Financing of Public Programs that Serve the Elderly

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This paper examines state cost-containment strategies on long-term care, consumer directed home and community service programs for older people, and federal and state initiatives to develop a market for private long-term care insurance.

State Cost Containment Initiatives

States must address long-term care for the elderly in order to control Medicaid expenditures. Three broad strategies are used to control spending: (1) reforming the delivery system for greater efficiency; (2) utilizing outside resources to offset state expenditures; and (3) reducing Medicaid eligibility, reimbursement and services. States differ both in the extent to which they focus on each strategy, and in how far they have progressed in implementing long-term care reform.

System reform

Reorganizing the healthcare delivery system in ways that make care more efficient and effective is an important general strategy for saving money.

Expanding home and community-based services. The most wide-spread reform has been the effort to shift the delivery system away from institutional care and toward home and community-based services. Despite this policy initiative, Medicaid long-term care expenditures for the elderly are still overwhelming for nursing home care. This movement to noninstitutional services has been aided by recent court cases. The U.S. Supreme Court's 1999 *Olmstead v. L.C.* decision found that the Americans with Disabilities Act (ADA) meant unnecessary institutionalization was illegal discrimination, and created a limited right to home and community-based services.

Medicaid home care spending is very uneven, with California, Massachusetts, New York and Texas accounting for 54% of total home care expenditures for the elderly in 1997. Most states are increasingly choosing to finance their home and community-based services through the Medicaid program.

Medicaid funding strategies

•States can fund Medicaid home and community-based services through the regular Medicaid program with coverage of home health and personal care, or through home and community-based services (HCBS) waivers.

•States are increasingly choosing to expand their commitment to more tightly controlled Medicaid waivers, rather than open-ended entitlements. Under the waivers states can cover a wide range of nonmedical long-term care services, including case management, personal care services, home modification, transportation, adult day care, habilitation, rehabilitation, and respite care. States are required to target those at high risk for institutionalization, and assure the federal government that the average cost of providing services with the waiver will not exceed the average cost without the waiver. In addition, states may provide these services only to a pre-approved number of people.

•Regulatory changes implemented by the Clinton administration have made obtaining waivers routine, although states complain about the paperwork and staff time involved in obtaining them.

Cost containment strategies

•Home and community services are "sold" in almost every state primarily based on their ability to achieve cost savings. While states seek to substitute lower cost home and community-based services for more expensive nursing home care in order to save money, most research suggests that total long-term care costs are actually increased rather than decreased with this strategy (Wiener & Hanley 1992).

•Recent research about the cost-effectiveness of home and community-based care, however, is more encouraging. Some states point to low Medicaid waiver costs that are achieving cost neutrality, if not cost savings, even while serving additional people who would otherwise be institutionalized (Raetzman & Joseph 1999).

•Federal government programs such as "Date Certain" and "Nursing Home Transition" grants encourage states to identify and remedy barriers to community-based care and assist nursing home residents to relocate to the community.

•States have used a variety of ways to address the issue of cost-effectiveness of home and community-based services:

(1) Set a maximum amount that will be spent on home and community-based services for a single individual.

(2) Provide services to a population at higher risk of institutionalization than they did 10 years, increasing the probability of substituting home care for nursing care.

(3) Test consumer-direct home care programs which give beneficiaries, rather than agencies, the power to hire, train, supervise and fire workers (Tilly & Wiener 2000). Because independent workers receive less supervision and fringe benefits, and sometimes lower wages than agency-directed employees, consumer-directed care is less expensive.

(4) Explore the potential role of residential alternatives to nursing home care, such as adult foster care and assisted living, in order to offer services that are more home-like, provide greater personal autonomy, and cost less than nursing homes.

•Expanding these residential alternatives presents states with a number of very difficult issues.

(1) How do states superimpose these new concepts of consumer-oriented, homelike residential facilities onto the large existing stock of nonmedical residential facilities?

(2) How can these new facilities be regulated in a way that allows individuals to "age in place" without having to move to obtain needed services? Will these facilities become unlicensed nursing homes?

