be spent on other needs (e.g., home modifications). The demonstration enrolled over 6,000 beneficiaries (with random assignment into either treatment or control groups), including children, young adults and the aged. It has proved a resounding success with respect to virtually all of the program goals. According to the lead researcher in charge of the evaluation:

- “Consumers *love* the program—lives improved:
  - Fewer unmet needs; large increases in satisfaction with care
  - Quality of care same or better [than conventional services]
  - Fraud/abuse was rare

- Informal caregivers' well-being improved; workers satisfied, not exploited [; workers received wages the same or higher than agency workers]
- Care costs were generally higher, but:
  - Mostly due to traditional program's poor access [in that due to worker shortages and other factors, beneficiaries in the traditional programs rarely got all the services the care managers actually thought they optimally needed]
  - Partially offset by savings in nursing home and other long term care costs [; nursing home admissions and cost for those in the experimental program were 18 percent lower than for those in the conventional program].”  
(Brown, 2006)

The project developed systems to address some concerns that people have raised with respect to cash benefits. Among these are fiscal intermediary and counseling services. At the outset of the project, there were some concerns that beneficiaries (particularly the frail elderly) might be substantially challenged to understand and execute appropriately rules for withholding and paying taxes on the employees they hired to help with personal care and to otherwise manage the cash. Agencies were engaged to serve as fiscal intermediaries, and beneficiaries were given a choice of whether to receive the cash directly or have it go to the fiscal intermediary, who would then be responsible for paying the bills submitted by the beneficiary and handling the payroll taxes. Beneficiaries who chose to handle the cash on their own were given a test of their competency to do so. In the end, few beneficiaries chose to receive the cash directly and in even fewer cases were there any problems with this aspect of the cash benefits (Brown, 2006; Mahoney, et. al., 2000).

Beneficiary counselors are another notable feature of the demonstration. Each state's project developed unique details of this aspect of the program, working out such issues as “how consumers are matched with counselors, the acceptable ratio of counselors to consumers, appropriate training, and [how to] ensure that [counselor] performance standards are met” (Mahoney, et. al., 2000). In general, the system worked as follows. Beneficiaries enrolled in the

cash payments system met with a counselor at the outset to develop a plan and budget—so many hours of personal care per week, so much to be saved each month toward needed equipment, and so forth. Beneficiaries were free to consult with the counselors as needed but also had some minimal number of required check-ins. Items or services on the spending plan (which could be changed by mutual agreement) became “allowable expenses” that the fiscal intermediary could pay for on the beneficiary’s behalf. In general, most beneficiaries were also given roughly 10 percent of their monthly allowance in plain cash, to spend on anything, such as cab rides or whatever they needed (Brown, 2006).

The Cash and Counseling demonstration has provided a wealth of evaluation material from which important lessons can be learned to help guide any future expansion of the system. Based on findings from the initial evaluation, just becoming available in 2006, the systems developed in this project may provide for an optimal balance of the benefits of consumer choice without abandoning those with long-term care needs to fend for themselves.

### **The German Long-Term Care Insurance System: Choice Between Unfettered Cash or More Money for Purchased Services**

Eleven years ago, Germany had a long-term care financing system very similar to that in the United States today. A program similar to Medicaid paid for most of the care with costs shared by the federal government and state (Lander) and local authorities. Increasing costs of care and an aging population strained state and local authorities to the brink, and they joined with consumer advocates who had long urged that Germany extend its public/private health care financing system to include long-term care insurance (Shunk and Estes, 2001; Wilbers, 2004). In 1995, Germany implemented a new long-term care insurance system, financed by premiums paid through payroll taxes and administered by the quasi-public, quasi-private “sickness funds” (which derive from the old Guild system) that administer health insurance in the country.

The German system, which remains extremely popular and generally financially sound today, met the nation’s goals of shifting financing from a welfare system to an insurance system. It substantially shifted the costs from the “Medicaid” system to private funding, reducing unmet needs by expanding access to both residential and community-based services, increasing the use

of community based services, and providing support for family members caring for elderly persons at home (Cueller and Weiner, 2001). As noted above, beneficiaries are given a choice of benefits for each level of disability. The benefits for 1999 are shown in Exhibit 11.

