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May 14, 1999

Sarah Bianchi
Office of the Vice President
Old Executive Office Building, Room 217
Washington, D.C. 20503

Dear Sarah:

I enjoyed speaking with you on long-term care. Please find enclosed some of my writings that you might find of interest. If you have any questions or would like to discuss things further, please do not hesitate to call.

Sincerely,

Joshua M. Wiener
Principal Research Associate

Enclosures

Moses, S. A. (1995b). *The magic bullet. How to pay for universal long-term care, a case study in Illinois.* Seattle, WA: LTC.
Moses, S. A. (1995c). *The Long-term care financing crisis. Danger or opportunity?* Seattle, WA: LTC.
Mui, A. C. (1992). Caregiver strain among black and white daughter caregivers: A role theory perspective. *The Gerontologist, 32,* 203–212.
National Chronic Care Consortium. (1991). *Fact sheet.* Bloomington, MN: author.
National Chronic Care Consortium. (1993). *Health care reform: Barriers to integration.* Bloomington, MN: author.
Northrup, F. (1995). Arizona's integrated acute and LTC program. *LTC News & Comment, 4*(11), 5.
Nyman, J. A. (1988a). Excess demand, the percentage of Medicaid patients, and the quality of nursing home care. *Journal of Human Resources, 23,* 76–92.
Nyman, J. A. (1988b). The effect of competition on nursing home expenditures under prospective reimbursement. *Health Services Research, 23,* 555–574.
Nyman, J., Levey, S., & Rohrer, J. E. (1987). RUGS and equity to access to nursing home care. *Medical Care, 25,* 363–374.
Office of National Cost Estimates. (1995). [Estimated spending for nursing home care, 1960–93]. Unpublished data, Health Care Financing Administration, Baltimore, MD.
Office of the Inspector General. (1994). *Medicaid estate recovery programs.* Washington, DC: U.S. Department of Health and Human Services.
On Lok, Inc. (1993). *PACE: Who is served and what services are used? PACE progress report on the replication of the On Lok model.* San Francisco, CA: author.
On Lok, Inc. (1995). *PACE fact book: Information about the Program of All-inclusive Care for the Elderly.* San Francisco, CA: author.
Pearlin, L. I., Mullan, J. T., Semple, S. J., & Skaff, M. M. (1990). Caregiving and the stress process: An overview of concepts and their measures. *The Gerontologist, 30,* 583–594.
Rivlin, A., & Wiener, J., with Hanley, R. J., & Spence, D. A. (1988). *Caring for the disabled elderly: Who will pay?* Washington, DC: The Brookings Institution.
Scanlon, W. (1980). A Theory of the Nursing Home Market. *Inquiry, 17,* 25–41.
Schmidt, S., & Rich, S. (1995, October 2). Democrats counter GOP Medicare cuts without new patient costs. *The Washington Post,* p. A7.
Serafini, M. W. (1995). Plugging a big drain on Medicaid. *National Journal, 27,* 687.
Semple, S. J. (1992). Conflict in Alzheimer's caregiving families: Its dimensions and consequences. *The Gerontologist, 32,* 648–655.
Schorr, A. (1980). *. . . Thy Father and Thy Mother . . . A Second Look at Filial Responsibility and Family Policy* (SSA Publication No. 13-11953). Washington, DC: Social Security Administration, Office of Policy.
Sheiner, L., & Weil, D. N. (1992). The housing wealth of the aged (Working Paper No. 4115). Cambridge, MA: National Bureau of Economic Research.
Skaff, M. M., & Pearlin, L. I. (1992). Caregiving: Role engulfment and the loss of self. *The Gerontologist, 32,* 656–664.
Smallegan, M. (1985). There was nothing else to do: Needs for care before nursing home admission. *The Gerontologist, 25,* 364–369.
Stark, A. L., Kane, R. L., Kane, R. A., & Finch, M. (1995). Effect of physical functioning of care in adult foster homes and nursing homes. *The Gerontologist, 35,* 648–655.
U.S. General Accounting Office. (1989). *Medicaid: Recoveries from nursing home residents' estates could offset program costs* (GAO/HRD-89-56). Washington, DC: author.
U.S. General Accounting Office. (1993). *Medicaid estate planning* (GAO/HRD-93-29R). Washington, DC: author.
U.S. General Accounting Office. (1994). *Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs* (GAO/HEHS-94-167). Washington, DC: author.
U.S. Select Committee on Aging. (1983). *Medicaid and Family Responsibility* (98 Cong. 1 SESS). Washington, DC: Committee Print.
Vladeck, B. C. (1980). *Unloving Care.* New York: Basic Books.
Weissert W. (1992). Effectiveness of the preadmission screening instrument and level of care determination. In N. McCall, M. Crane, E. Bauer, W. Weissert, L. Paringer, and W. Wrightson (Eds.), *Evaluation of the Arizona health care cost containment system demonstration: Second implementation and operation report* (pp. 139–172). San Francisco, CA: Laguna Research Associates.
Weissert, W. G., Cready, C. M., & Pawelak, J. E. (1988). The past and future of home and community-based long-term care. *Milbank Quarterly, 66,* 309–388.
Wiener, J. M. (1981). *A sociological analysis of government regulation: The case of nursing homes.* Cambridge, MA: Harvard University, Department of Sociology.
Wiener, J. M. (1996). Long-term care reform: An international perspective. *Health Care Reform: The Will to Change* (pp. 67–80). Paris, France: Organization for Economic Cooperation and Development.
Wiener, J. M., & Hanley, R. J. (1992). Caring for the disabled elderly: There's no place like home. In S. M. Shortell & U. E. Reinhardt (Eds.), *Improving Health Policy and Management: Nine Critical Issues for the 1990s* (pp. 75–110). Ann Arbor, MI: Health Administration Press.
Wiener, J. M., Hanley, R. J., & Harris, K. M. (1994a). *The economic status of elderly nursing home users.* Washington, DC: The Brookings Institution.
Wiener, J. M., Illston, L. H., & Hanley, R. J. (1994b). *Sharing the burden: Strategies for public and private long-term care insurance.* Washington, DC: The Brookings Institution.
Wiener, J. M., & Skaggs, J. (1995). *Current approaches to integrating acute and long-term care financing and services.* Washington, DC: American Association of Retired Persons.
Wiener, J. M., Sullivan, C. M., & Skaggs, J. (1996). *Spending down to Medicaid. New data on the role of Medicaid in paying for nursing home care.* Washington, DC: American Association of Retired Persons.
Zawadski, R. T., & Eng, C. (1988). Case management in capitated long-term care. *Health Care Financing Review Annual Supplement,* 75–81.
Zedlewski, S. R., & McBride, T. D. (1992). The changing profile of the elderly: Effects on future long-term care needs and financing. *Milbank Quarterly, 70,* 247–275.

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The Limits of the Robert Wood Johnson Foundation Public/Private Partnerships for Long-Term Care: Where Do We Go From Here?

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The Limits of the Robert Wood Johnson Foundation Public/Private Partnerships for Long-Term Care: Where Do We Go From Here?

The current American system of financing and delivering long-term care for the elderly and the younger disabled population is badly broken. At present, the United States does not have, either in the private or the public sectors, satisfactory mechanisms for helping people anticipate and pay for long-term care. In particular, the disabled elderly and their families find, often to their astonishment, that the costs of nursing home and home care are not covered to any significant extent either by Medicare or their private insurance policies. Instead, the disabled elderly must rely on their own resources or, when those have been exhausted, turn to welfare in the form of Medicaid. Moreover, although the vast majority of disabled elderly live in the community, nearly two-thirds of public expenditures for long-term care for the elderly are for nursing home care (Wiener, Illston and Hanley, 1994).

To address these problems, a small, but growing private long-term care insurance market has developed over the last ten years. Although in 1995 over 95 percent of the elderly have Medicare coverage and about 70 percent have supplemental private insurance policies, insurance against the potentially devastating costs of long-term care is relatively rare (Committee on Ways and Means, 1998). As of the end of 1996, nearly 5 million long-term care policies had been sold (although far fewer were in force), mostly to the elderly on an individual rather than group basis (Coronel, 1998). Employer contributions toward the cost of long-term care insurance are rare.

By far the greatest impediment to the expansion of private long-term care insurance is the high cost of good quality policies. Despite the marked improvement in the financial position of the elderly over the past twenty years, long-term care insurance remains unaffordable for most

elderly. In 1996, the average annual premium for policies covering four years of nursing home and home care with inflation protection and nonforfeiture benefits was $2,432 a year if purchased at age 65 and $7,440 a year if purchased at age 79 (Coronel, 1998).

The policies are expensive for two reasons: 9 out of 10 are sold individually and, therefore, carry high administrative costs and most policies are bought by older people whose risk of needing long-term care is substantial. Consequently, using a variety of theoretical purchase criteria and cost of insurance, most studies estimate that only 10 to 20 percent of the elderly can afford good-quality private long-term care insurance (Wiener, Illston and Hanley, 1994; Crown, Capitman and Leutz, 1992; Rivlin and Wiener, 1988). Other research has found the percentage of the elderly who can afford private insurance to be higher, but these studies have done so by assuming purchase of policies with limited coverage, by assuming the elderly would use their assets as well as income to pay premiums, or by excluding a large proportion of the elderly from the pool of people considered interested in purchasing insurance (Cohen, Kumar, McGuire, and Wallack, 1992; Cohen, Tell, Greenberg, and Wallack, 1987). Although the financial status of the elderly is likely to improve over time, affordability probably will not increase dramatically over the next twenty years (Wiener, Illston and Hanley, 1994).

Given the limitations of current demand for private long-term care insurance, public subsidies to jump start the market are frequently proposed. One approach is to allow employers with a tax subsidy for the purchase of long-term care insurance policies for their employees by allowing them to deduct insurance contributions as a business expense. A second strategy is to provide a tax deduction or credit to individuals for purchase of private long-term care insurance.

Tax incentives for employers and individuals were part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

While changing the tax code is the most commonly proposed way of publicly subsidizing private long-term care insurance, the initiatives by Connecticut, Indiana, California, and New York take a substantially different approach. These states provide easier access to Medicaid for persons who purchase a state-approved private long-term care insurance policy. In essence, these states allow nursing home patients with private long-term care insurance to be Medicaid eligible with substantially higher levels of assets than is normally allowed.[a] At present, Medicaid only allows unmarried nursing home patients to retain $2,000 in assets (excluding the home). Under these programs, Medicaid acts as a kind of reinsurance policy for persons with limited private long-term care insurance.

The key observation supporting the public-private approaches is that long-term care insurance that covers shorter periods of nursing home and home care are cheaper and more affordable than policies that cover longer periods of care. At age 67, a prototype individual private insurance policy costs $2,337 a year for a policy that covers four years of nursing home and home care, but $1,617 a year for a policy that covers only two years of nursing home and home care (Wiener, Harris and Hanley, 1990). The problem with the current system is that if an

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[a] Medicaid law allows states great flexibility in determining countable income and assets of medically-needy patients--patients with high medical bills in relation to their income. In essence, states using this strategy exclude insurance-related assets from their definition of resources that must be counted in determining Medicaid eligibility. However, the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) severely restricts the ability of additional states to pursue this option by including the insurance-related protected assets in an individual's estate. OBRA 1993 requires states to attempt to recover the cost of institutional care from the estates of Medicaid patients. Thus, patients may not be able to pass on these additional funds to their heirs, substantially lessening the appeal of this approach.

individual buys a policy that covers, for example, two years of nursing home care and ends up staying in a nursing home for four years, then the insured's assets can still be lost. Thus, under these Medicaid initiatives, it is possible to obtain lifetime asset protection without having to buy an insurance policy that pays lifetime benefits. While employer-paid plans and tax incentives seek to reduce the net cost of insurance, the public-private partnership attempts to lower costs by reducing the amount of insurance that is needed and by increasing the amount of benefits received per dollar spent by the consumer.

POLITICS AND POLICY IN PUBLIC/PRIVATE PARTNERSHIPS

From the beginning, the public/private partnerships were controversial. Although supporters sought to cast the initiative as an option that stood between policies that would expand and those who would reduce the public role in long-term care, the partnerships largely were promoted by the private insurance industry as a way of warding off universal coverage programs. In addition, proponents often seemed to claim that the partnerships could be a major component of reform, rather than just a small element in a much larger initiative. Moreover, advocates for the partnership mostly extolled the virtues of private insurance rather than of the benefits of expanded public programs. And the partnership was often portrayed as an alternative to liberalizing Medicaid or social insurance. As a result, supporters of universal coverage programs, such as the American Association of Retired Persons and Representative Henry Waxman (D-CA), strongly opposed the partnerships as an unrealistic diversion from major reform. The arguments around the partnerships during the late 1980s and early 1990s was intense and heated, to say the least.

Aside from the politics, the partnerships approach never completely resolved three important substantive problems. First, the major selling point to the states is the assertion that under the partnership Medicaid long-term care expenditures might be reduced or, at least, will not increase more than they would otherwise. This argument is probably stronger for the approach used by Connecticut, Indiana, Iowa, and California, where there is a "dollar-for-dollar" correspondence between the amount the insurance pays and the level of Medicaid protected assets. In New York, the ability to protect potentially very large amounts of assets makes this argument weaker. To the extent that these systems are budget-neutral, the partnerships are a move toward what economists call "Pareto optimality," that is, making some people better off without making anybody worse off. Insurance dollars are simply substituted for private asset dollars.

Whether the public-private partnership will truly be budget-neutral is open to question and a case can be made that expenditures will increase, at least marginally. After all, significant Medicaid benefits are being offered to people who would not otherwise be eligible and insurance coverage is likely to induce some utilization that would not have occurred otherwise. If additional public expenditures should prove to be required, then one may well ask whether providing asset protection to relatively well-to-do elderly is the best way to spend our next long-term care dollar. Because most policies are sold to healthy young elderly who are at least 10 to 20 years away from needing nursing home care, even fragmentary evidence as to the effect of the partnership on the public purse will not be available for a long time. An indispensable element for assessing the effect of the partnerships on the Medicaid budget is establishing a comparison level of expenditures. In a world with no private long-term care

insurance at all, the partnerships may be roughly budget-neutral. However, there is likely to be continuing modest growth in the number of private long-term care insurance policies sold. Compared to this scenario, if the partnership does not induce substantial numbers of additional insurance purchasers, then the partnership will require larger Medicaid expenditures than would otherwise be needed. This is because under current Medicaid rules purchasers of insurance who would have bought policies without the public-private partnership would have to spend-down their assets after their insurance benefits have been exhausted before qualifying for Medicaid, something that they are not required to do under the partnership.

Supporters of the partnership also argue that by giving the elderly the alternative of protecting their assets by purchasing insurance, legal and illegal transfers of assets for the purpose of obtaining Medicaid eligibility would be reduced. Current rules prohibit the transfer of assets at less than fair market value for 36 months prior to application for Medicaid eligibility (Burwell and Crown, 1996). While the subject of many anecdotes, systematic evidence of the prevalence of this activity is lacking, but limited data suggests that it is far less common than often assumed (Wiener, 1996). The problem is that once the partnerships encourage the elderly to look to Medicaid as a way to protect their assets, some insurance purchasers may only buy the 36 months worth of coverage required to comply with Medicaid rules and then legally transfer the remainder of their financial wealth upon entry to a nursing home. Others may calculate that they can transfer or shelter their assets and obtain Medicaid benefits without purchase of any long-term care insurance policy. Thus, the partnerships might actually increase rather than reduce the level of asset transfer.

Second, although the avowed goal of supporters of the partnership is to reduce the price of insurance, policies remain expensive enough to provide a formidable financial barrier to the number of purchasers and arguably to limit buyers largely to upper-middle and upper-income elderly. Wiener, Illston and Hanley (1994) estimate that 39 percent of private insurance expenditures under the partnerships would be for older people with annual incomes less than $40,000 (in 1993 dollars) in 2018, only modestly better than the 30 percent for the regular insurance market. Importantly, the partnerships offer no benefits to lower- or lower-middle income elderly who could not afford the insurance policies, as would incremental changes in Medicaid, such as raising the level of Medicaid protected assets or increasing the personal needs allowance, or more comprehensive social insurance.