(3) How can these residential options be made available to the moderate- and lower-income elderly population? A recent analysis found that most moderate- and low-income individuals age 75 and older could not afford assisted living facilities unless assets were liquidated to help pay for them (Hawes et al. 1999).

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Integrate acute and long-term care services through managed care. While financing acute care is largely the province of Medicare and the federal government, long-term care is dominated by Medicaid and state governments. This separate financing system not only provides a strong incentive for both the federal government and states to shift costs, the lack of coordination in the delivery system presents difficulties to older individuals who require long-term services.

•States have four goals in integrating acute and long-term care services:

(1) Eliminate arbitrary divisions between acute and long-term care to achieve better quality care.

(2) Substitute lower-cost ambulatory and home-based care for more expensive hospital and nursing home care.

(3) Reduce the number of providers to facilitate setting contract standards and monitoring performance.

(4) Make state spending more predictable by using "per person" payments that shift financial risk from government to providers.

There are impediments to integration. Critics hold that joining acute and long-term care services could have an adverse effect on long-term care, contending that fiscal pressures could short-change long-term care by shifting funds to acute care. In addition, long-term care could become over-

medicalized and services less consumer-directed when the balance of power shifts from the individual client and provider to HMOs, insurance companies or other administrative entities. A final factor that slows the pace of integration initiatives is the turmoil in Medicaid and Medicare managed care efforts.

Increase private and federal resources

States are bringing additional private and federal resources into the long-term care financing system to offset state expenditures. This is done in several ways: encouraging the purchase of private long-term care insurance, strictly enforcing prohibitions against transfer of assets, and maximizing Medicare and Medicaid financing for long-term care services.

Encourage private long-term care insurance. Only 8% of the elderly have any type of long-term care insurance (Health Insurance Association of America, 2000), and by most estimates only 10 to 20% of the elderly can afford it (Wiener, Illston and Hanley, 1994). States are adopting three strategies to expand private long-term care insurance.

(1) Eighteen states offer tax incentives to individuals or employers to purchase private long-term care insurance (Wiener et al. 2000).

(2) Nineteen states offer, or are preparing to offer, private long-term care insurance to employees, retirees and, in some cases, parents and parents-in-law of employees (Wiener et al. 2000). All of these states are using an "employee-pay-all" financing system with no employer contribution.

(3) Four states, Indiana included, have established "public/private partnerships" to encourage the purchase of private long-term care insurance (Wiener et al. 2000). These partnerships allow individuals who purchase a state-approved private long-term care policy to keep far more assets and still qualify for Medicaid. Individuals in nursing homes in these states, however, must still contribute all of their *income* toward the cost of care, except for a small personal needs allowance.

Enforce prohibitions against asset transfer. Media have focused attention on the middle-class and wealthy elderly who transfer, shelter and under-report assets in order to appear poor enough to qualify for Medicaid-financed nursing home care (Burwell & Crown 1995). The goal of this effort, called "Medicaid-estate planning," is to protect private wealth against the costs of long-term care. State officials seek to prevet these transfers, arguing that Medicaid should be preserved for the truly needy.

Maximize federal financing. Public funding options for the elderly include Medicare, Medicaid and state-only funded programs. Since Medicare is entirely federally funded, states have long sought to shift state and Medicaid long-term care expenditures to Medicare. This effort has been frustrated by the narrow range of nursing home and home health services covered by Medicare. However, Medicare coverage expansions during the 1990s made this cost shifting more possible.

A traditional strategy to control spending

A more conventional mechanism that states can use to control expenditures includes cuts in reimbursement rates. Medicaid payment rates for nursing facility care are a logical target. States now have almost complete freedom in setting nursing home payments rates, except for a requirement to hold public hearings. In comparison to Medicare and private pay rates, Medicaid nursing home payment rates are already fairly low in many states. Thus, nursing homes often prefer higher paying private-pay to Medicaid residents, and this can result in access problems for Medicaid beneficiaries. However, since few nursing homes can survive without Medicaid residents, the extent to which facilities can reduce access is limited.