**Exhibit 11: Monthly Benefits of the German System, 1999**

Disability Level	Cash (at home)	Services at home (payments to allowed service providers up to this amount)	Care in Institution (the lesser of 75% of costs—i.e., the price paid by the consumer—or this amount)
I	\$200	\$375	\$1,000
II	\$400	\$900	\$1,250
III	\$650	\$1,400	\$1,400
“Hardship Cases”	N/A	\$1,875	\$1,650

Disability levels are determined by an assessment of a person’s need for help with activities of daily living (e.g., bathing, dressing, toileting) and instrumental activities of daily living (e.g., shopping, cleaning). Notice in Exhibit 11 that as the disability level increases from level I to Level III, the cash benefit is closer to the institutional benefit level. At disability level I, the cash benefit is just 20 percent of the institutional benefit, but at level III, the cash benefit is nearly half the institutional benefit. But differently, the cash benefit for a level III (most disabled) beneficiary is 3.25 times that for a level I beneficiary while the value of the institutional benefit for a Level III beneficiary is just 1.4 times that for a level I institutional beneficiary. Presumably, this recognizes that residential care has certain fixed costs that do not vary substantially with a resident’s level of care, while a person living at home can presumably more closely match service use to personal needs.

The institutional benefit is supposed to cover 75 percent of the consumer’s cost of nursing home care, with the remainder—assumed to be the share devoted to room and board—the

responsibility of the individual. Germany retains a residual “Medicaid” system for those too poor to pay even the remaining 25 percent, but the proportion of total costs paid by this welfare program have been roughly halved since the inception of the new insurance program.

Consumer protection concerns were at the heart of the early debate in Germany over whether a cash benefit should even be part of the new long-term care insurance plan introduced in 1995.

“Care experts feared that cash benefits would encourage abuse by discouraging caregivers from seeking professional help for their family member. However, surveys indicated that about 80 percent of people in need of care receive it from their families. A solution without cash benefits might encourage them to give up family care and turn to professional (and more expensive) help.” (Wilbers, p. 6)

In the end Germany did include cash as one of a choice of benefits in its insurance plan, introducing some mechanisms as safeguards for beneficiaries who selected cash, although those mechanisms have not worked as well as originally intended. As noted above, the German long-term care insurance system is administered by a set of quasi-public/quasi-private insurance plans. Each has a medical assessment unit—the MDK (Medizinischer der Krankenkassen). The MDK is responsible for determining the level of disability of persons seeking benefits from the insurance plan. Beneficiaries who are assessed to have needs qualifying for benefits may choose a cash benefit or services in the community or a nursing home. To protect consumers, the MDK has the authority to deny nursing home care (because it is not really needed) or effectively require it, by determining that the person cannot be cared for appropriately at home with either the cash or service benefit. Analysts report, however, that as a practical matter, these safeguards are ineffective because it is hard to prove that a person can only do well with care in a particular setting and “because it is cheaper for the care insurance plans to offer cash benefits.” (Wilbers, 2004).

Analysts were surprised at the popularity of the cash benefit choice in Germany and credit its popularity with restraining costs below original projections. In 1997, for example, 58 percent of beneficiaries chose the cash benefit. The popularity of the at-home cash benefits has raised concern among “[g]overnment experts, insurance companies, and the MDK [who] regard the

proportion of those receiving money alone as too high; but they also see that cash payment is much less expensive than either services or nursing home care” (Wilbers, 2004).

While Germany still has some concerns about whether those receiving the cash benefit are getting the help they really need, one advantage of the German system in terms of consumer protection is that the largest monthly sums of money (that is, those for institutional services) are not given out as cash but are paid directly to service providers. While some view this as consumer protection, champions of cash benefits argue that it is denying consumers the full choice of how to spend their insurance money by requiring that they be in a nursing home to get the highest benefits.

With respect to cost containment issues, one clear benefit of the German system is that it addresses the popularity of cash benefits (moral hazard as some see it) while maintaining an affordable insurance product. But this is done by underpaying the cash benefit, relative to the institutional benefit, which creates an “institutional bias.” As the term (institutional bias) is used in debates about long-term care systems, it refers to any aspect of policy or financing that lowers a barrier to institutional care, relative to care in the community. Thus a system that pays more for people in institutions than for those *with the same level of disability* in the community has an “institutional bias” by definition. Arguably that bias is not as great in the German system as in the current American Medicaid system in which Medicaid nursing home care is an entitlement while Medicaid home and community-based services are not.