Third, the partnership initiative is primarily a mechanism for asset protection, an issue about which Americans are highly ambivalent. Many people consider it extremely unfair that nursing home residents should have to lose their entire life savings simply because they were unlucky enough to develop Alzheimer's Disease and, through no fault of their own, require nursing home care. While granting problems with the current system, others question whether protecting financial estates to be passed on to adult children is an appropriate public policy goal because such transfers further inequality and are not based on the merits of their errors. What are personal savings for, they ask, if not for needed care toward the end of life? As such, some, such as Representative Henry Waxman have argued that it is improper to use a means-tested welfare program--Medicaid-- as a mechanism to protect the assets of upper-middle and upper-income elderly.

FAILING THE MARKET TEST

Although the partnerships have been the subject of extensive public policy debate, most of that debate has been rendered moot by the reality that the partnerships have failed the market test, at least so far. A startlingly small number of long-partnership insurance policies have been sold, making them insignificant as a mechanism of financing care in all of the states in which it has been tried. At the end of 1997, only about 30,000 policies were in force in the four states, even though they had a combined elderly population of 7.2 million (Laguna Research Associates, 1998; U.S. Bureau of the Census, 1998). Connecticut, which implemented its program in 1992 and is the home of the insurance industry, has only x,xxx policies in force. Not only have the number of purchasers been small, but nearly 70 percent reported that they "definitely" or "probably" would have purchased a long-term care insurance policy even if the partnership program did not exist (McCall, Driver, Bauer, and Knickman, 1997). Participating insurers overwhelmingly have been disappointed in the number of policies sold (Korb, Turner and McCall, 1998). Based on the existing extensive experience, the current partnerships are unlikely to be a significant source of financing for more than a tiny number of people. Because so few people have bought policies, it is unclear whether research on the experiences so far (including the characteristics of purchasers) gives us much insight on what would happen if market penetration was greater.

Why have so few people chosen to participate in the partnership program? It is hard to know for sure, but at least five reasons are plausible, if somewhat speculative. First, as noted above, although the premise of the partnership was to reduce the cost of insurance, policies remain expensive. The median price of a partnership policy purchased at age 65 was $1,663 as

of July 1996 (McCall and Korb, 1997). Thus, participation requires a substantial financial investment, especially by married couples if both are to be covered. Evidence to date, although highly flawed, suggests that partnership purchasers have somewhat higher income and significantly more assets than a randomly chosen comparison group aged 55-75, but that the differences are not as stark as some have feared would be the case (McCall, Driver, Bauer, and Knickman, 1996).[b] In California, a comparison between purchasers of partnership and nonpartnership policies suggests that partnership purchasers have lower levels of income and assets (McCall, 1997a). In both studies, however, a high proportions of respondents failed to report their income and assets, making it difficult to draw conclusions.

Second, the asset protection feature that is the hallmark of the partnership plans do not appear to be a major attraction for people who do participate in the program. Indeed, while most partnership purchasers reported that it was important "to leave an inheritance" to their heirs, only 7 percent of buyers indicated that it was the single most important reason for purchasing a long-term care insurance policy (McCall, Driver, Bauer, and Knickman, 1997). This is consistent with other studies that showed that asset protection, while important, is not the main reason people buy long-term care insurance (LifePlans, 1995). Asset protection may have a narrow appeal because most elderly have relatively modest levels of financial wealth, something that is especially true for 80-year old disabled widows which form the bulk of nursing home admissions (Radner, 1993; Wiener, Hanley, and Harris, 1994).

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[b] A major problem in the analysis is that the comparison group is much younger and has much high labor force participation than do partnership purchasers. In addition, Medicaid eligibles and non-English speaking individuals are excluded. The net effect of these design choices is a sample that is much higher in income and probably assets than a truly comparable population would be.

Third, many elderly do not want easier access to Medicaid. Indeed, one of the major reasons people buy long-term care insurance is to avoid having to apply for welfare. One survey of overall insurance purchasers found that 91 percent of respondents reported that avoiding Medicaid was an "important" or "very important" reason for buying a policy (LifePlans, 1995). Medicaid's relatively low reimbursement rates have led to potential problem of access and quality of care in nursing homes heavily dependent on Medicaid (Nyman, 1988; Institute of Medicine, 1986; Scanlon, 1980; Wiener and Stevenson, 1998).

Fourth, although the insurance industry advocated the partnership and saw it as a way of increasing the size of the private long-term care insurance market, the initiative seems to be inconsistent with the marketing incentives of the industry. Although figures are not available, partnership products appear to be only a small percentage of the private long-term care insurance products that are sold in the four states that have implemented programs. Substantial numbers of long-term care insurance policies were sold that did not meet the quality standards of the partnership program. In part, this reflects the higher standards (including inflation protection and nonforfeiture benefits) and the relatively higher costs of partnership policies (McCall and Korb, 1997; McCall 1997b). Especially since some of the product improvements (such as inflation protection and nonforfeiture benefits) are not well understood by purchasers, non-partnership policies are likely to be cheaper, may seem to be a better buy and may be easier to sell.

Moreover, the premise of the partnership--making it easier for people to obtain Medicaid benefits--is inconsistent with the primary message that insurance agents use to sell long-term care insurance. Long-term care insurance is sold primarily by stressing that Medicaid is a "terrible" program, with inferior access to poorer quality facilities. The sales pitch is essentially: buy this

product and you will avoiding depending on on that "horrible" program, Medicaid. The partnerships essentially require that agents make virtually the opposite argument: Medicaid is a pretty good program, except for the level of protected assets; buy this product and you will be able to get on Medicaid faster than you would otherwise. It would seem that few agents were willing to make that fundamental switch in their "sales pitch."

LESSONS FROM THE PARTNERSHIPS

The public/private partnerships for long-term care insurance are a sustained, reasonably well-funded and extensively researched effort to reform long-term care by merging private insurance with Medicaid benefits. They are not succeeding in changing how long-term care is financed in the states where they are operating. What lessons can be drawn from this "experiment"?

One lesson is that private insurance is unlikely to reform the financing of long-term care. Neither the partnerships nor the tax incentives enacted as part of HIPAA are succeeding in making private long-term care insurance into more than a niche product. While the number of people with insurance is likely to grow, policies cost too much for large numbers of people to purchase without very substantial public subsidies. And if large public subsidies are to be made, then the high administrative, profit, and overhead costs of private insurance make it a highly inefficient way to finance care. From a policy perspective, the questions is what should be done for the large majority of people who will never have private long-term care insurance.

Closely related to the first lesson is that voluntary approaches that depend on individuals making financial plans for an distant event--such as becoming seriously disabled when they are

85 years old--that they would rather not think about and do not believe will ever happen to them are not likely draw many participants. Even for retirement security issues that everyone personally expects to have to address--income support and health care--society has recognized the need for compulsory systems of financing.

Especially in a world where comprehensive health reform seems politically unrealistic and where expanding the public role seems unlikely, the notion of a public/private partnership is appealing but is hard to make more than a slogan. The hard reality is that the financing of long-term care is overwhelmingly the responsibility of the public sector. For example, in 1997 only 23 percent of nursing home residents were private pay, a proportion that has been declining slightly in recent years, mostly because of the increase in Medicare utilization (American Health Care Association, 1998). Moreover, a substantial portion of the private payments are publicly-financed Social Security benefits. Only about 22 percent of home care expenditures for the elderly are out-of-pocket or private insurance payments; public programs, especially Medicare, dominate financing (Committee on Ways and Means, U.S. House of Representatives, 1998). Given the limitations in private sector initiatives, public policy should focus on making the public programs work better rather than seeking to shift the burden from the public to private sectors.

Americans are obsessed with reducing the size of the public sector, but from the perspective of the burden on society, it scarcely matters whether long-term care is financed through the public or private sectors because the level of expenditures are likely to be comparable (especially if there is widespread private long-term care insurance). The real question is whether long-term care will be financed to a significant extent by catastrophic out-of-

pocket costs imposed on those individuals unlucky enough to need nursing home or home care or whether it will be spread more broadly over society as a whole.

It should be noted that the line between public and private institutions, and between taxes and premiums is not as bright in some other countries as it is in the United States. Germany, for example, has enacted a compulsory social insurance program for long-term care that depends on heavily regulated nongovernmental "sickness funds" and private insurance companies (Wiener and Evans, forthcoming 1999). Moreover, despite the fact that premium payments are mandatory, they are not viewed by the public as taxes. Germany is the only country in the world where private insurance plays a nontrivial role in financing long-term care because upper-middle class and upper income citizens have the option of receiving their coverage from private insurers rather than "sickness funds." Although it is astounding to Americans, Germany's expansion of mandatory social insurance actually reduced public spending by shifting funding from the Laender (the equivalent of states) to these nongovernmental agencies. The fuzziness of the line between the public and private sector allows Germany to use private organizations to achieve many social goals. In general, the United States lacks these intermediate kinds of organizations, although Blue Cross in earlier years had certain similarities to the "sickness funds." President Clinton's efforts to establish "health alliances," which also had certain similarities to the German "sickness funds," ended in failure.

WHERE DO WE GO FROM HERE?

The best solution to the problems of long-term care financing would be to increase public financing on a nonmeans-tested basis (Wiener, Illston, and Hanley; 1994; Rivlin and Wiener,

1988). Doing so would recognize long-term care as a normal risk of growing older, provide universal coverage for all Americans, prevent catastrophic out-of-pocket expenditures which are now routine, establish a strong base of public support, create a more balanced delivery system, and improve access and quality. However, doing so would mean a substantial tax increase, which is unlikely in the current political environment, especially given the long-run financial status of the Medicare and Social Security programs. In the wake of the collapse of health reform in 1994, comprehensive reform proposals are unlikely to be enacted in the near term.

Given that political reality, there are still a number of more modest options that should be considered positively and others that should not. First, the national regulatory standards for private long-term care insurance established by HIPAA should be substantially strengthened. Especially lacking are adequate protections for inflation, which can have devastating impact on a policy's purchasing power, and nonforfeiture benefits, the lack of which artificially reduce premiums and create products dependent on high rates of lapse to maintain profitability. While not too many people purchased partnership policies, they are of a much higher quality than nonpartnership policies (McCall and Korb, 1997, McCall, 1997). Since only "approved" policies are eligible for the enhanced asset protection, state regulators sought to use the partnerships as a "carrot" to induce insurance companies to upgrade the quality of their policies, but, as noted above, they did not prohibit the sale of lesser policies. From the perspective of the initiative, allowing insurance companies to sell noncomplying policies was a failure of political will that dramatically undercut the initiative and casts doubt on the commitment of the insurance industry to the partnership concept.

Relatedly, although private long-term care insurance obtained valuable tax benefits as part of HIPAA, the insurance industry has proposed additional tax incentives, such as allowing individuals to take a tax credit rather than a deduction for purchase of insurance and not to require that deductions be limited to expenditures in excess of 7.5 percent of adjusted gross income. Such additional tax benefits should not be enacted. To begin with, most of the tax expenditures will be for people who would have purchased policies anyway. As a result tax subsidies are very costly ways of promoting private insurance. For example, estimating the effect of an income-related tax credit for the purchase of private long-term care insurance, Wiener, Illston and Hanley (1994) calculated the cost per additional policy induced by the tax benefit at between $1,700 and $1,900 per year. In addition, these inefficient tax incentives are likely to result in substantial tax losses to the federal government. Insurance advocates argue that reductions in Medicaid nursing home and home care expenditures will offset the tax loss, but this is unlikely because of the financial status of people likely to purchase private long-term care insurance. Wiener, Illston and Hanley (1994) estimate that the tax loss through 2018 from an income-related tax credit would be at least four times the Medicaid savings. Finally, unless the benefit is a refundable tax credit (of which the Earned Income Tax Credit is the only example), tax incentives are ineffective for people who have little or no tax liability, who tend to be lower income. This is especially a problem for the elderly since only about half have any income tax liability (Committee on Ways and Means, 1998).

For the major public programs--Medicaid and Medicare--at least four incremental strategies should be considered. First, without costing an outlandish amount, the financial eligibility standards for Medicaid could be made more lenient. By liberalizing Medicaid

eligibility criteria, the safety net can be cast more widely so that fewer people face complete impoverishment before receiving benefits, while at the same time continuing to target public expenditures to those people with the greatest financial need. This option would accomplish much of the financial protections sought the partnership initiatives, albeit at additional public cost. Wiener, Illston, and Hanley (1994) estimated the cost of raising the level of protected assets to $30,000 for individuals and $60,000 for married couples, increasing the level of protected income for community-based spouses to 200 percent of the federal poverty level for couples, and augmenting the personal needs allowance to $100 per month would be about $5 billion a year. Obviously, less generous eligibility standards would cost less.

Beyond eligibility criteria, ways should be found to create a more balanced delivery system in Medicaid. Despite all of the policy rhetoric favoring expanding home and community-based services, only 10 percent of Medicaid long-term care expenditures for the elderly are for noninstitutional services (Wiener and Stevenson, 1998b). Eliminating the requirement that states obtain approval from the Health Care Financing Administration in order to implement Medicaid home and community-based services waivers would probably help marginally, but few states have found that requirement to seriously impede their implementing what they want to do. Although federal/state conflict over approval of waivers was substantial and bitter during the Reagan and Bush administrations, regulatory changes implemented by the Clinton administration have made obtaining home and community-based services waivers fairly routine (Holahan, Wiener, and Liska, 1997). More effective in altering the balance of care would probably be eliminating the home and community-based services waiver requirement that states limit eligibility to people at high risk of institutionalization and allow states to provide eligibility to

people higher up the income and asset distribution than is now permissible. There are many older people who are in need of long-term care services but are not so disabled as to qualify for nursing home care or who have more income and assets than allowed to qualify for Medicaid but not enough to pay for their own home care services.

Finally, the Medicare home health benefit needs to be rethought and the funds perhaps channeled into a new program. Medicare home health expenditures have skyrocketed from $2.6 billion in 1989 to approximately $20 billion in 1998, mostly as a result of the liberalization of Medicare coverage criteria in 1989. Yet if starting from scratch in 1989, few long-term care experts would have chosen to expand home and community-based services through the Medicare home health benefit. The Medicare home care benefit lacks independent assessment of need and case management, is restricted to a narrow range of expensive benefits and providers, and has virtually no incentives for utilization control. Many observers believe that there are more efficient and effective ways to provide home and community-based services.

One alternative might be to revamp the Medicare home health benefit to be more like state home care systems, but it would be difficult to merge the fairly rigid open-ended entitlement character of Medicare with the flexibility that is needed in long-term care. Another alternative might be to separate out the incremental funds spent as a result of the coverage liberalization and use it to fund a smaller version of the long-term care component of the Clinton health plan of 1993 (Wiener and Illston, 1994). That plan would have provided federal funds to the states on an extremely favorable matching basis to finance a very wide range of home and community-based services for persons with problems with three out of five activities of daily living or severe cognitive impairment of all ages and all income groups. Home health provider groups would

likely resist the change, however, as would some elderly advocacy groups who would perceive it as a Medicare cut.

Fourth, ways need to be found to integrate acute and long-term care services and financing, most likely through managed care, but in ways that protect long-term care. Older persons who need long-term care services currently encounter a fragmented financing and delivery system. Financing acute care is largely the province of Medicare and the federal government, whereas long-term care is dominated by Medicaid and state governments. Because of the separation of financial responsibilities, there exists a strong incentive for the federal government to shift costs to the states and vice versa.

The best know demonstrations of these types of strategies are the Social Health Maintenance Organizations (Social HMOs) and Program of All-inclusive Care of the Elderly (PACE). State officials are generally supportive of these demonstrations, but are looking for large-scale purchasing strategies that can enroll thousands of Medicare and Medicaid dually eligible individuals, and the Social HMO and PACE demonstrations do not provide that mechanism. Although states have been very interested in acute and long-term care integration, progress has been slow, in part because it is inherently difficult and in part because federal waivers of Medicaid and sometimes Medicare rules are required.