The Role of Consumers in Controlling Services

This study examines the experiences of public programs that serve older persons in eight states in order to assess the policy implications of consumer-directed home and community services for this population. These programs give beneficiaries, rather than agencies, the power to hire, train, supervise and fire workers. Both the quantitative research and most stakeholders interviewed for this study, indicate that many older beneficiaries want to and can manage their services, although significant issues exist when considering the management ability of those with cognitive impairments. Although quality of services remains a contentious issue, limited research results point to better—or at least no worse—quality of life for beneficiaries when they direct their services. Consumer-directed care has some disadvantages for workers, including fewer fringe benefits. State agencies, with few exceptions, have not provided extensive consumer or worker support, or aggressively regulated quality of care.

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Implications for programs serving older people

The extent to which clients control their services is a key issue in the design of home and community services programs. Consumer involvement in managing publicly funded Medicaid and state-funded programs currently runs the gamut from very little to virtually complete control over services. States use two broad models of consumer control in their programs—agency-directed and consumer-directed services. Advocates for younger adults with disabilities insist that consumers should be able to direct individual workers rather than having to rely on home care agencies. There is some controversy among advocates for older people, however, about whether that population should control their home and community services in this way.

Agency-directed model. The agency-directed model provides consumers with little direct control. States contract with home care agencies that are responsible for hiring and firing home care workers, directing services, monitoring quality of care, disciplining workers if necessary, and paying workers and applicable payroll taxes. The agency-directed model assumes that professional expertise matters a good deal more than the opinions of consumers. At its extreme, a "medical model" is imposed and individuals with disabilities are considered to be "sick," as opposed to simply needing compensatory services (Parsons 1951). Beneficiaries can express preferences for services or workers in this model, but have no formal controls over them.

Consumer-directed model. The other end of the management continuum is represented in the consumer-directed model offered by some Medicaid and state-funded programs. Beneficiaries assume the responsibility for decisions about their services, including recruiting, training, hiring, directing, and firing their workers (NCOA 1996).

There are several types of consumer-directed programs (Mahoney and Simon-Rusinowitz 1997). In most programs, consumers take on all worker management tasks with the exception of paying the worker. Some state-funded consumer-directed programs provide cash payments to beneficiaries, who then shop and pay for services that fit their needs and budgets. Medicaid-funded programs, however, must abide by the federal rule that prohibits Medicaid beneficiaries from receiving their benefits in cash (Flanagan and Green 1997).

A key policy question is whether programs serving older persons should provide them the opportunity to manage home and community services and, if so, under what conditions.

A growing number of states are incorporating consumer direction into their home care programs for older people, and some groups representing older people are strongly advocating that consumer-direction principles be built into home and community services programs. Thus, a key policy question is whether programs serving older persons should provide them the opportunity to manage home and community services and, if so, under what conditions.

Adding to this debate, this analysis compares publicly funded agency and consumer-directed services in relation to several issues: whether older persons want to and are capable of managing services, the quality of those services, and the effects of consumer direction on workers. A major focus of this effort was on state policy decisions and program design.

Research methods

Data collection for the comparative analysis was undertaken through an extensive literature search and interviews with government officials and key stakeholders in eight states with coexisting agency and consumer-directed models. This strategy satisfied the goal of gathering the views and opinions of those who had experience with consumer-directed programs that served significant numbers of older people as well obtaining information about the structure of the programs. The study authors identified relevant literature through a comprehensive search of published and unpublished literature using major bibliographic databases. Only four quantitative studies of consumers' willingness to manage services and two studies that compared beneficiary or worker outcomes under the two methods were found.

Several surveys of home care programs offering consumer-direction opportunities that were conducted in the mid-1990s or later (Flanagan and Green 1997; Scala and Mayberry 1997; National Association of State Units on Aging 1998; U.S. General Accounting Office 1999) were examined to identify potential case study states. To qualify for inclusion in the study, states had to provide both agency- and consumer-directed services to older adults with disabilities, have at least 2,000 beneficiaries, and have at least two years of experience with consumer direction. These criteria yielded study states with relatively large, mature programs that permitted comparisons between the two models. States that met the selection criteria and were included were

California, Colorado, Kansas, Maine, Michigan, Oregon, Washington and Wisconsin.