If the goal is to make the financing system indifferent to site of care (that is, let consumer preferences and needs drive decisions about site of care), then the system can’t provide higher benefits to people in nursing homes than to those with the same care needs at home, at least not across all levels of care. For the frailest, most dependent, and those needing substantial amounts of professional nursing, costs generally will be higher in a home setting than in a nursing home. But an insurance system that provided for benefits so generous that everyone could pay indefinitely for 24-hour private duty professional nursing at home would be far too expensive. Thus some degree of “institutional bias” will be built into any financially feasible long-term care insurance plan.

A system that provides the same benefit amount for people at the same level of care is already a compromise with the ideal of a financing system with no institutional bias. How much further is it appropriate to sacrifice optimal consumer choice for the sake of cost control? In other words, how much consumer choice are Americans willing to pay for in a long-term care insurance system?

The Finance Cabinet concluded that making judgments that depend on weighing costs against system design elements to a detailed degree is best left to a time when financial modeling can quantify the effects of various design choices. The German model, with its novel approach to creating an affordable disability plan by paying less for the most popular choice, should be left on the table as a possible option to consider when modeling is done.

## **Benefits Tied to Simple Level of Need Determination**

The Cabinet recommends that the dollar value of benefits be tied to a simple (e.g., three to six levels of need) determination that focuses on a person's need for assistance with activities of daily living (bathing, dressing, toileting, eating, mobility), with some consideration given to the possibility of a "skilled nursing needs" add-on. In general, age should not be a factor, although some consideration should be given to the extent to which very young children should be included in the same program. People assessed at a higher level of need should receive a higher level of benefits than people with lower assessed needs. The need for either supervision or hands-on assistance with activities of daily living (ADLs) should be taken into account in the level of need determination. Persons with mental illness should be included to the extent that their illness interferes with functioning in activities of daily living.

The Cabinet also recommends that consideration be given (either for an initial system or later refinements) to a level-of-need system that includes a special add-on amount for "skilled nursing needs." For example, there might be three basic levels of need, based on an assessment of ADL dependencies with (hypothetically) benefit payments of \$50/day (lowest level of ADL needs), \$75/day (medium level), and \$100/day (highest level). The assessment also would determine if the person has an ongoing need (e.g., expected to last at least a month) for a certain level of skilled nursing assistance (e.g., injections and/or dressing changes at least twice a week)

not otherwise covered by Medicare. The add-on benefit for that “skilled nursing need” could (hypothetically) be something like \$25/day, added to the basic benefit determined by ADL need.

The purpose of the skilled nursing need benefit add-on would be to recognize the higher cost of skilled nursing whether it is provided at home or in a nursing home. As noted above, the German system provides for higher benefit payments to people in institutions, which is one way of recognizing that, regardless of ADL needs, people in nursing homes typically do need more nursing services than people remaining at home. But providing for a “skilled nursing need” add-on, regardless of where a person chooses to receive help, is a possible alternative that would make the system more site-neutral. The downside is that the assessment would then have to take “service need” (rather than just a person’s physical and cognitive condition) into account. Service needs are thought to be more choice-driven (e.g., oral versus injectable medications), leading those who construct case-mix classification systems to try to avoid them when possible to reduce the incentive for “gaming.”

The Cabinet considered, but rejected, a level of needs system that takes into account need for assistance with instrumental activities of daily living (IADLs) such as shopping, cleaning and the like. The German system takes both ADLs and IADLs into account in determining level of need. The Cabinet reasoned that determining the hours of needed IADL services for potential beneficiaries would introduce more administrative complexity, subjectivity and inter-rater reliability problems into the system than justified by the potential gains in equity.