Of great concern to long-term care advocates is the potentially negative effect that these models might have on long-term care. Many HMOs have little experience or skill with the elderly in general and almost none with long-term care, raising questions about whether they know how to care for this population. Fiscal pressures within an integrated system could short-change long-term care services if managed care entities do not view long-term care as a priority

or if acute care overruns its budget. In addition, long-term care could become overmedicalized and services less consumer directed if the balance of power shifts from the individual client and his or her chosen provider to HMOs.

Finally, President Clinton has proposed a $1,000 nonrefundable tax credit for severely disabled taxpayers or their caregivers. The President is to be commended for raising the long-term care issue, which has been ignored in the debate on Social Security and Medicare but is the part of retirement security for which Americans are least well prepared. However, as noted above, half of the elderly pay no federal income taxes at all and the proportion of disabled elderly with no tax liability is almost certain to be higher. Moreover, younger people with severe disabilities have very low labor force participation rates and few are likely to pay taxes, making them ineligible for the benefit (Wiener and Sullivan, 1995). Thus, while most beneficiaries of the credit are likely to be relatively middle class, the proposal provides nothing for most moderate and lower-income older and younger people with disabilities. And the $1,000 credit, while not a trivial amount of money with which to buy services, is not sufficient to meet the needs of people with severe disabilities. Moreover, there is no guarantee that the money will be spent on long-term care services. With a $1 billion a year price tag, direct spending through the Social Services Block Grant or Older Americans Act programs would probably do a better job of targeting services to people needing long-term care services.

CONCLUSION

No other part of the health care system generates as much passionate dissatisfaction as the organization and financing of long-term care services. Given strong resistance to increasing public spending, there has been increasing interest in private long-term care insurance, in part driven by the hope that Medicaid expenditures could be reduced. The high costs of private insurance and the modest incomes of most elderly have stymied large scale growth in the number of policies sold. As a result, a number of proposals have been put forward to promote private insurance of which the public/private partnership for long-term care is one of the best known in policy circles.

While there has been extensive debate (at least within long-term care experts) on the pros and cons of the partnership plans, with skeptics arguing that budget neutrality is not assured, policies are too expensive and only likely to benefit the well-to-do, and that asset protection is an improper role for Medicaid. This policy debate, however, has been made moot by the very few number of people who have been willing to purchase qualified policies. The market seems to be much smaller than anyone had anticipated.

Reasons for the small number of policies being sold probably include the still high cost of policies, the limited appeal of asset protection, the unwillingness of people to use Medicaid, and the lack of real commitment by insurance agents. The modest results of the partnership provide several sobering messages for policymakers on the limitations of private insurance, voluntary approaches, and options that attempt to meld public and private approaches. Efforts in other countries to create public/private partnerships seem to be easier because of the more widescale use of nongovernmental organizations to administer mandatory programs.

If the public/private partnerships for long-term care seem unlikely to advance long-term care reform very far and comprehensive social insurance approaches seem unlikely to be enacted, there are still a number of incremental options that would be worthwhile. These include strengthening regulation of private long-term care insurance, liberalizing Medicaid eligibility rules and expanding its funding of home and community-based services, reforming the Medicare home health benefit, integrating acute and long-term care, and providing tax credits for family caregivers. These are all incremental steps that ought to be within the reach of policymakers.

For long-term care policymakers and advocates, the current situation is extremely frustrating. On the one hand, private sector initiatives and incremental changes are unlikely to provide the comprehensive solutions that are needed. On the other hand, there is little political appetite for more expansive public programs. Indeed, getting public attention to the issue of long-term care at all has been difficult, despite an aging population.

Changing demographics will, of course, eventually put long-term care on center stage. This will certainly happen when the baby boom generations needs long-term care, but may occur well before then. In the near future, virtually all of the parents of the baby boom generation will be elderly and start to need long-term care. These older persons will turn to their adult children for care and, in some cases, financial assistance. At that point, long-term care will no longer be merely an academic issue, but an intensely personal one. The question of "How are we going to take care of Mom?" will become a major concern for a substantial portion of the population. At that time, the combination of the elderly and their adult children may make it into an issue that nobody will be able to ignore.

REFERENCES

American Health Care Association. (1998). *Facts and Trends: The Nursing Facility Sourcebook, 1998*. Washington, DC: American Health Care Association.

Burwell B. and Crown W. (1996). Medicaid eligibility policy and asset transfers: Does any of this make sense? *Generations* 20(3): 78--83.

Cohen M.A., Tell E.J., Greenberg J.N., and Wallack S.S. (1987). The financial capacity of the elderly to insure for long-term care. *The Gerontologist* 27(4): 494-502.

Cohen M.A., Kumar N., McGuire T., and Wallack, S.S. (1992). Financing long-term care: A practical mix of public and private. *Journal of Health Politics, Policy and Law* 17(3): 403-423.

Committee on Ways and Means, U.S. House of Representatives. (1998). *Overview of Entitlement Programs: Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means, 1998.* Washington, DC: U.S. Government Printing Office.

Coronel S. (1998). *Long-Term Care Insurance in 1996*. Washington, DC: Health Insurance Association of America.

Crown W.H., Capitman J., and Leutz W.N. (1992). Economic rationality, the affordability of private long-term care insurance, and the role of public policy. *The Gerontologist* 32(4): 478-85.

Holahan, J., Wiener, J., and Liska, D. (1997). *The Medicaid Reform Debate in 1997*. Assessing the New Federalism Occasional Paper Number 1. Washington, DC: The Urban Institute.

Institute of Medicine. (1986). *Improving the Quality of Care in Nursing Homes*. Washington, DC: National Academy Press.

LifePlans, Inc. (1995). *Who Buys Long-Term Care Insurance: 1994-95 Profiles and Innovations in a Dynamic Market.* Washington, DC: Health Insurance Association of America.

McCall, N. (1997a). *How Partnership Purchasers Differ From Purchasers of Other Long-Term Care Insurance in California.* Health Policy Research Series Discussion Paper #97-5. San Francisco, CA: Laguna Research Associates.

McCall, N. (1997b). *Insurance Regulation and the Partnership for Long-Term Care.* Health Policy Research Series Discussion Paper #97-2. San Francisco, CA: Laguna Research Associates.

McCall, N. and Korb, J. (1997). *Characteristics of the Partnership for Long-Term Care Insurance Policies.* Health Policy Research Series Discussion Paper #97-8. San Francisco, CA: Laguna Research Associates.

Nyman J.A. (1988). The effects of competition on nursing home expenditures under prospective payment. *Health Services Research.* 23(4): 555-74.

Radner D.B. (1993). An assessment of the economic status of the aged. *Studies in Income Distribution.* No. 16. Washington, DC: Social Security Administration.

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

Scanlon W.J. (1980). A theory of the nursing home market. *Inquiry* 17(1): 25-41.

U.S. Bureau of the Census. (1998). Estimates of the U.S., regions, and states by selected age groups and sex: Annual time series, July 1 1990, to July 1, 1997. http://census.gov/population/estimate/state/97/agesex.txt. Accessed January 10, 1999.

Wiener, J.M. (1996). Public policies on Medicaid asset transfer and estate recovery: How much money to be saved? *Generations* 20(3): 72-76.

Wiener, J.M. and Evans, A. (forthcoming 1999). Public and private responsibilities: Home and community-based services in the United Kingdom and Germany. *Journal of Aging and Health.*

Wiener, J.M., Hanley, R.J., and Harris, K.M. (1994). The economic status of elderly nursing home users. Washington, DC: The Brookings Institution.

Wiener J.M., Harris K.M., and Hanley, R.J. (1990). Premium pricing of prototype private long-term care insurance policies. Washington, DC: The Brookings Institution.

Wiener, J.M. and Illston, L.H. (1994). Health reform in the 1990s: Where does long-term care fit in? *Gerontologist* 34(3): 402-8.

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

Wiener, J.M. and Stevenson, D.G. (1998a). Long-term care financing and quality of care. Washington, DC: Institute of Medicine.

Wiener, J.M. and Stevenson, D.G. (1998b). State policy on long-term care for the elderly. *Health Affairs.*17(3): 81-100.

Wiener, J.M. and Sullivan, C.M. (1995). Long-term care for the younger population: A policy synthesis. In *Persons with Disabilities: Issues in Health Care Financing and Service Delivery.* Edited by J.M. Wiener, S.B. Clauser, and D.L. Kennell. Washington, D.C.: The Brookings Institution, 1995. 291-324.

State Policy On Long-Term Care For The Elderly

States approach their long-term care policies differently, but all agree that curbing spending is the top priority.

by Joshua M. Wiener and David G. Stevenson

ABSTRACT: In the thirteen Assessing the New Federalism states, strategies to control the rate of increase in long-term care spending are extremely varied, especially in comparison with acute care's single-minded focus on managed care. States use three broad strategies: offsetting state spending with increased private and federal contributions, making the delivery system more efficient, and using traditional cost-control mechanisms, including controlling the nursing home bed supply and cutting Medicaid reimbursement rates.

LONG-TERM CARE SERVICES for older adults represent a major share of total health care spending in the United States and an area of growing concern for state policymakers. Nursing home and home health care accounted for almost 12 percent of personal health expenditures in 1995 and approximately 14 percent of all state and local health care spending.[1] Importantly, neither private insurance nor Medicare covers long-term care to any significant extent, and few older adults have private long-term care insurance. The disabled elderly must rely on their own resources or, when these are depleted, turn to Medicaid or state-funded programs to pay for their long-term care. Medicaid long-term care expenditures for the elderly are projected to more than double in inflation-adjusted dollars between 1993 and 2018 because of the aging of the population and price increases in excess of general inflation.[2]

Because of the high cost of long-term care (a year in a nursing home cost an average of $46,000 in 1995), Medicaid coverage for long-term care provides a safety net for the middle class as well as for the poor.[3] Approximately one-third of discharged nursing home

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residents pay out of private funds when admitted and eventually spend down to Medicaid eligibility.[4] In 1997, 68 percent of nursing home residents were dependent on Medicaid to finance at least some of their care.[5]

Although states are motivated by a variety of goals, the vast majority of long-term care initiatives are aimed at controlling the rate of increase in state spending, especially since Medicaid is the primary source of financing for long-term care. As in the rest of the Medicaid program, states have considerable flexibility in providing long-term care services. In fact, states' strategies to limit long-term care spending are far more varied than for acute care, where there is a single-minded focus on increasing managed care enrollment.

Methodology And Background

This analysis is part of the Urban Institute's Assessing the New Federalism (ANF) project.[6] In brief, the project analyzes state health, income support, and social service programs for the low-income population, primarily in thirteen states that account for 54 percent of total Medicaid spending for long-term care for the elderly.[7] The information included in this paper was collected largely from interviews and documents collected at site visits performed in the second half of 1996 and the first half of 1997, with updates obtained from various tracking services and publications. Qualitative data collected from representatives of state health and social service agencies, state legislators, long-term care provider associations, and advocates for the elderly and disabled provide the basis for the state-specific information we present. Persons interviewed were assured that they would not be quoted by name.

Exhibits 1 and 2 present indicators of potential demand for and supply of long-term care services in the ANF states and nationally. Almost $54 billion was spent on long-term care for persons of all ages by the Medicaid program in 1995 (34 percent of total Medicaid expenditures). Long-term care spending on older beneficiaries accounted for the majority ($30 billion) of this spending. Three-fourths of Medicaid expenditures for the elderly were for long-term care services.

There was considerable diversity among the ANF states in the level and distribution of long-term care spending for the elderly in 1995 (Exhibit 3). The growth in Medicaid long-term care spending nationwide was 10.7 percent annually from 1990 to 1995 (compared with 16.7 percent for total Medicaid spending); nursing facility spending outpaced home care spending over this same period (Exhibit 4).

EXHIBIT 1
Demographic Characteristics And Potential Demand For Long-Term Care Services In Thirteen States, 1995 and 1996

	Total elderly population (thousands)[a]	Elderly as percent of total population[a]	Elderly Medicaid beneficiaries (thousands)[b]	Elderly beneficiaries as percent of total beneficiaries[b]
United States	34,100	12.8%	3,889	11.1%
Alabama	566	13.1	71	13.3
California	3,486	10.6	486	9.8
Colorado	382	10.1	37	12.5
Florida	2,743	19.0	211	12.2
Massachusetts	841	14.1	101	14.0
Michigan	1,193	12.4	86	7.4
Minnesota	583	12.5	57	12.3
Mississippi	338	12.6	67	12.8
New Jersey	1,100	13.8	90	11.6
New York	2,419	13.3	371	12.3
Texas	1,927	10.2	308	12.2
Washington	646	11.5	53	8.3
Wisconsin	698	13.4	64	14.0

SOURCES: See below.
[a] U.S. Department of Commerce, Bureau of the Census, Current Population Survey projections for 1996.
[b] Urban Institute calculations based on Health Care Financing Administration (HCFA) Form 64 data for 1995.

Strategies To Control Long-Term Care Spending

Overall, states might use three broad strategies to control spending: (1) offset state spending for long-term care with increased private and Medicare contributions; (2) reform the delivery system so that care can be provided more efficiently; and (3) use traditional cost-control mechanisms such as controlling nursing home bed supply and cutting Medicaid reimbursement rates. The thirteen ANF states vary in the extent to which they focus on each of these strategies and in how far they have progressed in implementing substantial reform.

■ **Increase private and federal resources.** States are bringing additional private and federal resources into the long-term care financing system in several ways.

Encourage private long-term care insurance. For middle-class nursing home residents, private long-term care insurance could prevent both their impoverishment and subsequent Medicaid spending. However, only about 5 percent of the elderly have any type of long-term care insurance, primarily because of its high cost.[8] While Joshua Wiener and his colleagues found that long-term care insurance policies are unlikely to have much impact on Medicaid long-term care expenditures, Marc Cohen and his colleagues had more optimistic projections.[9]

Although some ANF states (such as California, Minnesota, Washington, and Wisconsin) offer private long-term care insurance

EXHIBIT 2
Characteristics Of The Long-Term Care Systems In Thirteen States, 1995

	Licensed nursing facilities			Licensed residential care			Licensed home health care	
	Total facilities	Total beds	Beds per thousand persons age 75 and older	Total facilities	Total beds	Beds per thousand persons age 75 and older	Total agencies	Agencies per thousand persons age 75 and older
United States	14,264	1,781,912	133.1	44,564	707,024	52.8	13,140	0.98
Alabama	238	24,318	90.0	208	4,892	18.1	180[a]	0.67
California	1,397	130,125	90.7	9,572	152,419	106.2	807	0.56
Colorado	226	20,251	207.5	372	7,444	76.3	183[a]	1.88
Florida	678	77,145	76.7	2,341	63,877	63.5	1,912	1.90
Massachusetts	591	56,912	168.7	167	5,500	16.3	178[a]	0.53
Michigan	453	51,203	83.9	4,760	44,793	73.4	190[a]	0.31
Minnesota	440	44,792	200.9	2,688	11,304	50.7	659	2.96
Mississippi	176	16,604	140.9	140	2,710	23.0	74	0.63
New Jersey	363	49,818	121.3	493	17,840	43.4	75	0.18
New York	663	114,601	111.7	1,341	38,926	37.9	913	0.89
Texas	1,346	129,677	185.2	508	14,548	20.8	2,399	3.43
Washington	304	28,869	122.5	2,188	22,912	97.2	166	0.70
Wisconsin	424	48,332	211.8	1,605	20,157	88.3	202	0.89

SOURCE: B. Bedney et al., *1995 State Data Book on Long-Term Care Program and Market Characteristics* (San Francisco: University of California, San Francisco, November 1996).
[a] Certified home health agencies

to state employees, few states have organized efforts to promote the purchase of policies. Nonetheless, many Medicaid officials and providers voice great anxiety over whether the current financing system is sustainable and hope for a long-run shift of financing from Medicaid to private insurance.

Of the ANF states, California and New York are the most active in promoting private long-term care insurance and have established public/private partnerships to encourage its purchase.[10] Under these partnerships states allow persons who buy a state-approved long-term care policy to keep more assets than normally allowed to qualify for Medicaid. California consumers can buy a level of private coverage equal to the amount of assets that they wish to protect.[11] New York consumers can protect an unlimited amount of assets from spend-down by purchasing three years of coverage.