For each state, the study authors interviewed the state program officials responsible for home and community services programs, state Medicaid or State Unit on Aging officials, and representatives of key stakeholder groups who had the most knowledge of consumer-directed programs. These included advocates for younger people with disabilities, advocates for older beneficiaries, unions and home care agency associations. Contact information for program officials and representatives of key stakeholders was gathered from surveys of consumer-directed programs and from Web sites on independent living and home care agencies. Additionally, each program official or key stakeholder interviewed was asked to suggest other stakeholders who were considered knowledgeable about the state's home- and community-based services system.

While program officials and representatives for younger people with disabilities in every state agreed to be interviewed, stakeholders representing the older population were interviewed in only half of the states because program officials and other stakeholders could not identify a knowledgeable person to interview. Home care agency representatives agreed to be interviewed in every state except Michigan, and union representatives were identified in six states. Thirty-three sets of interviews were conducted with government officials and key stakeholders:

- eight with government officials
- eight with advocates for younger people with disabilities
- four with advocates for older people
- seven with home care agency association staff
- six with union officials

When more than one agency official participated in an interview, their responses were considered as one. Respondents were guaranteed anonymity to encourage candor. Open-ended, structured interview protocols were developed that addressed program structure and policy issues related to consumer direction for older persons.

Program description

The eight case study states had to make a number of program design decisions about financing, eligibility, cost containment, and quality assurance in order to establish their programs. Generally, states relied on a combination of Medicaid and state funds to finance their programs, with Medicaid home- and community-based services playing an important role in financing the services. The programs measured a person's inability to perform daily activities to determine functional eligibility for benefits, and access to most programs was means-tested, with eligibility being limited to the low-income population. Expenditures were controlled by limiting the number of people served or the hours of service covered. In some cases there was a cap on the cost of services that an individual could receive. Most programs allowed beneficiaries to hire family members other than spouses, and quality assurance involved minimal monitoring of beneficiaries.

Key policy issues

Four key policy issues were identified:

The bottom line is that older beneficiaries do not comprise a homogeneous group and should therefore be provided with a choice of management models.

Preference for consumer direction. While survey and interview results indicate that older people are less likely to want consumer direction than younger people, a significant minority of older people do prefer consumer direction. Providing the consumer-direction option will require a substantial restructuring of current home and community services programs in most states. Programs should have the flexibility to allow beneficiaries to manage their own services when they want to, while providing agency services to those who do not want to manage or are incapable of management. The bottom line is that older beneficiaries do not comprise a homogeneous group and should therefore be provided with a choice of management models.

The effect of cognitive impairment on directing services. Although some older beneficiaries want to and currently do direct their own services, a significant number of stakeholders raised questions about their capacity to do so, citing the prevalence of cognitive impairment among the older population. Despite these concerns, every study state allowed the cognitively impaired to participate in consumer-directed programs through reliance on surrogates to make care decisions for the consumers when necessary. This is a reasonable accommodation for the cognitively impaired, but it should be recognized that decisions made by surrogates are unlikely to be a perfect representation of the choices that the consumer would have made if not impaired. Surrogate decisions will sometimes reflect their own preferences, schedules and interests. And, despite raising questions about cognitive impairment, most states do relatively little to help clients cope with management tasks. The exception to this is that states used fiscal agents to pay workers and withhold applicable taxes, substantially reducing the paperwork clients must complete.

Quality of care and monitoring services. The most contentious issue surrounding consumer-directed programs relates to whether the quality of care is adequate and how services should be monitored. Consumer-directed services often lack the standard quality assurance structures, such as training of paraprofessionals and professional supervision. Limited quantitative research on the cognitively intact population and interviews with stakeholders suggest that consumer-directed services are no worse than agency-directed care, and may be better because the service is more tailored to the preferences of the client. Stakeholders did express a higher degree of concern over the quality of care provided the cognitively impaired because of their vulnerability to abuse.