A simple level-of-need system—that is, one with just three to six levels rather than a complex multi-factorial case-mix system like those used for hospital payments (DRGs) or nursing home reimbursement (RUGs)—sacrifices precision for administrative ease, consumer comprehension and uniformity of assessments (inter-rater reliability). A system like the nursing home case-mix classification system RUGs, with over 50 different levels of need, potentially better differentiates individuals than a system with just three to six levels. The downside of a simpler level-of-need system is that there will be greater variation in actual need among people in a single level than in a more refined system. But the more complex and multi-factorial the classification system is, the greater the chance that people will be misclassified due to assessor errors. Further, the Cabinet throughout deliberations gave considerable weight to the goal of

having a system that consumers could easily understand. These factors led to a decision to recommend, at least initially, a simple level-of-need system. After a few years of system operation, both the German and Japanese long-term care insurance systems are considering refinements to their need classification systems [add cites]. This would likely be the case with a system implemented in the United States.

## **Benefit Levels Consistent with a Financially Sound Program**

Figuring out benefit levels consistent with a financially sound program will require considering trade-offs informed by actuarial analyses. In general, the Cabinet favored a broader program, with more modest benefits, rather than a narrower program with full coverage for high-cost services. This contrasts, for example, with the plan proposed in 1990 by the Pepper Commission—a bipartisan commission that was convened to develop proposals for improving health and long-term care financing for the nation. A key recommendation of that commission was a social insurance plan for long-term care that paid for 100 percent of nursing home admissions for the first three months with varying but relatively modest levels of cost-sharing, depending on income. The Finance Cabinet believes that benefits should be available regardless of setting and that one goal of the insurance plan should be to help maintain people with disabilities in the community and well as to pay a share of the higher costs of formal care in residential settings.

The number of people who may obtain benefits—the broadness of the program—is a function of whether there are age limitations and the level of disability required to trigger the benefit. Japan, for example, targets benefits to persons age 40 and older. As noted above, the Finance Cabinet believes that a program that includes all (or nearly all) ages is preferable because 40 percent of people needing long-term care are under age 65 and because contributions of younger workers are important to keeping the program solvent.

With regard to the level of triggering disability, the higher the level of required disability, the fewer the people covered, the lower the cost, all else being equal. But setting the level of disability high means fewer people will obtain benefits at an earlier stage of need and get the help they need to slow deterioration (Merlis, 2004). The Cash and Counseling experiment, for

example, found that those who got the personal care services they wanted and needed with the cash benefit used more hours of service (much of it from non-agency paid help such as relatives and friends) than those who got the standard Medicaid personal care services through an agency, but they had lower rates of nursing home use (Brown, 2006). Countries that have implemented long-term care insurance programs have made various choices about this issue, as shown in Exhibit 12. Japan, which has a quite low level of need for entry-level benefits, specifically intended to provide aid for preventative services (Merlis, 2004; Campbell and Ikegami, 2000). Germany, by contrast, set its minimal requirement fairly high as it balanced costs against potential benefits.

**Exhibit 12: Functional Disability or Care Need Standard for Long Term Care in Various Countries**

<b>Country</b>	<b>Minimum Eligibility Standard</b>	<b>Percentage of Elderly Eligible</b>
<b>Austria</b>	1 ADL & needs 50 hours of care/month	21% of 65+
<b>Belgium</b>	3 ADLs	5.5% of 65+
<b>Denmark</b>	1 ADL & 4 IADLs	10% of 70+
<b>France</b>	3 ADLs	NA
<b>Germany</b>	2 ADLs & needs 90 minutes/day help	5.6% of 60-80 year olds; 18% of 80+
<b>Japan</b>	Needs 25-29 minutes care/day, meets other specified criteria	14% of 65+
<b>U.S. (for comparison)</b>	2 ADLs	7-8% of 65+

**Source: Merlis, 2004**

What level of benefits is it plausible to assume can be purchased for an “affordable” price? Hawaii backed into its benefit package, starting with an assumption, supported in part by survey data, that a \$10/month mandatory premium would be acceptable. Based on actuarial analyses, the benefit that could be purchased for that turned out to be a \$75/day cash benefit for a year. Benefits and premiums were to increase annually with inflation. Proponents noted that the benefit was not meant to cover all long-term care expenses, but did provide a foundation on which to

build, and was better than nothing at all. Critics claimed that the modest benefit would lull people into thinking they were covered and hence avoiding the necessary purchase of additional private, wrap-around long-term care insurance. Proponents argued, to the contrary, that introducing a new long-term care plan to the public would increase awareness and stimulate the purchase of wrap-around insurance. In Germany, introduction of the new public long-term care insurance plan did appear to have that effect as a bump in the purchase of private policies followed introduction of the public plan.