Other states have considered similar approaches. In Massachusetts a planned partnership program similar to California's was discontinued by Gov. William Weld's administration in 1990 out of concern that it contributed to the perception that Medicaid was a middle-class entitlement rather than a program limited to the poor. Colorado and Michigan have sought to establish partnerships but have not implemented them because federal rules established in the Omnibus Budget Reconciliation Act (OBRA) of 1993 make the protected assets subject to mandatory estate recovery.

EXHIBIT 3
Medicaid Long-Term Care Expenditures For Elderly Beneficiaries In Thirteen States, By State And Type Of Service, 1995

	Total long-term care spending (thousands)	Long-term care as percent of total Medicaid	Long-term care spending		Proportion of long-term care spending			
			Per elderly beneficiary	Per elderly resident	Nursing facility	ICF-MR[a]	Mental health	Home care
United States	$30,413,715	19.5%	$ 7,821	$ 967	84.1%	2.0%	3.6%	10.3%
Alabama	371,497	19.0	5,210	632	92.0	0.4	3.1	4.5
California	2,100,690	11.1	4,319	620	79.8	3.4	8.4	8.4
Colorado	266,248	17.5	7,290	862	89.9	0.1	0.8	9.1
Florida	1,117,491	18.2	5,293	475	94.2	0.6	1.2	4.0
Massachusetts	1,302,359	23.3	12,872	1,763	92.7	2.3	1.1	4.0
Michigan	934,999	18.3	10,859	793	89.9	1.4	4.7	4.0
Minnesota	871,810	31.7	15,403	1,817	93.2	1.4	1.8	3.6
Mississippi	239,414	15.7	3,593	752	98.6	1.2	0.0	0.2
New Jersey	1,011,315	18.8	11,184	1,008	83.7	3.5	2.3	10.5
New York	5,702,398	24.2	15,354	2,444	66.4	3.2	7.4	23.1
Texas	1,400,461	16.1	4,547	785	76.3	2.5	0.0	21.2
Washington	483,899	17.1	9,111	876	92.7	1.4	0.2	5.7
Wisconsin	747,715	31.0	11,676	1,418	92.4	2.5	0.7	4.4

SOURCE: Urban Institute calculations based on Health Care Financing Administration (HCFA) Form 64 data. Prepared for the Kaiser Commission on the Future of Medicaid.
NOTES: Does not include disproportionate-share hospital (DSH) payments, administrative costs, accounting adjustments, or spending in the U.S. Territories. Totals may not add because of rounding. "Nursing facility" refers to skilled nursing facilities/other intermediate care facilities.
[a] Intermediate care facility for the mentally retarded.

So far, the partnerships have failed the market test. The California and New York partnerships have spurred the purchase of fewer than 17,000 policies in both states combined, despite the presence of more than six million elderly persons in the two states.[12] Yet both states remain committed to expanding private coverage for long-term care. California intends to make its insurance product more affordable. New York Governor George Pataki has made increasing private

EXHIBIT 4
Medicaid Long-Term Care Expenditures For Elderly Beneficiaries Nationally, By Type Of Service, 1990–1995

	Long-term care expenditures (millions)		Average annual growth
	1990	1995	1990–1995
Total	18,307	30,414	10.7%
SNF/ICF–other[a]	15,072	25,572	11.2
ICF-MR[b]	384	616	9.9
Mental health	959	1,107	2.9
Home care	1,892	3,119	10.5

SOURCE: Urban Institute calculations based on Health Care Financing Administration (HCFA) Forms 2082 and 64 data.
NOTES: Does not include disproportionate-share hospital (DSH) payments, administrative costs, accounting adjustments, or spending in the U.S. Territories. Totals may not add because of rounding.
[a] Skilled nursing facilities/other intermediate care facilities.
[b] Intermediate care facility for the mentally retarded.

financing the centerpiece of "Securing New York's Future," the state's plan for long-term care, and the legislature has provided permanent statutory authorization for the partnership. Both states hope that improved marketing strategies will boost enrollment.

Reduce Medicaid estate planning. Over the past several years policymakers and the media have focused attention on middle-class and wealthy elderly persons who transfer, shelter, and underreport assets—so-called Medicaid estate planning—to appear poor enough to qualify for Medicaid-financed nursing home care.[13] Congress has legislated against these practices on numerous occasions (most recently in the Balanced Budget Act [BBA] of 1997), but some argue that the legislative prohibitions are easy to circumvent.

Although the rhetoric surrounding the issue is passionate and all states acknowledge it as somewhat of a problem, Massachusetts, New Jersey, and New York were the only ANF states in which asset transfer was thought to be a major public policy issue. It is of particular concern in New York, where there are approximately 1,200 elder-law attorneys and where newspaper and magazine advertisements relating to asset transfer are said to be ubiquitous. The litigious culture and the hostility of the state courts to rules requiring middle-class citizens to impoverish themselves make cracking down on asset transfer difficult. Nonetheless, state officials believe that reducing asset transfer is a critical prerequisite to motivating citizens to purchase long-term care insurance policies and, more generally, to viewing long-term care as a private responsibility.

Maximize Medicare financing. States have long sought to shift Medicaid long-term care expenditures to Medicare but have been frustrated by the narrow range of Medicare coverage for nursing home and home health care. That situation has changed dramatically since the late 1980s, when Medicare postacute coverage rules were liberalized, making the benefits more oriented toward long-term care. Medicare home health spending totaled $17.2 billion in 1995, dwarfing the $3.1 billion spent by Medicaid on home and community-based services for the elderly.[14]

In response, some states have initiated "Medicare maximization" efforts to ensure that Medicare pays for home health and nursing facility care whenever possible. These efforts take the form of educating providers and consumers about Medicare benefits, improving the data system to identify dual eligibles (persons eligible for both Medicare and Medicaid) and instances of inappropriate billing, and requiring that all long-term care providers be certified by both programs and that they bill Medicare whenever there is the slightest chance of reimbursement. Partly reflecting these initiatives, one recent study of home health expenditures suggested an inverse rela-

tionship between Medicare and Medicaid home health spending.[15]

Among the ANF states, Massachusetts and New York have linked Medicaid nursing home payment rates to the industry's success in Medicare maximization. Nursing home and home care providers in New York were required to increase Medicare revenues by 1 percent (in aggregate) over base expenditures in 1995 and 1996 or face cuts in Medicaid payment. Medicaid nursing home rates in Massachusetts are actively negotiated annually with adjustments contingent upon Medicare utilization rates. The industry seems to have responded: The Medicare occupancy rate in Massachusetts nursing homes increased from 2 percent in 1990 to 11 percent in 1996; and home health providers billed almost $12 million retrospectively to Medicare.

These strategies are not without their problems, however. Agencies in Wisconsin struggle to respond to extensive audits and directives to bill Medicare first. Home health agencies there contend that this mandate subjects agencies to Medicare penalties, which are levied if too many inappropriate claims are submitted. Retrospective home health payment audits also are difficult for providers, sometimes coming after Medicare's window for billing has closed.

Finally, incentives to maximize Medicare reimbursement also depend on the comparability of Medicare and Medicaid payment rates. For example, home health agencies in Alabama and Minnesota believe that Medicaid rates are low enough that economic incentives, not policy, drive providers to seek Medicare payments whenever possible. Conversely, Medicare payments seem to be less sought by home health agencies in New York because Medicaid reimbursement is perceived to be adequate.

■ **System reform.** A second general strategy for saving money is to reorganize the health care delivery system in ways that make care more efficient and effective. This can be accomplished through extending managed care to include long-term care and by expanding home care and nonmedical, residential long-term care services.

Integrate acute and long-term care services through managed care. States have four goals in integrating acute and long-term care services, primarily through expanding managed care. First, they hope to achieve better-quality care, with providers no longer hamstrung by arbitrary divisions between acute and long-term care. Second, states seek to lower costs, as providers substitute lower-cost ambulatory and home-based care for more expensive inpatient care. Additionally, states hope to save money by shifting costs to Medicare for dual eligibles and by claiming most of the potential savings for Medicaid. For example, in its demonstration in the Houston area, Texas hopes to use "zero-premium" health maintenance organizations (HMOs) (that is, HMOs that charge no additional premiums to Medicare

"Progress for integration efforts is often slow because almost all require Medicaid and sometimes Medicare waivers."

beneficiaries), which provide more generous benefits than traditional Medicare does. Since Texas Medicaid now pays for some of these benefits (such as prescription drugs), the state can save money simply by enrolling dual eligibles in these HMOs. Third, some states, such as Massachusetts, Minnesota, and Wisconsin, are deliberately reducing the number of providers so that officials can focus on setting contract standards and monitoring performance. Finally, capitation payments shift much of the financial risk from government to providers and make state spending more predictable.

Although several ANF states (including California, Colorado, Massachusetts, New York, Texas, Washington, and Wisconsin) have Program of All-inclusive Care of the Elderly (PACE) or social HMO demonstration sites, state officials are more interested in strategies to enroll thousands of dual eligibles.[16] All of the ANF states (except Alabama and Mississippi, which have little managed care on which to build) are planning or implementing initiatives to enroll persons in managed care programs that integrate acute and long-term care. Especially notable are Minnesota's Senior Health Options demonstration, Colorado's Integrated Long-Term Care Financing Project, Florida's Long-Term Care Community Diversion Pilot Project, Texas's STAR+Plus Integrated Care Project, and Massachusetts's Senior Care Organizations. However, many of these efforts are small in scale and preliminary in their implementation.

Although there are exceptions, most of these efforts emulate the PACE model's focus on dual eligibles (although not PACE's focus on persons at risk of institutionalization) and the social HMO model's use of conventional HMOs. New York, Michigan, and Wisconsin are beginning the process by integrating long-term care alone, without adding acute care services.

Progress for these integration efforts is often slow because almost all require Medicaid and sometimes Medicare research and demonstration, freedom-of-choice, or home and community-based services waivers. States generally have found negotiations with the Health Care Financing Administration (HCFA) and the Office of Management and Budget (OMB) to be frustrating on two major points. First, several states would like to receive Medicare payments directly and combine them with Medicaid funds into a single capitated payment, but HCFA has maintained that it will not "block grant" the Medicare program to the states. Second, several states

fear that participation in these integrated systems will be modest unless enrollment is mandatory. HCFA, however, has insisted that dual eligibles are Medicare beneficiaries first and foremost and are entitled to freedom of choice.[17]

The integration of acute and long-term care services could realign service delivery and financing in ways that not all agree are desirable. In May 1997 the Wisconsin Department of Health and Family Services proposed to "redesign" the public long-term care system across the age spectrum by relying on managed care and a single capitated payment to integrate acute and long-term care. The nursing home industry was generally supportive of the plan, believing that it would benefit financially from the substitution of nursing home care for hospital care. The state's proposal, however, was withdrawn in June 1997 in response to heavy criticism from elderly and disability advocacy groups and county officials.

Opponents of the redesign were critical of the state's reliance on managed care organizations that they believed had little experience or skill with the elderly or with long-term care. Critics in Wisconsin also worried that fiscal pressures within an integrated system could short-change long-term care if providers do not view long-term care as a priority or if acute care overruns its budget. In addition, long-term care could become overmedicalized and services less consumer directed if the balance of power shifts from the individual client and his or her chosen provider to HMOs. Home care providers also were concerned about their relative negotiating strength and the potential bias of managed care toward institutional care. Finally, counties were concerned that the redesign would diminish their traditional role in long-term care service delivery.

Expand home and community-based services. Policymakers in every ANF state endorse expanding home care and creating a more balanced delivery system as goals. However, only 10 percent of Medicaid long-term care expenditures for the elderly were for home care in 1995, and spending was uneven across the states.[18] California, Massachusetts, New York, and Texas accounted for 60 percent of national Medicaid home care expenditures for the elderly in 1995 (33 percent of all elderly Medicaid beneficiaries reside in these states).[19]

In addition, California, Florida, Massachusetts, and Wisconsin have sizable state-funded home and community-based care programs. Forgoing federal Medicaid matching funds allows states maximum flexibility in determining eligibility, providing services, and setting budgets. All states together spent only $1.2 billion on state-funded home care programs for the elderly, mostly for persons who could not qualify for Medicaid.[20]

States can fund Medicaid home and community-based services

either through coverage of home health (a mandatory benefit) and personal care (an optional benefit) or by applying for home and community-based services waivers through Section 1915(c) of the Social Security Act. All of the ANF states deliver long-term care services for the elderly through home and community-based waivers, but the extent to which Medicaid home care in each state is defined by these waivers varies greatly.[21]

California, Massachusetts, New York, and Texas have accomplished most of their expansion of home and community-based services through coverage of personal care and home health through the regular Medicaid program. If states choose this approach, then services must be offered as an open-ended entitlement.

Because of a fear of runaway spending, many states have chosen to use Medicaid home and community-based waivers, which give states greater control over utilization and eligibility.[22] After a relatively slow start in the early 1980s, home and community-based waiver expenditures (for the elderly and nonelderly) have risen from $0.7 billion in 1988 to $4.6 billion in 1995, although the vast majority of spending is for younger persons with mental retardation or developmental disabilities.[23]

Although federal/state conflict over approval of waivers was substantial and bitter during the Reagan and Bush administrations, regulatory changes implemented by the Clinton administration have made obtaining home and community-based services waivers fairly routine. Indeed, some states—including Alabama, Florida, and Texas—have not used all of the "slots" approved by HCFA, primarily because state matching funds are not available. ANF states uniformly described their relationship with HCFA regarding home and community-based waivers as good.

Cost containment strategies. In almost every state, home and community-based services are "sold" primarily on their ability to achieve cost savings, although meeting unmet needs in the community and responding to consumers' preferences also are important. Most research, however, suggests that total long-term care costs are likely to rise as large increases in the use of home care more than offset small reductions in nursing home use.[24] On the other hand, a 1996 study of Washington, Oregon, and Colorado concluded that home and community-based services were cost-effective alternatives to institutional care in these states.[25]

As the policy commitment to community care has increased, some in the nursing home industry have questioned the cost-effectiveness of these services. Proponents of community care in Wisconsin believe that the significant decline in Medicaid nursing home utilization rates in the state is a sign of success, but others caution against

reading too much into these declines because of the potentially confounding effects of the nursing home moratorium, tightened eligibility standards for Medicaid nursing home coverage, and increased Medicare funding for skilled nursing care.[26]

To generate savings through the use of home and community-based services, states must limit per person spending and overall use for these services. Many states have established per person spending limits—generally, the average Medicaid nursing home care cost. According to some researchers, expenditures at this level are probably too high to achieve budgetary savings because of the difficulty in limiting use to those who otherwise would be institutionalized.[27] In Colorado the average per recipient cost of in-home and alternative care facilities is 16 percent and 14 percent, respectively, of the average per recipient Medicaid expenditure for nursing home care.

To mitigate the "woodwork effect," states also must limit use of home and community-based care to those who otherwise would be institutionalized without services. Colorado is one of the few ANF states to impose two screens: first to determine whether a person needs nursing home care, and second to determine risk of institutionalization. This process is criticized by some as making it more difficult to obtain home and community-based services than to obtain nursing home care, which reinforces the institutional bias of the delivery system. Similarly, Texas sought to use "unmet need" as a criterion for obtaining waiver services but did not make the change because of resistance from providers and consumer groups, who said it posed an unfair burden on informal caregivers.

All of the ANF states are exploring the potential role of residential alternatives to nursing home care. Florida, New Jersey, and New York finance the "care" part of some residential facilities through their Medicaid home and community-based waivers (Washington and Massachusetts provide residential care through a combination of state and Supplemental Security Income [SSI] funds), and California and Alabama are debating the provision of such benefits. The states hope to provide services that are more homelike, provide greater personal autonomy, and cost less than nursing homes do. In general, the nursing home industry contends that its residents are too disabled to be served adequately in these alternative settings, although in some states, such as Wisconsin, the nursing home industry is expanding into nonmedical residential facilities.

As states consider these alternatives, they face a number of difficult issues. States are struggling over how to superimpose new concepts of consumer-oriented, homelike care on a surprisingly large existing stock of nonmedical residential facilities (see Exhibit 2). For example, although California has 130,000 nursing home beds, it

also has more than 152,000 residential facility beds. Moreover, residential care settings are expanding rapidly in many states and are often not subject to certificate-of-need (CON) restrictions.