Despite the expressed concerns about quality of services, most states have taken relatively minimalist approaches to monitoring quality, identifying problems through complaints and case manager interaction with clients. Although most of the services provided in consumer-directed programs are unskilled, the lack of training requirements and monitoring is striking during a time when proposals for increased regulation of nursing facilities are commonplace. Consumer advocates and policymakers have placed greater priority on maintaining flexibility and consumer choice in the home and

community services setting, perhaps fearing that increased regulation will replicate an "oppressive" nursing home setting.

Consumer-directed programs rely on the client's ability to fire unsatisfactory workers and hire replacements in order to assure quality. The current labor shortage makes recruitment difficult for all long-term care services, and may threaten quality by undermining the willingness of clients to fire sub-standard workers. This may increase the need for more formal quality assurance mechanisms.

Worker environment and compensation. Independent workers appear to fare better than agency workers in their work environment, although home care and union representatives question this finding. Independent workers, however, do less well financially than agency workers. Part of the attraction for states to employ the consumer-directed model is its lower per-person cost. Although workers' hourly wage rates in the study states appeared to be about the same in both models, the lower payment rates for consumer-directed care are due to the absence of administrative overhead in part, and also because workers receive less in the way of health, vacation and other fringe benefits.

It is important to consider that a significant portion of independent workers—as many as half in some study states—are family members. In California the vast majority of independent workers were known by the consumer before they became paid caregivers. The issues of management, training, quality assurance and payment levels take on a very different cast if the independent worker is a family member or friend. This may account for some of the states' relatively *laissez-faire* approach to quality assurance, as well as for some of the positive results on quality.

Conclusions

The protective or paternalistic nature of most home and community services programs for older people is challenged by consumer-directed home care advocates who assert that clients want to and are capable of managing their own care. The situation becomes more complicated for those who are cognitively impaired, although surrogate decision-makers can allow participation even for them. States may want to consider whether a more activist approach toward providing supports, such as worker registries and monitoring client satisfaction, is warranted.

Initiatives to Jump-start the Market for Private Long-term Care Insurance

Various strategies at federal and state levels are designed to encourage the purchase of long-term care policies: individual tax incentives, tax incentives for employer contributions, state and federal "role models," and public-private partnerships that relax Medicaid requirements. These initiatives have produced only modest gains with the effect being more symbolic than substantive. These initiatives raise a number of fundamental policy issues that must be addressed before progress can be made.

Should the government encourage private long-term care insurance?

Should the government fund long-term care via direct spending in federal benefit programs?

Which strategy is most effective/efficient?

Long-term care is overwhelming financed through public programs and out-of-pocket payments (Frolik & Kaplan 1999). People with disabilities may find that neither Medicare nor their private health insurance cover nursing home and home care to any significant extent, and have to rely instead on their own resources and Medicaid. Long-term care is a major source of catastrophic out-of-pocket costs for the disabled elderly, with nursing home care exceeding $50,000 in 1997 (Wiener 1999). This financial strain on individuals and their families, as well as both federal and state governments, is expected to escalate as it is anticipated that Medicaid long-term care expenditures for the elderly will roughly double between 2000 and 2020 (U.S. Congressional Budget Office 1999).

Long-term care is a major source of catastrophic out-of-pocket costs for the disabled elderly, with nursing home care exceeding $50,000 in 1997.

Private long-term care insurance currently plays only a small role in financing care for the older population, accounting for only about 2.5% of national long-term care expenditures in 2000 (U.S. Congressional Budget Office 1999).

In order to induce more people to purchase long-term care policies by lowering premium costs, policymakers have considered or enacted three strategies of governmental intervention:

Provide individuals with tax incentives to encourage purchase. These incentives have become law at both federal and state levels, although only modestly reducing the net price of private long-term care insurance policies. Insurance advocates argue that these tax incentives signal purchasers that the government believes such policies are a worthwhile product.