More generous benefits than in Hawaii are proposed in the CLASS Act, a bill to provide for a national, voluntary, premium-based cash payment disability insurance plan recently filed by Senators De Wine (R., Ohio) and Kennedy (D., Mass.). In that plan, premiums of \$30/month are proposed to finance benefits triggered by need for assistance performing activities of daily living: 2+ ADLs would qualify a person for a \$50/day benefit while 4+ ADLs would qualify for a \$100/day benefit. The \$30/month premium was derived from focus groups with college-aged people around the country and represents the amount they said they would pay for a disability benefit.<sup>18</sup> The actuarial soundness of the benefit amount, relative to premiums, has not been formally evaluated at this time. Solvency estimates at present rely on computations showing that since monies would accrue for five years (earning 3% interest per year, it is assumed) before benefits would begin, there would be a pool of \$283 billion dollars available when benefits began to be paid.<sup>19</sup> By contrast, supporters note, total annual national expenditures for long-term care (including Medicare, Medicaid, private insurance and out-of-pocket spending) are just 64 percent of that (\$183 billion). Sponsors of the bill are well aware that adjustments will need to be made as refined actuarial studies become available. We developed preliminary estimates to illustrate the types of choices that will need to be made as debates proceed on this or any other new long-term care financing plan.

The challenge in pricing a disability plan, compared to one that requires service use (particularly nursing home use) to trigger benefits, is that most people with functional limitations do not use formal, paid services. This is particularly true of non-elderly persons with functional

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<sup>18</sup> Personal communication, Connie Garner, staff assistant to Sen. Ted Kennedy, January 2006.

<sup>19</sup> Assumption: 90 percent of the 141 million working people over 18 participate joined by 19 million eligible spouses.  $\$30/\text{month} \times 12 \text{ months} \times 5 \text{ years} \times 144,000,000 = \$283 \text{ Billion}$  (assuming 3% annual return compounded).

impairments, who constitute 40 percent of all those needing help to function. For example, national surveys conducted in the mid-1990s (the latest available) revealed that 70 percent of persons aged 18 to 64 with severe functional impairments (need for help with three or more ADLs) lived in the community and received only informal care (Exhibit 13). For the most part, the help these people receive does not show up in the national long-term care expenditure calculations.

**Exhibit 13: Persons Age 18 -64 with Functional Limitations and the Type of Help They Receive**

Functional Limitation	Living in The Community				In a Nursing Home	TOTAL Number Percent
	Informal Care Only	Some Formal Services	Formal Service Only	Type of Help Unknown		
IADL	83.5%	4.1 %	7.4 %	4.6%	0.5 %	2,103,600 100%
1-2 ADLs	81.7%	7.6%	2.5%	5.8%	1.0 %	2,049,700 100%
3-6 ADLs	69.7%	13.6%	6.4%	5.5%	4.9%	2,136,900 100%

**Source: Computed from tables in Spector et. al., 1996, which present data from the 1994 National Health Interview Survey and the 1994 National Long Term Care Survey.**

A larger proportion of the elderly do receive formal, paid services. But even among seniors living in the community with the greatest risk of nursing home use (those with three or more ADLs) the amount of formal, paid services is small on average.<sup>20</sup> “Eighty-six percent of elders [with] three or more ADL limitations live with others and receive about 60 hours of informal care per week, supplemented by a little over 14 hours of paid assistance” (Stone, 2000).

<sup>20</sup> Roughly half of persons aged 65 and older with 3+ ADL limitations reside in nursing homes, contrasting with just 5 % of similarly impaired younger persons.

The fact that such a substantial proportion of people with functional impairments rely heavily on informal supports, rather than paid care, has raised concerns that long-term care insurance will simply substitute paid for unpaid services, rather than provide additional care to those who need it, make a real difference in the quality of their lives and help to sustain them in the community. As noted earlier, however, significant research, finds those fears substantially unfounded.