Another major issue is how to regulate these facilities in a way that allows persons to "age in place" while ensuring high-quality care. The problem is that federal and state regulatory structures are built on the concept of a continuum of care in which persons move from one level to another as they become more disabled. However, the whole notion of allowing persons to age in place means bringing services to them in their "homes," wherever they may be, as they become more disabled. The result is sometimes a regulatory structure that is puzzling. Wisconsin, for example, has adopted detailed, institutionally oriented regulations for "community-based residential facilities," which are limited to persons without severe disabilities. Yet the state has adopted very little regulation for assisted-living facilities, even though it allows these facilities to serve disabled persons needing up to twenty-eight hours of care a week.

Finally, states are concerned about how to make these new residential options available to the moderate- and lower-income elderly population. Outside of Oregon, most assisted-living facilities are geared to upper-income elderly persons. In Alabama, Minnesota, and Wisconsin some critics contend that middle-class persons exhaust their private resources paying for care in residential facilities and, once impoverished, apply to nursing homes as Medicaid recipients.

■ **Traditional strategies to control spending.** Existing federal law gives states considerable flexibility in conventional cost-saving mechanisms such as controlling the supply of long-term care providers and limiting reimbursement rates.

Control the supply of providers. Many states have responded to rising Medicaid long-term care spending by limiting the number of providers. These efforts have focused largely on nursing homes, where the general premise is that beds are likely to be filled with Medicaid residents. Although most ANF states limit nursing home beds through either CON requirements or moratoria for new construction, fewer states control the supply of home health agencies.[28]

Although CON programs can limit nursing home supply, they are usually required to judge only "need" and to ignore state budgetary concerns.[29] A blunter strategy used by many states is to pass a law prohibiting construction of new nursing home beds, often through a moratorium on certifying additional beds for Medicaid participation. Nationally, seventeen states had a moratorium on new construction of nursing homes in 1995.[30] Six ANF states (Colorado, Massachusetts, Minnesota, Mississippi, Texas, Wisconsin, and, until 1996, Alabama) had moratoria on nursing home construction in

1997. In Alabama, Texas, and Mississippi exceptions have meant that the moratorium on new construction is not total.

In Florida and Mississippi the nursing home industry is particularly concerned about a saturated hospital market and has sought to limit the conversion of hospital beds to skilled nursing units. This "back-door" expansion of hospital-based skilled beds in Mississippi, especially in rural areas, has drawn a heated response from the nursing home industry, which has sought remedies through the state legislature. The New Jersey legislature required hospitals to meet long-term care licensure and certification requirements and prohibited them from serving subacute patients for more than eight days. HCFA is holding up implementation out of a concern that imposing an eight-day maximum might violate Medicare rules.

Although limiting nursing home provider supply is likely to control spending over the short-to-medium term, the care needs of the elderly do not disappear just because provider supply is limited. Medicaid savings may be reduced to the extent that substitute services are provided. Moreover, in several ANF states in which the nursing home supply has been limited (Alabama, Florida, Michigan, and Mississippi), some observers contend that access to nursing home care can be difficult, especially in rural areas.

Cut reimbursement rates. Medicaid payment rates for nursing facility care are a logical target for states trying to reduce the rate of growth in long-term care spending for the elderly. The impact of nursing home rate reductions on state budgets is predictable, immediate, and potentially large. Thus, it is not surprising that reimbursement rates were targeted for savings in almost all of the ANF states during 1996 and 1997. Proposals to achieve these savings rely on a wide variety of mechanisms, including reducing the ceilings on payment levels, curbing administrative costs, and changing from facility-specific, cost-based reimbursement to case-mix-adjusted, flat-rate systems. In an interesting innovation, Minnesota established a demonstration project in which 120 nursing facilities have agreed to a freeze in rates in exchange for waiver of certain state regulations (for example, that half of the beds must be Medicare certified).

Between 1980 and 1997 the Boren amendment governed how states reimbursed nursing homes under Medicaid. The amendment required that rates be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards" (Section 1902(a)(13) of the Social Security Act).

Although the Boren standard might appear to be minimal, states contended that it was nearly impossible to operationalize and that

the courts were unreasonable in its interpretation. As of 1993 thirty-eight nursing home reimbursement lawsuits had been filed against states for violation of the Boren amendment's procedural or substantive standards.[31] Of the thirteen ANF states, nine have been the subject of a nursing home lawsuit. Despite the willingness to go to court in many states, the nursing home industry in Florida, Massachusetts, New Jersey, and Wisconsin had decided in recent years not to file Boren amendment suits because of the legal costs, the length of time it takes lawsuits to be resolved, the possibility that federal rules would be repealed, and the fear that a court case would sour relations with state officials.

State Medicaid officials universally opposed the Boren amendment, although they differed as to how much they thought payment policies would change if it were eliminated. States felt that they were forced to spend too much on nursing homes and to go far beyond the minimalist language of the statute. In some states, such as Wisconsin, consumer advocacy groups supported the repeal of the Boren amendment and saw it as an opportunity to shift money from nursing homes to home care.

With the repeal of the Boren amendment as part of the 1997 BBA, states will now have almost complete freedom in setting nursing home payment rates (although they must hold public hearings).[32] In a few states, including Texas, the nursing home industry believes that existing state laws can be used to force adequate payments.

The problem with repealing the reimbursement standard is that Medicaid nursing home payment rates are already fairly low, and access to nursing home care could be compromised for Medicaid beneficiaries as the payment differential between private-pay and Medicaid patients widens. (Few nursing homes can survive without Medicaid residents, however, which limits the extent to which facilities can reduce access.) Recognizing the payment gap as a potential problem, Minnesota requires nursing homes to charge private-pay residents the same amount that Medicaid pays.

In addition, although there is little evidence of a simple relationship between cost and quality, there is probably some threshold level of reimbursement below which it is impossible to provide adequate quality of care. Quality of care in nursing homes has improved over the past twenty years, but advocates for nursing home residents remain extremely concerned about the quality of care provided in many facilities. A recent *Time* magazine report on poor quality of care in California nursing homes, which allegedly has resulted in a large number of deaths, triggered a state and U.S. General Accounting Office investigation.[33] In Texas, where quality has been a persistent issue, the nursing home industry contends that

the level of care is a direct result of low payment rates; the state argues that nursing homes have not always used the money provided to improve care. In many states the nursing home industry is fearful that it will be required to meet federal and state quality standards but will not be reimbursed enough to do so.

The future impact of the Boren amendment's repeal on payment rates in ANF states is unclear. The nursing home industry is politically powerful in every state and may succeed in maintaining the current level of reimbursement or close to it. To many observers, the Boren amendment was a "fig leaf," providing a convenient excuse to give the nursing home industry what it wanted. Nonetheless, nursing homes in every state are concerned that Boren's repeal will leave them vulnerable to significant Medicaid rate cuts.

Alabama is a case in point. Despite the political power of the nursing home association, Gov. Fob James Jr. moved to cut nursing home rates by as much as 30 percent after nursing home spending was identified as a primary reason for an $80 million (federal and state) Medicaid deficit in March 1997. The governor bitterly attacked the nursing home industry for its "greed," reasoning that Alabama's rates had grown much more quickly than national or regional averages had. The nursing home industry responded by warning about reduced quality of care and the possibility of patients' being turned out of their residences. In fall 1997 the legislature adopted a compromise establishing a commission to investigate nursing home reimbursement, making modest rate reductions, and raising the provider tax. Since the provider tax is an allowable Medicaid expense, the net effect is that the federal government will finance most of the Medicaid shortfall that generated the crisis.

Resource Allocation And Politics

Efforts to reform long-term care are strongly influenced by state politics. In the ANF states the political landscape is dominated by the nursing home industry, and the strength of home care groups and consumer groups for the elderly and young persons with disabilities varies by state.

The for-profit nursing home industry is viewed as the strongest health lobby on Medicaid issues in all of the ANF states. This influence derives from several sources. First, nursing homes are far more focused on Medicaid and state policy than other provider groups are. Comparatively, nursing homes are much more dependent on Medicaid revenue than hospitals or physicians are. Second, because nursing homes are so focused on state policy, they meet frequently with state officials, which increases the level of personal acquaintance and friendship.[34] Third, the industry is large and well financed

enough to afford highly paid lobbyists and can commission studies to support its positions. Finally, nursing homes are frequent and large contributors to the political campaigns of governors and state legislators.[35] Moreover, almost every legislative district contains some nursing homes, which means that nursing homes are constituents as well as lobbyists. In many states the nursing home industry is aligned with Republicans, who share the antiregulation views of the providers, even though they are often more fiscally conservative and less willing to support Medicaid than Democrats are.

The industry may be strong, but it does not always get its way. Much of what nursing homes want is higher rates, which states are not always willing or able to fund. In addition, a history of quality concerns and of fraud and abuse has damaged the industry's public image, and policymakers and the public may be unconvinced that more money will improve patient care. Moreover, the for-profit status of most nursing homes leaves them vulnerable to charges that they are maximizing profits at the expense of residents.

Finally, there are other players on the long-term care stage, including various home care associations and advocacy groups for the elderly and young persons with disabilities. In general, except in New York, the home health care associations are not very influential in state Medicaid policy, in part because they often focus on Medicare rather than Medicaid policies. In all of the ANF states the elderly are believed to be a powerful group, but that power often does not derive from identifiable organizations. While in some states, such as New York and Wisconsin, elderly advocacy groups are well organized and well financed, they are largely lacking in other states, such as Alabama and Mississippi.[36]

There seems to be little "generational warfare" over Medicaid funding in the ANF states, contrary to popular belief. Few observers see explicit trade-offs between Medicaid services for low-income children and younger adults and services for the elderly. Instead, spending decisions within Medicaid, especially within low-benefit states, are made largely in response to federal mandates and requirements. Almost everyone, however, believes that situation would have changed radically if the Medicaid block grant had been enacted, as Medicaid would have become a zero-sum game. It is widely believed that the elderly would do well in such a world, in part because of the nursing home industry's influence and in part because the elderly are a politically favored group.

With the long-term care population, there is a significant amount of cooperation and strategic unity between advocacy groups for the elderly and younger persons with disabilities. In some states, however, there is tension over perceived inequity in resource allocation.

In California there is a perception among some that younger persons with disabilities have been more successful than the elderly have been in their lobbying efforts. In Florida some feel that the elderly dominate social services because they represent such a large percentage of the population. Elderly and disabled groups in Wisconsin recently have worked together successfully to increase funding for home and community-based services, but in the past there has been tension over a decline in the share of home and community-based care funds spent on the elderly. This led to the establishment in law of minimum percentages for each target group.

In general, there is not much conflict for resources between nursing homes and home care providers, but the potential for competition for resources is greater in states with more-developed home care systems. This is particularly true in Massachusetts, Texas, and Wisconsin, where home care advocates have sought to reduce nursing home expenditures and shift the money to noninstitutional services. Nursing home providers in these states have been vocal in questioning the cost-effectiveness of community-based services.

Conclusions

There is enormous variation in states' policies on long-term care for the elderly. Private long-term care insurance has been heralded by some as a potential fix for rising Medicaid long-term care spending; however, only two ANF states seem seriously committed to this strategy. And while most states believe that "Medicaid estate planning" is a problem, it is a major policy concern in only a few ANF states. Finally, some states are increasing federal contributions through effective Medicare maximization, but this strategy simply shifts costs to the federal government.

In a more ambitious approach, almost all of the ANF states are looking to managed care and the integration of aute and long-term care services as a way to reduce spending. However, progress on these initiatives has been slow, in part because Medicaid and, often, Mediare waivers are needed for their implementation.

All of the ANF states express a policy commitment to expanding home and community-based care for the elderly; however, the recent growth in Medicaid home care has been mostly for younger persons with disabilities. In fact, all but a few ANF states spend the vast majority of Medicaid long-term care dollars for the elderly on institutional care. To achieve cost savings, states will have to keep per person costs down and limit the woodwork effect. Finally, several states are debating what role the sizable stock of nonmedical residential care facilities should have.

In the short run, states are likely to rely on traditional strategies

to reduce long-term care spending. However, this does not address the underlying demographics of an aging population. With the repeal of the Boren amendment in the 1997 BBA, states will have much greater legal freedom to impose rate cuts on nursing homes. Yet doing so may still be very difficult, since the for-profit nursing home industry is powerful at the state level. Moreover, to the extent that these cuts are believed to affect nursing home residents adversely, elderly advocacy groups will oppose them as well.

Almost all states complain about the high costs of long-term care for the elderly, but the hard reality is that the current method of Medicaid long-term care financing is actually quite economical. Payment rates are usually much lower than Medicare and the private sector. Persons receive government help only after depleting most of their assets. Finally, the institutional bias of the delivery system limits services largely to persons with the most severe disabilities who do not have family supports. Within this system, it is difficult to obtain large savings.

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NOTES

1. K. Levit et al., "National Health Expenditures, 1995," *Health Care Financing Review* (Fall 1996): 175–214.
2. J.M. Wiener, L.H. Illston, and R.J. Hanley, *Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance* (Washington: Brookings Institution, 1994).
3. Unpublished estimates of nursing home revenue per day, Office of National Health Statistics, Office of the Actuary, Health Care Financing Administration, January 1997.
4. J.M Wiener, C.M. Sullivan, and J. Skaggs, *Spending Down to Medicaid: New Data on the Role of Medicaid in Paying for Nursing Home Care* (Washington: American Association of Retired Persons, June 1996).
5. Ibid.
6. For a discussion of the project, see A. Kondratas, A. Weil, and N. Goldstein, "Assessing the New Federalism: An Introduction," in this volume of *Health Affairs*.
7. Unless otherwise noted, all Medicaid data presented in this paper come from Urban Institute analysis of Health Care Financing Administration (HCFA) Forms 64 and 2082 data for 1995.
8. Authors' estimate based on data from S. Coronel and M. Kitchman, *Long-Term Care Insurance in 1995* (Washington: Health Insurance Association of America,

1997). On cost, see Wiener et al., *Sharing the Burden*; W.H. Crown, J. Capitman, and W.N. Leutz, "Economic Rationality, the Affordability of Private Long-Term Care Insurance, and the Role of Public Policy," *Gerontologist* 32, no. 4 (1992): 478–485; and A.M. Rivlin and J.M. Wiener, *Caring for the Disabled Elderly: Who Will Pay?* (Washington: Brookings Institution, 1988).