At the federal level the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides certain federal tax benefits for "qualified" private long-term care insurance premiums, but only under certain circumstances. Most observers believe that these tax incentives are not large enough to lead to major increases in sales, noting that only about half of the older people pay federal income tax (1998 Green Book) and that few itemize their deductions. HIPAA clarified that payment of long-term care insurance is a medical expense, but it is only tax deductible when the taxpayer has out-of-pocket medical expenses that exceed 7.5 percent of adjusted gross income. Advocates agree that changes to federal tax incentives are necessary to substantially increase sales, arguing that the entire premium should be tax deductible and not subject to the 7.5% adjusted gross income requirement. Other suggestions include allowing employers to offer long-term care insurance on their cafeteria plans and flexible spending accounts, and allowing individuals to draw from their retirement accounts to pay premiums without encountering a penalty for the withdrawal.

A number of states have enacted tax incentives over the last few years to encourage the purchase of long-term care insurance. Eighteen states provided tax deductions or credits to purchasers in 1999, and tax incentive legislation was introduced in another 18 states during the 1999 legislative sessions.

These tax incentives are likely to have only a minimal impact because of relatively low state tax rates, which make a deduction or credit less attractive. In some cases a taxpayer must choose between the federal or state incentive and, although state tax incentives are available to a broader population than HIPAA , they are quite modest in reducing the cost of insurance.

Encourage employer-based private long-term care insurance through tax incentives and offering of coverage by federal and state governments. These initiatives that encourage the purchase of insurance at a younger age offer several advantages over policies that older people purchase individually, although the employer-sponsored market remains very small.

Premiums for young policyholders are, first of all, less expensive because premium earnings have time to build before benefit pay outs (Weiner et al 1994; Crown et al 1992; Rivlin & Wiener 1998). Secondly, group policies take advantage of economies of scale in marketing and administrative expenses, and allow negotiation of lower prices (and thus, lower premiums). Finally, because benefit managers of these employer-based programs have a stronger negotiating position than individuals, the quality of long-term care insurance plans might improve.

Tax incentives to encourage employer contributions into these programs have been provided by both the federal government and some state governments. Possible contributions, however, have been overwhelmed by the financial problems of under-funded employer-sponsored acute health insurance benefits for retired employees. A large number of employers have cut back on retiree acute benefits, made retirees pay a larger part of the cost, or have dropped the coverage altogether. In this environment it seems unlikely that employers will want to contribute to a new, potentially expensive insurance plan that will primarily benefit retirees years after they have left the company. It is conceivable, however, that they may be more willing to offer private long-term care insurance on an employee pay-all basis to help compensate for decreases in acute care coverage.

This employee pay-all basis has been embraced by the federal and 19 state governments—a strategy that, it is hoped, will set a "good example" for other employers and bring visibility to the issue.

Waive Medicaid asset-depletion requirements so that purchasers of long-term care policies can retain some of their assets and still qualify for Medicaid. Under these public-private partnerships, a few states (Connecticut, New York, Indiana and California) provide higher levels of protected assets to individuals who purchase state-approved private long-term care policies. Unlike employer-paid plans and tax incentives that aim to reduce the net cost of insurance, these partnerships seek to increase the amount of benefits per dollar spent by combining insurance with more liberal Medicaid financial

eligibility standards (McCall et al. 1991; Meiners 1993; Meiners & Goss 1994; Meiners & McKay 1990; Meiners 1998).

A key observation that supports this public-private approach is that the long-term care products that cover shorter periods of nursing home and home care rather than lifetime benefits are less expensive and more affordable than policies with longer periods of coverage. Outside of this program, individuals who buy policies that cover two years of nursing home care could lose all of their assets if the in-care period extended to five years, despite the purchase of insurance. Thus, under these initiatives, lifetime asset protection can be obtained without having to buy lifetime benefits. And since many of those who use nursing home care do not stay for long periods, policies of relatively short coverage (i.e., one to two years) provide "full" coverage for about half of all users (Kemper & Murtaugh 1991).