Despite the proven advantages to both persons with disabilities and their caregivers of having sufficient money for needed help, the question remains of how much care can be purchased for an affordable premium when substantial numbers of people who currently use little formal help are beneficiaries. An estimate of the one-year cost of the CLASS Act proposal is shown in Exhibit 14. Assuming all of the people with 2 + ADLs received full benefits for an entire year, the one-year cost for 2005 would be approximately \$105.9 billion, with 68 percent going to people living in the community. All but about 12 percent of the people in nursing homes would receive benefits of \$50 to \$100 per day if the CLASS Act plan were implemented, reflecting the proportion of people in nursing homes with no need for ADL assistance. By comparison, 2005 total national expenditures from all sources on nursing home care are estimated to be \$121.7 billion (\$104 billion excluding Medicare expenditures).

**Exhibit 14: Estimated One-Year Cost of CLASS Act Benefits for 2005 Population**

Site	ADLs	Population	Per Diem Benefits	Total Benefits
Nursing Home	2-3	632,800	\$50/day	\$11,548,600,000
	4+	603,400	\$100/day	\$22,024,100,000
Community	2-3	1,654,436	\$50/day	\$30,193,457,000
	4+	1,181,740	\$100/day	\$43,133,510,000
<b>TOTAL</b>		4,072,376		\$106,899,667,000

**Sources:** Nursing home estimates based on applying disability rates from the 1999 National Nursing Home Survey to the December 2005 nursing home census reported in OSCAR. Community estimates based on applying disability rates for population aged 5+ from the 1999 Medical Expenditure Study to Bureau of the Census population (aged 5+) estimates (middle estimate) for 2005.

The estimated CLASS Act cost at \$106.9 billion for 2005 is slightly more than twice the estimated one-year income from premiums at \$51.8 billion, suggesting that even with five years of reserves built up, adjustments will need to be made for sustainable financial solvency. Choices for a more affordable benefit structure include increasing requirements for receiving benefits, reducing benefits across the board, or changing the benefit structure to something closer to the German system (with lower benefits for those taking cash rather than services), despite the attractiveness of benefits paid equally based on level of disability, regardless of site of care.

**Systems to Ensure that Beneficiaries Have Access to Appropriate Help and Consumer Protections Must be Available**

The Finance Cabinet is aware that today families and seniors are challenged to make their way through the long-term care maze, trying to patch together services and finances. Too frequently there is no one knowledgeable about all the options and possibilities to turn to for guidance. Services are fragmented and difficult to access. Addressing financial issues through a new national insurance plan does not in itself necessarily help those with long-term care needs get

optimal value for their money. Indeed, things might be made worse if vulnerable consumers were placed at increased risk of exploitation by scam artists and defrauders. Cash benefits, particularly large sums, may carry enhanced risks. But rather than reject cash benefits out of concern for consumer protection, the Cabinet believes that systems should be developed to provide the necessary help. This includes enhancing systems for vulnerable adult protection, perhaps linked in some way to the new benefit system.

The Cabinet also recommends that consideration be given to modeling aspects of the new insurance benefit on lessons learned from the Cash and Counseling demonstration. When cash is at least one of the options as a benefit, beneficiaries at a minimum should have the option of working with a fiscal intermediary and counselor; in some or all cases, this assistance might be made mandatory. Beneficiaries and their counselors should have access to good information about purchasing needed services that provide value. While some beneficiaries may prefer to find and hire personal care workers on their own, others may prefer to pay “brokers” who, for a fee, will do that for them, finding the best values available. In brief, providing greater choices for beneficiaries though financing based more on a disability insurance model requires that consumers also have improved access to information to evaluate choices wisely. Speeding development of this must be as much a national priority as implementing a national insurance plan.

## **Administration**

The Cabinet recommends that the system be administered by a new, federally chartered organization with responsibility for managing and investing the premiums and making appropriate payments. The goal is to have the finances managed outside of the federal treasury and budget, similar to the way funds are managed in a number of the European health and long-term care insurance systems.

To maximize consistency, the disability determination and appeals system should be a centralized, national system. The Cabinet envisioned new systems for providing consumers with help managing choices and accessing services. These systems could be modeled on those

developed in leading states and likely contracted to public or private entities with expertise. The lessons learned in the Cash and Counseling demonstrations can provide valuable guidance.

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