9. Wiener et al., *Sharing the Burden*; Rivlin and Wiener, *Caring for the Disabled Elderly*; and M.A. Cohen, N. Kumar, and S.S. Wallach, "Long-Term Care Insurance and Medicaid," *Health Affairs* (Fall 1994): 127–139.
10. See J.M. Wiener, "Trying to Jump Start the Market: Public Subsidies for Private Long-Term Care Insurance," in *Balancing Responsibilities for Financing Long-Term Care: The Integration of Public and Private Roles*, ed. L. Walker, B. Bradley, and T. Wetle (Baltimore: Johns Hopkins University Press, forthcoming).
11. For example, a person who buys a policy that pays $100,000 in benefits can keep $100,000 in assets and still qualify for Medicaid nursing home benefits.
12. University of Maryland Center on Aging, "Partnership Update" (College Park: University of Maryland, 1997); and U.S. Department of Commerce, Bureau of the Census, *Current Population Projections, 1996* (Washington: U.S. Government Printing Office, 1996).
13. B. Burwell and W.H. Crown, "Medicaid Estate Planning: Case Studies of Four States," in *Persons with Disabilities: Issues in Health Care Financing and Service Delivery*, ed. J.M. Wiener, S.B. Clauser, and D.L. Kennell (Washington: Brookings Institution, 1995), 61–94.
14. G. Kenney and M. Moon, *Reining in Home Health Services under Medicare* (New York: Commonwealth Fund, 1997).
15. G. Kenney, S. Rajan, and S. Soscia, "State Spending for the Medicare and Medicaid Home Care Programs," *Health Affairs* (January/February 1998): 201–212.
16. PACE demonstration sites operate as geriatrics-oriented, staff-model HMOs that provide the complete range of acute and long-term care services to persons who meet nursing home admission criteria. Social HMOs extend the traditional HMO concept by adding a modest amount of long-term care benefits. They seek to enroll a cross-section of the elderly population in terms of disability levels.
17. HCFA allows states to require dual eligibles to join HMOs but does not allow states to require beneficiaries to receive Medicare services through the HMOs. If beneficiaries choose to receive services outside of the HMO, then either the state or the HMO must pay the applicable deductibles and coinsurance.
18. Although total Medicaid home and community-based service spending has increased significantly in recent years, almost 80 percent of the growth in these expenditures between 1990 and 1995 was for younger persons with disabilities. Authors' estimate based on Urban Institute calculations.
19. Spending in New York alone accounted for more than 40 percent of all Medicaid home care expenditures for the elderly in 1995 (elderly beneficiaries in New York were almost 10 percent of all elderly Medicaid beneficiaries).
20. E. Kassner and L. Williams, *Taking Care of Their Own: State-Funded Home and Community-Based Care Programs for Older Persons* (Washington: AARP, 1997).
21. Although data solely on the elderly are not available, home and community-based waiver programs were 75 percent of total Medicaid home care expenditures in Alabama but only 13 percent in Mississippi. Urban Institute calculations based on HCFA Forms 64 and 2082 data.
22. Using these waivers, states can cover a wide range of nonmedical long-term care services. States must target persons at high risk of institutionalization and assure HCFA that the average cost of providing services with the waiver will not exceed that without the waiver. Because of this cost-effectiveness

requirement, states may provide these services only to a preapproved number of persons, limiting the potential financial liability that would accompany an open-ended entitlement benefit. Under the waiver provisions, services do not have to be offered statewide and can be limited to highly targeted groups of Medicaid eligibles.

23. G.A. Smith and R.M. Gettings, *The Medicaid Home and Community Based Waiver Program* (Alexandria, Va.: National Association of State Directors of Developmental Disabilities Services, 1996).
24. J.M. Wiener and R.J. Hanley, "Caring for the Disabled Elderly: There's No Place like Home," in *Improving Health Policy and Management: Nine Critical Research Issues for the 1990s*, ed. S.M. Shortell and U.E. Reinhardt (Ann Arbor, Mich.: Health Administration Press, 1992), 75–110.
25. L.M.B. Alecxih, S. Lutzky, and J. Corea, *Estimated Savings from the Use of Home and Community-Based Alternatives to Nursing Facility Care in Three States* (Washington: AARP, 1996). A 1994 study by the U.S. General Accounting Office came to similar conclusions in Washington, Oregon, and Wisconsin. U.S. General Accounting Office, *Medicaid and Long-Term Care: Successful Efforts to Expand Home Services while Limiting Costs* (Washington: GAO, 1994).
26. M.A. Sager and G. Arling, *A Review of Community Based Long-Term Care with Emphasis on Wisconsin's Community Options Program* (Madison: University of Wisconsin, 1995).
27. W.G. Weissert, "One More Battle Lost to Friendly Fire—Or If You Spend Too Much It's Hard to Save Money," *Medical Care* 31, no. 9 (1993): SS119–SS121.
28. CON requirements and moratoria affect the number of home health agencies, but they have no impact on the amount of services provided or the number of persons served by a particular agency. Any agency that wishes to expand services greatly can do so. Thus, CON in these instances serves to protect existing providers but is a particularly weak expenditure control.
29. C. Harrington et al., "The Effect of Certificate of Need and Moratoria Policy on Change in Nursing Home Beds in the United States," *Medical Care* 35, no. 6 (1997): 574–587.
30. B. Bedney et al., *State Data Book on Long-Term Care Program and Market Characteristics* (San Francisco: University of California, San Francisco, 1995).
31. J.K. Weinburg et al., *Nursing Home Litigation under the Boren Amendment* (San Francisco: UCSF, 1993).
32. The retention of the "equal access provision," a clause within the Medicaid legislation requiring states to set payments "consistent with efficiency, economy, and quality of care," could provide nursing homes with some legal protection, but physicians, home care agencies, and other noninstitutional providers generally have not found this standard to be much help in forcing higher Medicaid reimbursement rates.
33. "Fatal Neglect," *Time*, 27 October 1997, 34–38.
34. In two ANF states high-level bureaucrats have become senior officials in the nursing home association or obtained senior management positions in major nursing home chains. There is nothing inherently wrong in that, but it underlines the ongoing personal relationship between state officials and the industry.
35. Nursing home groups in California, Texas, Florida, and New York contributed $637,737 to political action committees in 1996; California facilities alone contributed $437,946. H.P. Weiss, "What Does $842,000 Buy?" *McKnight's Long-Term Care NEWS*, November 1997, 1, 13.
36. In Wisconsin the coalition of elderly advocacy groups even had its own MasterCard credit card, the use of which resulted in contributions to the coalition.

THE URBAN INSTITUTE

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Younger People with Disabilities and State Health Policy

Joshua M. Wiener

Services to younger persons with disabilities (children and adults under 65 years of age) form a substantial share of overall state health spending and are an important part of the Medicaid program. This population accounted for 16 percent of all Medicaid beneficiaries in 1995 (about 5.7 million persons), but 32 percent of Medicaid expenditures (almost $50 billion). Younger persons with disabilities also accounted for nearly one-third of the extraordinary growth in Medicaid spending over the 1988–1995 period.[1] Thus, this population is critical to state efforts to control Medicaid expenditures and to reform health care generally.

Younger persons with disabilities accounted for nearly one-third of the extraordinary growth in Medicaid spending over the 1988–1995 period.

This brief discusses a variety of delivery and financing issues that states are facing as they rethink Medicaid and other health programs. A brief overview of the population and the costs associated with health services provided to this group helps set the stage for the discussion.

The Population and Its Service Costs

Younger people with disabilities are a very heterogeneous group, consisting of individuals with physical disabilities, mental illnesses, and mental retardation/developmental disabilities. The number of younger people with substantial disabilities living in the community ranged from 1.0 to 14.1 million people in 1995, depending on the definition used.[2] In addition, about 500,000 younger people with disabilities were in institutions: 135,000 in intermediate care facilities for the mentally retarded (ICF/MRs), 220,000 inpatients in psychiatric institutions, and 150,000 in nursing homes.[3] There is an ongoing trend away from institutional use.

As noted above, the Medicaid program served about 5.7 million younger persons with disabilities in 1995. Spending on blind and disabled Medicaid beneficiaries averaged $8,685 per person in 1995, compared to $1,728 for younger beneficiaries who are not disabled.[4] For the very severely disabled, the cost can be much higher. For example, the average cost of a year's institutional care in an ICF/MR was almost $71,000 in 1995.[5] These institutional costs are particularly high because of extensive quality standards, use of (relatively expensive) unionized state employees in public facilities, and low occupancy rates resulting from the deinstitutionalization movement. The average Medicaid cost of serving younger people with mental retardation/developmental disabilities in home and community-based settings under Medicaid waivers was just over $24,000 in 1996.

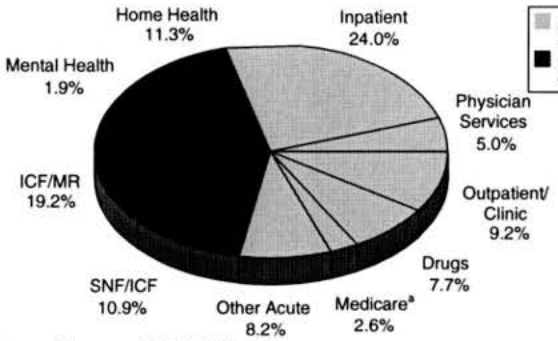
Medicaid expenditures for younger persons with disabilities historically have been about evenly split between acute and long-term care services, but in recent years the balance has shifted toward acute care expenditures. In 1994, 57 percent of Medicaid expenditures for blind

and disabled beneficiaries were for acute care, while 43 percent were for long-term care (figure 1).

Service Delivery

States play a much larger role in the direct provision of services for younger people with disabilities than they do for the elderly. They are especially important providers of institutional services for younger persons with mental retardation/developmental disabilities and with chronic mental illnesses. Two major issues concern states as they review their delivery of services to younger people with disabilities: the balance between institutional and home and community-based care and the integration of acute and long-term care services within a managed care system. Both are important features of ongoing debates about cost and appropriateness of care with respect to this population.

Figure 1
Medicaid Expenditures for Younger Beneficiaries Ages 0 to 64 with Disabilities, by Type of Service, 1994



Total Expenditures = $45.3 billion

Source: Urban Institute 1997, based on HCFA 2082 and 64 data for nonelderly blind and disabled beneficiaries.
Notes: Does not include administrative costs, accounting adjustments, or the U.S. territories. Totals may not add to 100 due to rounding. "Other Acute" care services include case management, family planning, dental, EPSDT (health screening for children), vision, other practitioners' care, etc. "ICF/MR" refers to intermediate care facilities for the mentally retarded. "SNF/ICF" refers to skilled nursing facilities/other intermediate care facilities.
a. Medicaid payments to Medicare are distributed proportionately among aged, blind, and disabled beneficiaries. The 2.6% figure is the share for the blind and disabled.

Balance Between Institutional and Noninstitutional Services

There is an extremely widespread, although not unchallenged, policy consensus among state policymakers and disability advocates that institutions should play a far smaller role in providing services to younger persons with disabilities than has traditionally been the case. Many advocates go further than policymakers and are unwilling to grant even a residual role for institutional care (which sharply distinguishes the disability movement from advocates for the elderly). There have been numerous lawsuits forcing deinstitutionalization at many state mental hospitals and ICF/MRs. As a result of transferring less disabled individuals to other settings, the remaining residents of state institutions are very severely disabled; moving them to less structured environments may be more difficult and expensive than past shifts. Although the institutionalized population has declined, funds and services have not always followed individuals from the institution to the community.

Home and community-based services are expanding rapidly and embrace an increasingly wide range of services, including home health, personal care, homemaker services, assisted living, adult foster care, day habilitation, prevocational services, supported employment, supported living, chore service, homemaker services, meals-on-wheels, respite care, family training, modifications to the home, and personal emergency response systems. Many of these services are beyond the traditional definition of "medical care," but are important supports for people with disabilities. As a sign of the shifting balance of care, in 1994 for the first time the number of Medicaid beneficiaries with mental retardation or developmental disabilities receiving home and community-based services exceeded the number of persons receiving care in ICF/MRs.[6]

For home and community-based services, two key issues are the flexibility and scope of services and the use of "personal assistance services." Advocates argue that because each person is different, people with disabilities should be able to tailor services to their own needs by choosing from a very broad array of services. In the most far-reaching formulation of this argument, some advocates have proposed "cashing out" services and giving individual consumers total freedom to spend the money as they see fit. Although supporting increased flexibility, federal and state officials worry that, with an ever-widening array of services on the list of offerings, more and more persons with disabilities will come forward to claim services. In an open-ended program like Medicaid, according to this view, people cannot be entitled to "everything" without expenditures increasing greatly.

Advocates reject this argument, contending that flexibility would lead clients to choose lower-cost, less intensive services than are now forced upon them by the narrower set of services traditionally available.

Closely related to this issue of service flexibility is how much control the client should have over the service provider. This choice is crystallized in the debate over personal assistance services and agency-directed services. Under the traditional agency-directed service approach, an organization hires and directs the personnel who deliver the services. In contrast, in the personal assistance service model, the individual client hires, fires, and directs the service provider. Some states, such as California, have been drawn to personal assistance services because of the potential to lower costs while at the same time giving persons with disabilities greater control over their lives. Other states, however, have been wary of this approach because of potential problems of quality assurance and the administrative complexities. Can persons with severe disabilities enforce acceptable service standards? And can they be counted on to handle income tax, unemployment, Social Security taxes, and workers' compensation contributions for their employees?

Integration of Acute and Long-Term Care Services through Managed Care

Managed care is increasingly being seen as a way for states to control their Medicaid costs. For younger people with disabilities, as with the elderly population, there is increasing state policy interest in integrating acute and long-term care services through the use of health maintenance organizations (HMOs) and other managed care organizations. Initiatives are either under way or being developed in several states (including Wisconsin, Ohio, and Massachusetts). Because costs are so high for persons with disabilities, the potential savings of more efficient service management are large. But debate rages over whether managed care is appropriate for this group.

People with disabilities currently receive their care in a fragmented and uncoordinated system. Proponents argue that applying the principles of managed care can greatly improve the quality of and access to care at the same time that it controls spending. Opponents, including advocates for younger people with disabilities, point out that managed care organizations have very little experience in serving younger people with disabilities and may not be sensitive to their needs or capable of meeting them. The medical necessity criteria often used by HMOs for home care, rehabilitation, durable medical equipment, and therapies are typically much narrower than commonly exist under Medicaid, raising questions of whether these Medicaid-covered services will be provided as required.

In addition, most managed care organizations depend on primary care physicians to reduce use of specialist care. But persons with disabilities often prefer to rely, even for routine care, on specialists who are knowledgeable about their conditions. This factor is potentially aggravated by managed care's restrictions on provider choice, which may mean losing access to the providers best qualified to deal with the problems connected with a specific disability.

Finally, managed care organizations are typically dominated by "the medical profession," i.e., physicians and hospitals. This carries two dangers. Long-term care may become overmedicalized and less consumer directed. And managed care organizations may end up shifting Medicaid resources from long-term care to acute care services.

Financing

States are involved in financing a substantial portion of health care for younger people with disabilities. Medicaid accounts for the lion's share of state health care spending on this population, but a variety of state-only programs provide significant additional funds. As policymakers at the federal and state levels continue to debate ways to restructure the Medicaid program, four financing issues stand out among the many that confront them with respect to younger people with disabilities: the great variation among states in Medicaid spending for this population; the link between Medicaid eligibility and the definition of disability used to qualify for Supplemental Security Income (SSI); the use of Medicaid home and community-based waivers; and the incentives currently facing states to put as many service programs for younger people with disabilities (as well as for other eligible groups) under the Medicaid umbrella as possible in order to partially shift state-only costs to the federal government.

There is increasing state policy interest in integrating acute and long-term care services through managed care organizations. But debate rages over whether managed care is appropriate for people with disabilities.

Medicaid Variation among States

State Medicaid programs vary widely in the size of their younger population with disabilities, in total Medicaid expenditures for this population, in the proportions of Medicaid program funds spent on this population, and in per-beneficiary expenditures on this group (table 1). New York spends considerably more Medicaid dollars on this group than any other state ($7.6 billion in 1994), with California second ($4.3 billion) and Wyoming at the low end ($61 million). Idaho spends the largest share of its Medicaid dollars on younger persons with disabilities (45.6 percent) and Arizona the smallest (16.6 percent). In terms of expenditures per younger disabled beneficiary, Connecticut spends the most ($16,262 in 1994) and Tennessee the least ($3,136).

Changing Medicaid into a block grant (as was proposed by Congress in 1995) or imposing per-beneficiary caps on spending (as proposed by President Clinton in 1995 and 1997) could lock into place existing interstate differences in spending if allocations or caps are based on historical spending patterns. Without adjustments to loosen the grip of historical spending patterns on federal allocations, there would be no way for low-spending states to come up to the national average, let alone to the levels of high-spending states—and still obtain a federal match. Conversely, high-spending states will be allowed to retain their more generous programs (with the federal match) if they like.