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These partnerships have not had a major impact on the financing of long-term care. Only 52,560 policies were in force in the four states as of Sept. 30, 1999, compared to over seven million older people living in these states (U.S. Bureau of the Census). From the consumer point of view, three reasons can be identified to help explain the low participation rate: (1) the policies are still expensive; (2) asset protection is not a driving force for the purchase of insurance; and (3) easier access to Medicaid is not perceived as desirable. The insurance industry continues to see the partnership as an opportunity to increase the size of the private long-term care insurance market, but has offered only lukewarm support despite initially advocating the partnership. The number of policies sold has been disappointing (Korb et al. 1998), and the long-term care partnership is unattractive because it requires reversing basic sales strategies and lacks portability of Medicaid benefits from one state to another.

Conclusion

Since the collapse of proposals for comprehensive health care reform in 1994, and for a Medicaid block grant in 1996, long-term care reform proposals have focused on private insurance. The emphasis on private solutions to long-term care is reinforced by the unwillingness of Congress to spend the large sums of public money necessary to substantially address the many problems. There is, however, a fundamental problem with this strategy: Despite more than a decade of double-digit sales growth, private long-term care insurance remains a small niche product, with affordability being the principal barrier to purchase (Wiener et al. 1994). Also playing a role are lack of knowledge about the risks of needing long-term care, misinformation about Medicare coverage, and competing priorities.

A number of incentives have been implemented to "jump-start" the market for private long-term care insurance, but they are modest and are likely to have only minimal effect on the number of people carrying policies. The HIPAA tax deduction bears a low value because only about half of the elderly population pay federal taxes; marginal tax rates are low for the vast majority, and few have enough out-of-pocket medical expenses to qualify for deductions. State tax incentives average $100 or less, and virtually no state officials interviewed thought that the incentives were having a major impact. Very few

employers are contributing toward the cost of premiums, and take-up rates for state employer-sponsored long-term care insurance for employees and retirees are low. The number of partnership policies remains small and represents only a modest portion of the market, although sales are increasing.

Overall, these initiatives have not significantly changed market dynamics, and raise the following policy questions:

- Money spent or revenue lost in support of promoting these initiatives is not available for tax credits for informal caregivers or persons with severe disabilities, or for direct funding of services through Medicaid Medicare, the Older Americans Act, or the Social Services Block Grant. How hard should policymakers work to make private long-term care insurance a major source of financing?

- Proposals to promote private long-term care insurance depend on tax incentives, which inevitably raise issues of equity and efficiency. Should the federal tax code be used to subsidize private long-term care insurance?

- Demand for long-term care and its financial pressures are sure to increase as the population ages. Americans must have realistic expectations about the ability of private sector initiatives to improve the situation. Private insurance can do more, but at best will finance only a small proportion of long-term care expenses. Thus the public policy question becomes: What should we do about the large majority of disabled older individuals who have no private care insurance?

This article is based on the following:

Wiener, J. M., D. G. Stevenson & J. Kasten. (2000) *State Cost Containment Initiatives for Long-Term Care Services for Older People.* CRS Report for Congress.

Wiener, J. M., & J. Tilly. (2001) *Consumer-Directed Home and Community Services: Policy Issues.* Occasional Paper Number 44, The Urban Institute.

Wiener, J. M., J. Tilly, & S. M. Goldenson. Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance. *Elder Law Journal,* in press 2000.

References

Burwell, B. & W. H. Crown. (1995) *Medicaid Estate Planning: Case Studies of Four States,* in Wiener, J. M., S. B. Clauser & D. L. Kennell, editors, *Persons with Disabilities: Issues in Health Care Financing and Service Delivery.* Washington, Brookings Institution.

Coronel, S. (2000) *Long-Term Care Insurance in 1997-1998,* Washington, Health Insurance Association of America.

Crown, W. H., J. Capitman, & W.N. Leutz. (1992) Economic Rationality, the Affordability of Private Long-Term Care Insurance, and the Role of Public Policy, *The Gerontologist,* v. 32, no. 4, p. 478-485.

Flanagan, S. A., & P. S. Green. (1997) *Consumer-Directed Personal Assistance Services: Key Operational Issues for State CD-PAS Programs Using Intermediary Service Organizations.* Cambridge: MED-STAT Group.

Frolick, L. A., & R. L. Kaplan, *Elder Law in a Nutshell* 131 (2d ed. 1999).

Hawes, C., M. Rose, & C. D. Phillips. (1999) *A National Study of Assisted Living for the Frail Elderly: Results of a National Survey of Facilities.* Prepared for the Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy, U.S. Department of Health and Human Services, U.S. Department of Health and Human Services, December 1999.

Kemper, P., & C. M. Murtaugh. (1991) *Lifetime Use of Nursing Home Care,* New England Journal of Medicine 324.

Korb, J. et al. (1998) Laguna Researchers Assocs., Insurers' Views of the Partnership for Long-Term Care, 22.

Mahoney, Kevin J., & Lori Simon-Rusinowitz. (1997) "Cash and Counseling Demonstrations and Evaluation Start-Up Activities," *Journal of Case Management 6* (1): 25-30.

McCall, N., et al. (1991) *Public/Private Partnerships: A New Approach to Long-Term Care,* Health Aff., Spring 1991, at 164.

Meiners, M. R. (1993) *Paying for Long-Term Care Without Breaking the Bank,* 3, Journal of American Health Policy 44.

Meiners, M. R. (1992) *Public-Private Partnerships in Long-Term Care,* in Public and Private Responsibilities in Long-Term Care: Finding the Balance, 115 (Leslie C. Walker et al. eds., p. 135.

Meiners, M. R., & S. C. Goss. (1992)*Passing the 'Laugh Test' for Long-Term Care Insurance Partnerships,* Health Aff., Winter, p. 225.

Meiners, M. R., & H. L. McKay. (1990) *Beware the Comparison: Private vs. Social Insurance,* Generations, Spring, p. 34-36.

National Association of State Units on Aging. (1998) Unpublished survey of consumer-directed programs serving the older population conducted for AARP.

National Council on the Aging (NCOA). (1996) "Principles of Consumer-Directed Home and Community-Based Services." Washington, D.C.: The National Institute on Consumer-Directed Long-Term Care Services, housed at the National Council on the Aging. July.

Parsons, T. (1951) *The Social System.* Glencoe, Ill.: Free Press.

Raetzman, Susan & Susan Joseph. (1999) *Long-Term Care in New York: Innovations in for Care Elderly and Disabled People.* Issue brief, New York, The Commonwealth Fund.

Rivlin, A. M. and J. M. Wiener. (1988) *Caring for the Disabled Elderly: Who Will Pay?* Washington, The Brookings Institution.

Scala, M. A., & P. A. Mayberry. (1997) *Consumer-Directed Home Services: Issues and Models.* Oxford, Ohio: Scripps Gerontology Center.

Tilly, J. & J. M. Wiener. (2000) Consumer-Directed Home Care Programs: Ex*perience of Beneficiaries, Caregivers, and Workers.* Washington, The Urban Institute.

Wiener, J. M., et al. (1994) *Catastrophic Costs for Long-Term Care for Elderly Americans,* in *Persons with Disabilities: Issues in Health Care Financing and Service Delivery 182,* 182-83 (Joshua M. Wiener et al. eds.)

Wiener, J. M., & and R. J. Hanley. (1992) *Caring for the Disabled Elderly: There's No Place Like Home,* in S. M. Shortell and U. E. Reinhardt, *Improving Health Policy and Management: Nine Critical Research Issues for the 1990s.* Ann Arbor, Health Administration Press, p. 75-110.

Wiener, J. M., L. H. Illston, & R. J. Hanley. (1994) *Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance.* Washington, The Brookings Institution.

Wiener, J. M., J. Tilly, & S. M. Goldenson. Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance. *Elder Law Journal,* in press 2000.

U.S. Bureau of the Census, *Population Estimates for the U.S. Regions ad States by Selected Age Groups, Annual Time Series July 1, 1998*

U.S. Congressional Budget Office (1999)

U.S. General Accounting Office. (1999) "Adults with Severe Disabilities, Federal and State Approaches for Personal Care and Other Services: GAP/HEHS-99-101. Washington, D.C.: GAO.

1998 Green Book