The SSI-Medicaid Eligibility Link

To a large extent, Medicaid eligibility policy drives Medicaid spending. Medicaid eligibility for younger persons with disabilities is tightly linked to the definition of disability used by the SSI program. The SSI rolls have been increasing for both children and nonelderly adults. Between 1988 and 1995, the number of blind and disabled Medicaid beneficiaries increased by over two-thirds (68 percent), partly reflecting the 1990 Supreme Court decision in *Sullivan v. Zebley*, which greatly broadened SSI eligibility for

Table 1

Medicaid Beneficiary Totals and Expenditures for Younger Persons Ages 0 to 64 with Disabilities, 1994, by State

State	Younger Beneficiaries with Disabilities (thousands)	Expenditures on Younger Persons with Disabilities		
		Total (millions of dollars)	Share of Total Medicaid Expenditures (percent)	Spending per Beneficiary (dollars)
Alabama	125	$ 541.3	30.6%	$ 4,322
Alaska	6	76.5	26.6	12,708
Arizona	56	260.2	16.6	4,626
Arkansas	83	482.8	44.9	5,783
California	704	4,339.8	30.9	6,168
Colorado	39	376.7	33.7	9,771
Connecticut	50	809.6	33.4	16,262
Delaware	11	125.0	44.5	11,342
District of Columbia	22	311.2	39.4	14,354
Florida	251	1,605.2	30.0	6,394
Georgia	177	1,105.3	33.8	6,229
Hawaii	18	137.7	30.1	7,776
Idaho	17	142.3	45.6	8,477
Illinois	260	2,352.3	44.5	9,055
Indiana	67	817.9	29.1	12,189
Iowa	47	443.3	40.7	9,358
Kansas	36	340.2	34.7	9,486
Kentucky	145	790.5	42.3	5,446
Louisiana	136	1,174.3	28.9	8,621
Maine	33	292.0	31.3	8,720
Maryland	81	846.6	37.7	10,432
Massachusetts	137	1,636.3	34.8	11,947
Michigan	213	1,767.9	35.9	8,293
Minnesota	65	910.9	36.9	14,067
Mississippi	117	475.7	35.8	4,055
Missouri	92	630.0	24.9	6,848
Montana	15	151.3	43.9	10,115
Nebraska	22	213.7	34.7	9,867
Nevada	14	139.0	33.3	9,697
New Hampshire	13	159.2	19.2	11,998
New Jersey	137	1,641.6	34.3	12,010
New Mexico	34	261.3	39.3	7,626
New York	471	7,646.6	36.0	16,224
North Carolina	113	896.3	28.2	7,906
North Dakota	8	108.9	39.0	12,957
Ohio	220	1,839.1	33.4	8,352
Oklahoma	52	350.7	33.7	6,686
Oregon	44	392.4	35.5	8,869
Pennsylvania	264	1,930.6	30.0	7,324
Rhode Island	25	304.7	38.7	12,244
South Carolina	88	588.2	30.9	6,710
South Dakota	12	128.5	44.2	10,320
Tennessee	203	635.5	23.6	3,136
Texas	251	1,940.4	23.8	7,730
Utah	17	177.6	34.6	10,375
Vermont	14	110.0	38.7	8,112
Virginia	97	624.2	33.4	6,444
Washington	101	898.4	35.3	8,895
West Virginia	67	444.2	35.4	6,635
Wisconsin	104	882.9	39.1	8,482
Wyoming	5	61.0	38.5	11,156
U.S. Total	5,381	45,317.9	33.1	8,421

Source: Urban Institute 1997, based on HCFA 2082 and 64 data for nonelderly blind and disabled beneficiaries.
Note: Expenditures do not include administrative costs or accounting adjustments, or the U.S. territories. Medicaid payments to Medicare are allocated proportionately among aged, blind, and disabled beneficiaries. This table includes the share for the blind and disabled.

children.[7] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 tightened SSI eligibility for children. Under current law, however, most children would continue to qualify for Medicaid as low-income children even if they lose eligibility for SSI.[8]

For adults, the SSI definition of disability is based on an inability to work. Many people on SSI have little work experience, reflecting in part a greater likelihood of congenital problems (such as mental retardation). Only about a quarter of disabled Medicaid beneficiaries have enough quarters of work and earnings to be eligible for Medicare before age 65. As a result of the lack of work experience and their disabilities, transition from public assistance to work is difficult and relatively rare. In fact, the linkage of Medicaid eligibility to an inability to work creates a Catch-22 for younger persons with disabilities who might want to work (and the social service agency personnel who want to find them jobs). If Medicaid-funded services help an individual to find and keep a job, then the person is deemed to be no longer disabled, and the very services that enabled him or her to function in the labor market (such as personal assistance services or prescription drugs) are withdrawn after a transitional period because the person will no longer be covered by Medicaid. Without those services, the person may no longer be able to work and will again qualify for SSI and therefore Medicaid. Both the employment and associated Medicaid savings will have been temporary.

Even if younger persons with disabilities are able to find jobs that provide comprehensive private health insurance, this problem is not likely to disappear. Such insurance is unlikely to include the long-term care services covered by Medicaid and may well exclude coverage for preexisting conditions, which this population has by definition. Existing Medicaid provisions that attempt to alleviate these problems have not succeeded in moving many persons with disabilities into the labor force.

Medicaid Home and Community-Based Waivers

All states have Medicaid home and community-based waiver programs for younger persons with disabilities, most commonly for people with mental retardation or developmental disabilities. (Arizona operates a similar program through an 1115 research and demonstration waiver.) Under these programs, states offer a wide range of home and community-based services to a population that is at high risk of institutionalization without these services. In order to obtain federal approval for its waiver, a state must demonstrate that its program will be "cost effective," that is, that the state's average per capita Medicaid costs with the waiver will not exceed its average per capita costs without the waiver. Unlike the rest of the Medicaid program, states may explicitly limit participation in these programs to a predetermined number of people. To help make this possible, the Health Care Financing Administration waives requirements for "comparability" (i.e., the requirement that services be provided to all groups equally) and "statewideness" (i.e., the requirement that all benefits be covered in all parts of the state).

Advocates of increased state flexibility argue that states have substantial experience with long-term care services for people with disabilities and, according to this view, can be trusted with more latitude.

After a reasonably slow start in the early 1980s, home and community-based waiver programs (for both the elderly and disabled) have grown extremely rapidly in recent years, increasing from $735 million in state and federal spending in 1988 to $4,631 million in 1995. Most of the expenditure growth in recent years has been due to the increase in the number of people participating in programs for people with mental retardation/developmental disabilities.

President Clinton has proposed to allow states to implement Medicaid home and community-based service programs on a cost-neutral basis without having to obtain a federal waiver. Advocates of increased state flexibility argue that many of the waiver requirements are needlessly bureaucratic and do not address quality of care. Moreover, states have substantial experience with long-term care services for people with disabilities and, according to this view, can be trusted with more latitude. Although conflict between the federal government and the states over approval of waivers was substantial and bitter during the Reagan and Bush Administrations, regulatory changes implemented by the Clinton Administration have made obtaining waivers fairly routine. Thus, according to this line of argument, little is to be gained by requiring states to go through the federal waiver process.

Opponents of greater state flexibility argue that the current ease of obtaining waivers is precisely the problem. In this view, the Health Care Financing Administration has not been tough enough in requiring that services be cost effective. And because of lax standards, services are often provided to people—especially the elderly—who are not at a high risk of institutionalization. The net result is an inappropriate increase in federal Medicaid spending.

Cost Shifting and Medicaid Maximization

Because states have a substantial commitment to the financing and direct provision of services for younger persons with disabilities, they have a strong incentive to shift the cost of such services to the Medicaid program (where a federal match is available). For example, in 1993, states spent almost as much for non-Medicaid long-term care services for nonelderly people with physical disabilities and nonelderly people with mental retardation/developmental disabilities as they did for Medicaid-financed services.[9] Particularly for services for persons with mental retardation/developmental disabilities, the increased expenditures

for Medicaid home and community-based waivers in recent years represented, in part, refinancing of existing state programs.[10] The line between health care and social services, vocational training, and education is fuzzy, especially for long-term care services for the mentally retarded/developmentally disabled and the chronically mentally ill. Thus, vocational training, education, and social services are typically state funded, but if categorized as a Medicaid service will be eligible for a federal match.

Another example of Medicaid maximization is the use of the Medicaid disproportionate share hospital (DSH) program. By federal law Medicaid does not provide coverage for persons between the ages of 22 and 64 who are in "institutions for mental disease" (that is, mental hospitals). Under the DSH provisions of the statute, however, state Medicaid agencies can make extra payments to hospitals that serve a disproportionate share of people who are Medicaid-eligible or uninsured. Some states have made extremely large payments under this provision to their state mental hospitals, using federal Medicaid dollars for the very purpose that is disallowed at the individual beneficiary level under federal law.

How much further states can shift additional expenses for younger persons with disabilities to Medicaid is unclear. The potential may be limited, at least in the case of services for the mentally retarded/developmentally disabled. Some observers believe that Medicaid home and community-based waiver expenditures will grow more slowly in the future because "further increases are more and more dependent on hard-to-obtain new state matching dollars."[11] In addition, the Omnibus Budget Reconciliation Acts of 1990 and 1993 effectively capped increases in spending on DSH payments.

Conclusion

Younger persons with disabilities account for a substantial portion of state health spending. It is probably not possible to control Medicaid expenditures over the long run without addressing services and costs for this population. As states consider their health programs for younger persons with disabilities, there are at least five points to keep in mind:

- Given the high Medicaid costs of persons with disabilities, it is likely that states will enroll greater numbers of persons with disabilities into managed care. To date, however, managed care organizations have not had much experience with low-income persons with mental retardation, mental illness, or serious physical impairments. Efforts to quickly enroll large numbers of people with disabilities into managed care run the risk of either not producing the expected savings or reducing the quality of care that enrollees receive.

It is probably not possible to control Medicaid expenditures over the long run without addressing services and costs for younger persons with disabilities.

- As with the rest of the Medicaid program, spending on younger persons with disabilities varies tremendously across states, both in terms of total dollars and spending per beneficiary.[12] Without substantial adjustments, Medicaid block grants or caps on the rate of growth in per-beneficiary spending will lock into place existing variations, making it impossible for low-expenditure states to reach the levels of states that currently spend more.

- There is a tension between covering a broader range of services and the open-ended entitlement structure of Medicaid. While disability advocates argue that, with a very broad menu of services, persons with disabilities will use cheaper and fewer services than professionals would choose, budget officials worry that a broader range of services will lead to higher utilization and substantially greater expenditures. The Medicaid home and community-based waivers put fiscal constraints on an otherwise very large potential demand by limiting the number of people who can receive services. At its extreme, a Medicaid block grant without an individual entitlement to coverage would give states maximum flexibility to provide flexible benefits without having to worry about entitlement-driven increases in demand driving up expenditures. The danger in this scenario is that funding will be inadequate to provide services to all the persons with disabilities who meet current eligibility criteria.

- Efforts to move SSI beneficiaries into the workforce face special difficulties. Persons with disabilities are particularly dependent on Medicaid and other services that come with being "unable to work." Movement into jobs can mean the loss of the very benefits they need.

- Because the costs of serving persons with disabilities are so high, there is a strong incentive on the part of the states to shift costs to the federal government. Many states have refinanced their state-funded programs for younger people with disabilities by moving them into the Medicaid program, thus gaining a federal match for those state (and sometimes local) expenditures. Some states have used the federal match to expand services; others have taken the opportunity to cut back on their own spending. How much more state and local spending on younger persons with disabilities can be shifted to the federal government could have a strong influence on the rate of increase in Medicaid spending in the years ahead.

Notes

1. See John Holahan and David Liska, "Reassessing the Outlook for Medicaid Spending Growth," *New Federalism: Issues and Options for States*, Series A, no. A-6 (Washington, D.C.: Urban Institute, March 1997).

2. Joshua M. Wiener and Catherine M. Sullivan, "Long-Term Care for the Younger Population: A Policy Synthesis," in Joshua M. Wiener, Steven B. Clauser, and David L. Kennell, *Persons with Disabilities: Issues in Health Care Financing and Service Delivery* (Washington, D.C.: Brookings Institution, 1995), pp. 291-324.

3. Wiener and Sullivan, "Long-Term Care for the Younger Population"; Gary A. Smith and Robert M. Gettings, *The Medicaid Home and Community-Based Waiver Program: Recent and Emerging Trends in Serving People with Developmental Disabilities* (Alexandria, Va.: National Association of State Directors of Developmental Disabilities, 1996).

4. Holahan and Liska (1997).

5. Smith and Gettings (1996).

6. Ibid.

7. Holahan and Liska (1997).

8. See Leighton Ku and Teresa A. Coughlin, "How the New Welfare Reform Law Affects Medicaid," *New Federalism: Issues and Options for States*, Series A, no. A-5 (Washington, D.C.: Urban Institute, February 1997).

9. Office of the Assistant Secretary for Planning and Evaluation, *Cost Estimates for the Long-Term Care Provisions under the Health Security Act* (Washington, D.C.: U.S. Department of Health and Human Services, 1994).

10. Smith and Gettings (1996).

11. Ibid., p. 19.

12. For further variation in Medicaid spending generally, see John Holahan and David Liska, "Variations in Medicaid Spending among States," *New Federalism: Issues and Options for States*, Series A, no. A-3 (Washington, D.C.: Urban Institute, January 1997).

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No. A-9

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Long-Term Care for the Elderly and State Health Policy

Joshua M. Wiener and David G. Stevenson

Long-term care services for older adults represent a substantial share of total health care spending and an area of increasing concern for state policymakers. Nursing home and home health care accounted for almost 12 percent of personal health expenditures in 1995, and they were approximately 14 percent of all state and local health care spending.[1] Importantly, neither private insurance nor Medicare cover long-term care to any significant extent, and less than 5 percent of older adults have private long-term care insurance. The disabled elderly must rely on their own resources or, when these are depleted, turn to Medicaid to pay for long-term care. Medicaid is the dominant source of public financing for long-term care for the elderly, and expenditures are projected to more than double in inflation-adjusted dollars between 1993 and 2018 due to the aging of the population and to price increases in excess of general inflation.[2]

Medicaid is the dominant source of public financing for long-term care for the elderly, and expenditures are projected to more than double in inflation-adjusted dollars between 1993 and 2018.

Because of the high cost of long-term care (a year in a nursing home cost an average of $41,000 in 1995[3]), Medicaid coverage for long-term care provides a safety net for the middle class as well as the poor. Approximately one-third of discharged nursing home residents pay privately when admitted and eventually spend down to Medicaid. In order to be eligible for Medicaid in nursing homes, single individuals must have less than $2,000 in nonhousing assets and must contribute all of their income toward the cost of their care, except for a small personal needs allowance (generally $30 a month). When the institutionalized person is married, the community-based spouse may keep significantly more in income and assets. In 1997, 68 percent of nursing home residents were dependent on Medicaid to finance their care.[4]

This policy brief discusses three broad strategies that states could use to control spending for Medicaid long-term care services for the elderly. An overview of utilization and expenditures associated with long-term care for the elderly provides context for the discussion.

Utilization and Expenditures

Most older adults are free of disability and do not need long-term care. In 1994, 21 percent of the 33 million individuals over age 65 were disabled. Of the 7.1 million elderly who were disabled, almost three-fourths lived at home, usually receiving unpaid care from relatives and friends. In recent years, a growing number

of these individuals have received home care services through Medicaid and Medicare. Approximately one-fourth of older persons with disabilities lived in institutional settings.[5] However, a much greater number—over two-fifths of people who live to age 65—will spend some time in a nursing home before they die. The number of disabled elderly, along with the absolute number of older persons, will increase substantially over the next several decades as the population ages.

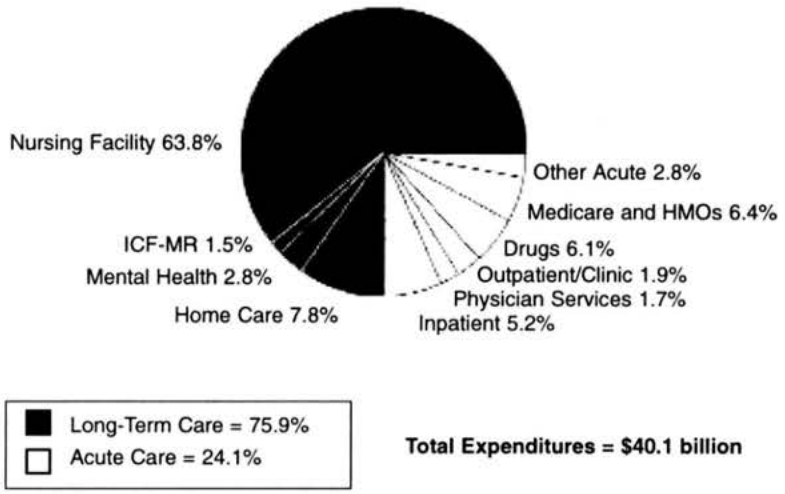
Medicaid and out-of-pocket spending are the primary sources of financing of long-term care for the elderly in the United States. In 1993, Medicaid paid for 35 percent of long-term care for the elderly while older adults and their families paid for 42 percent, whereas Medicare and private insurance paid for 19 percent and less than 1 percent, respectively.[6] Other federal and state spending accounted for almost 4 percent of long-term care spending. These figures understate the importance of Medicaid because contributions of income by Medicaid beneficiaries toward the cost of care are counted as an out-of-pocket rather than a Medicaid payment.

Almost $54 billion was spent on long-term care for people of all ages by the Medicaid program in 1995, 34 percent of total Medicaid expenditures, and long-term care spending on older beneficiaries accounted for the majority ($30 billion) of this spending. In that same year, older persons were 11.1 percent of all Medicaid beneficiaries but accounted for 26.3 percent of total Medicaid expenditures. As shown in figure 1, three-fourths of Medicaid expenditures for the elderly were for long-term care services. Almost 85 percent of these long-term care expenditures were for institutional care, while around 10 percent were for home care services.

Table 1 shows Medicaid long-term care spending on the elderly for each state, spending per elderly beneficiary and resident, and the proportion of expenditures by type of service. There is considerable variation across states. Per elderly beneficiary spending for long-term care ranges from a low of $3,593 in Mississippi to a high of $19,406 in the District of Columbia. The proportion of long-term care spending for the elderly for nursing facilities ranges from 58.7 percent in Oregon to 98.6 percent in Mississippi. These same states were also the extremes in the proportion of spending for Medicaid home care. The share spent on home care varied from 0.2 percent in Mississippi to 38.8 percent in Oregon.

Table 2 presents more detailed data for Medicaid long-term care expenditures for the elderly between 1990 and 1995. Medicaid long-term care spending for the elderly increased an average of 10.7 percent annually from 1990 to 1995 (compared to 16.7 percent for total Medicaid expenditures over the same time period) and has grown more slowly in recent years. More than 40 states reported lower rates of growth for these expenditures for 1993–95 than for 1990–93 (not shown). There is considerable variation among states: Medicaid long-term care expenditures for the elderly grew less than 5 percent annually from 1993 to 1995 in 12 states, while they grew over 10 percent annually in 15 states. The emphasis on institutional care for the elderly mentioned above has not changed in recent years. Recent rates of growth for Medicaid home care spending for the elderly have usually been below rates of growth for nursing facility spending.

Figure 1
Medicaid Expenditures for Elderly Beneficiaries by Type of Service, 1995



Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data.
Does not include disproportionate share hospital payments, administrative costs, accounting adjustments, or the U.S. Territories. Totals may not add due to rounding. "Other Acute" care services include case management, family planning, dental, EPSDT, vision, other practitioners' care, etc. "ICF/MR" refers to intermediate care facilities for the mentally retarded. "Nursing Facility" refers to skilled nursing facilities/other intermediate care facilities.

Strategies to Reduce Long-Term Care Expenditures for the Elderly

If states are to control Medicaid expenditures, they will have to address long-term care for the elderly. Overall, there are three broad strategies that states might use to control spending: bring more outside resources (e.g., private resources and Medicare) into the Medicaid long-term care system to offset state expenditures; reform the delivery system so that care can be provided more cheaply; and reduce Medicaid eligibility, reimbursement, and service coverage.

Strategies to Control Spending: Increase Outside Resources

Bringing additional outside resources into the Medicaid long-term care system could be done in four ways: encouraging private long-term

Table 1: Medicaid Long-Term Care Expenditures by State, 1995
Elderly Beneficiaries, by Type of Service

State	Total Long-Term Care ($ in thousands)	Per Elderly Beneficiary	Per Elderly Resident	Proportion of Long-Term Care Expenditures by Type of Service			
				Nursing Facility	ICF-MR	Mental Health	Home Care
Alabama	$371,497	$5,210	$632	92.0%	0.4%	3.1%	4.5%
Alaska	39,175	8,776	1,641	94.3	0.0	0.0	5.6
Arizona[a]	201,839	8,188	383	84.6	2.3	3.2	9.8
Arkansas	268,337	5,100	839	83.2	0.1	0.0	16.7
California	2,100,690	4,319	620	79.8	3.4	8.4	8.4
Colorado	266,248	7,290	862	89.9	0.1	0.8	9.1
Connecticut	835,759	15,785	1,792	88.0	0.6	1.2	10.2
Delaware	66,787	10,945	836	79.2	2.6	7.7	10.5
District of Columbia	151,695	19,406	2,356	78.6	1.8	16.2	3.3
Florida	1,117,491	5,293	475	94.2	0.6	1.2	4.0
Georgia	417,923	4,023	552	88.4	0.4	2.8	8.4
Hawaii[a]	117,972	6,793	816	94.5	0.2	0.0	5.2
Idaho	73,224	7,842	566	90.1	0.2	0.0	9.8
Illinois	803,594	6,344	581	96.9	0.4	0.2	2.5
Indiana	604,075	9,157	828	94.8	2.8	1.3	1.1
Iowa	230,354	6,141	590	95.8	0.1	0.2	3.9
Kansas	212,452	8,254	697	92.1	1.5	1.0	5.4
Kentucky	346,672	5,484	701	93.3	0.1	0.3	6.3
Louisiana	484,577	4,995	1,080	96.3	1.9	0.2	1.5
Maine	233,822	10,413	1,424	94.1	2.0	0.2	3.7
Maryland	435,324	9,331	721	87.7	0.0	0.3	12.1
Massachusetts	1,302,359	12,872	1,763	92.7	2.3	1.1	4.0
Michigan	934,999	10,859	793	89.9	1.4	4.7	4.0
Minnesota	871,810	15,403	1,817	93.2	1.4	1.8	3.6
Mississippi	239,414	3,593	752	98.6	1.2	0.0	0.2
Missouri	574,465	6,180	808	77.7	1.0	0.6	20.7
Montana	111,270	12,456	917	82.0	0.0	6.0	11.9
Nebraska	184,337	8,881	983	91.6	1.0	0.5	6.9
Nevada	58,505	5,172	314	93.1	0.0	0.4	6.5
New Hampshire	200,747	11,853	1,434	89.5	0.2	4.4	5.9
New Jersey	1,011,315	11,184	1,008	83.7	3.5	2.3	10.5
New Mexico	98,519	5,667	525	91.0	0.2	0.0	8.7
New York	5,702,398	15,354	2,444	66.4	3.2	7.4	23.1
North Carolina	766,499	5,036	854	83.5	1.4	2.0	13.1
North Dakota	106,757	9,893	1,296	86.9	2.7	5.4	5.0
Ohio	1,712,214	10,124	1,232	90.0	2.3	3.1	4.6
Oklahoma	250,866	4,892	605	92.3	1.2	0.5	6.0
Oregon[a]	237,439	6,284	656	58.7	1.0	1.6	38.8
Pennsylvania	2,086,621	12,459	1,202	91.1	2.2	6.2	0.5
Rhode Island	213,086	10,875	1,386	94.2	0.5	0.0	5.3
South Carolina	280,831	3,669	700	78.3	4.5	6.7	10.4
South Dakota	90,268	10,052	987	91.3	1.1	6.2	1.3
Tennessee[a]	509,983	4,463	928	96.5	1.4	0.2	1.8
Texas	1,400,461	4,547	785	76.3	2.5	0.0	21.2
Utah	70,412	7,716	374	95.1	2.5	0.6	1.8
Vermont	71,662	7,107	1,114	91.5	0.9	0.0	7.6
Virginia	452,584	5,302	659	72.4	1.6	11.6	14.4
Washington	483,899	9,111	876	92.7	1.4	0.2	5.7
West Virginia	219,041	6,301	762	95.8	0.3	0.0	3.9
Wisconsin	747,715	11,676	1,418	92.4	2.5	0.7	4.4
Wyoming	43,734	7,382	1,032	90.3	3.2	0.1	6.3
United States	**$30,413,715**	**$7,821**	**$967**	**84.1%**	**2.0%**	**3.6%**	**10.3%**

Source: Urban Institute calculations based on HCFA 64 data.
Does not include disproportionate share hospital payments, administrative costs, accounting adjustments, or the U.S. Territories. Totals may not add due to rounding. "ICF/MR" refers to intermediate care facilities for the mentally retarded. "Nursing Facility" refers to skilled nursing facilities/other intermediate care facilities.
a. For certain states with active 1115 waivers (Ariz., Hawaii, Oreg., and Tenn.), expenditure and beneficiary data were supplemented with data received directly from the state; adjustments were made to categorize these numbers in the same manner as other states report to HCFA.

Table 2
Medicaid Long-Term Care Expenditures by Type of Service, 1990–1995
Elderly Beneficiaries

	Long-Term Care Expenditures ($ in millions)						Average Annual Growth			
	1990	1991	1992	1993	1994	1995	1990–95	1990–93	1993–95	1994–95
Service										
Nursing Facility	$15,072	$17,449	$20,512	$21,965	$23,723	$25,572	11.2%	13.4%	7.9%	7.8%
ICF-MR	384	471	535	622	662	616	9.9	17.4	-0.5	-7.0
Mental Health	959	1,103	1,326	1,015	960	1,107	2.9	1.9	4.5	15.3
Home Care	1,892	2,193	2,500	2,649	2,933	3,119	10.5	11.9	8.5	6.4
Total	**$18,307**	**$21,216**	**$24,873**	**$26,251**	**$28,278**	**$30,414**	**10.7%**	**12.8%**	**7.6%**	**7.6%**

Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data.

Does not include administrative costs, accounting adjustments, or the U.S. Territories. Totals may not add due to rounding. "ICF-MR" refers to intermediate care facilities for the mentally retarded. "Nursing Facility" refers to skilled nursing facilities/other intermediate care facilities.

care insurance; more strictly enforcing prohibitions against transfer of assets; more aggressively recovering money from the estates of deceased recipients of Medicaid long-term care; and maximizing Medicare payments for long-term care services.

Encourage Purchase of Long-Term Care Insurance

For the middle class Medicaid nursing home population, private long-term care insurance could possibly prevent both their own impoverishment and subsequent Medicaid expenditures. Currently, however, only about 5 percent of the elderly have any type of long-term care insurance, some of which is deficient in terms of coverage. In order to encourage more purchasing of private long-term care insurance, some states offer small tax incentives and others are experimenting with so-called public/private partnerships. Under these partnerships, states apply more generous Medicaid asset standards to individuals who purchase an approved private long-term care insurance policy.

The high price of long-term care insurance explains much of why so few people have policies and why the expansion of this coverage has limited potential for saving Medicaid dollars. A good-quality policy can cost $2,186 a year if purchased at age 65 and much more if purchased at older ages.[7] Most studies have found that only 10 to 20 percent of the elderly can afford private long-term care insurance. Thus, long-term care policies are affordable mostly by people who would not spend down to Medicaid without the insurance. Policies are much more affordable if purchased at younger ages, but very few middle-aged workers are interested in buying policies because they have more pressing expenses.

Prevent Transfer of Assets

Asset transfer is a process by which individuals purposefully divest their assets in order to become eligible for Medicaid benefits. The goal of this transfer—often called Medicaid estate planning—is to appear poor on paper and yet preserve private wealth in the face of long-term care expenses. Congress has legislated against these practices on numerous occasions (most recently in the Balanced Budget Act of 1997). But some argue that the legislative prohibitions are easy to circumvent and that the prevalence of Medicaid estate planning has increased dramatically in recent years.

While it seems likely that an increasing number of persons are transferring their assets, the limited evidence suggests that the numbers are much smaller than commonly thought. A 1993 General Accounting Office (GAO) study in Massachusetts, for example, found that although some Medicaid nursing home applicants did transfer assets, existing rules kept most off the Medicaid rolls.[8] Moreover, older persons cannot transfer large amounts of assets they do not have. Older persons with disabilities, and especially the very old who account for a large majority of nursing home patients, have quite low income and asset levels. In 1989, for example, about three-quarters of nursing home patients had less than $50,000 in non-housing assets at the time of their admission to the nursing home, and almost half had less than $10,000.[9]

Expand Estate Recovery

Since the Omnibus Budget Reconciliation Act of 1993, states have been required to recover the cost of Medicaid long-term care from the estates of beneficiaries who have died. Data from earlier estate recovery programs suggest that they are likely to recoup only a small proportion of long-term care expenditures. According to the Office of the Inspector General of the U.S. Department of Health and Human Services, the amount of money collected by the top 10 estate recovery programs averaged only about 1 percent of Medicaid nursing home expenditures in 1993. Total estate recovery in all states was $124.8 million in 1995, less than half of 1 percent of Medicaid nursing home expenditures for the elderly.[10]

Medicare Maximization

Medicare expenditures for home health and skilled nursing facility (SNF) care have increased dramatically in recent years and now account for almost 15 percent of Medicare expenditures. While Medicare primarily provides short-term, post-

acute care for nursing facility care, its home health benefit has become more long term in recent years.

Some states, including New York, Wisconsin, and Massachusetts, have initiated aggressive "Medicare maximization" efforts in an attempt to reduce Medicaid expenditures for beneficiaries who are eligible for both Medicare and Medicaid. Medicare maximization initiatives attempt to ensure that Medicare rather than Medicaid pays for home health and nursing facility care whenever possible. Medicare maximization programs take the form of provider and consumer education about Medicare benefits, data system improvements to identify dual eligibles and instances of inappropriate billing, and requirements that all home health providers be Medicare as well as Medicaid certified and that they bill Medicare when there is the slightest chance of receiving reimbursement. One recent study of Medicare and Medicaid home care expenditures suggests an inverse relationship between Medicare and Medicaid home care spending.[11]

Strategies to Control Spending: System Reform

A second general strategy for saving money is to reorganize the health care delivery system in ways that make care more efficient. This can be accomplished through extending managed care to include long-term as well as acute care and by expanding home care and nonmedicalized, residential long-term care services.

Integrating Acute and Long-Term Care Services through Managed Care

Older persons who need long-term care services currently encounter a fragmented financing and delivery system.

Financing acute care is largely the province of Medicare and the federal government, whereas long-term care is dominated by Medicaid and state governments. Because of the separation of financial responsibilities, there exists a strong incentive for the federal government to shift costs to the states and vice versa.

There is also lack of coordination in the delivery of services. For example, some elderly patients may remain unnecessarily in expensive acute care hospitals because appropriate long-term care services are not immediately obtainable, appropriate follow-up physician care cannot be arranged, or financing for long-term care is not available. A major consequence of this fragmentation may be that total costs are higher than they would be in an integrated system. Another argument in favor of integrated systems is that quality of care and consumer satisfaction could be improved because artificial barriers between care providers would be eliminated.

There is increasing interest among policymakers in finding ways to integrate the acute and long-term care sectors, primarily through expanding the role of managed care and capitated payments to include long-term care services. Several demonstration projects are under way to test various approaches to integrating acute and long-term care services. These include Social Health Maintenance Organizations (SHMOs), On Lok and its Program for All-Inclusive Care for the Elderly (PACE) replications, and the Arizona Long-Term Care System (ALTCS). Several states, including Colorado, Maine, Massachusetts, Minnesota, Texas, and Wisconsin, are also undertaking demonstration efforts to coordinate acute and long-term care through use of managed care. However, in response to waiver requests from various states, the Health Care Financing Administration has insisted that enrollment in managed care for individuals dually eligible for Medicaid and Medicare must be voluntary and has not been willing to allow Medicare and Medicaid monies to be combined into a single state-administered capitated payment to managed care organizations.

Although the integration of acute and long-term care services offers the opportunity for improved quality of care, long-term care advocates are concerned with this model for a variety of reasons. First, most managed care providers have little experience with the elderly and the disabled and none with long-term care. Thus, they may not be skilled in providing services to this population. Second, fiscal pressures within an integrated system could shortchange long-term care by shifting funds from long-term care to acute care if providers do not view long-term care as a priority or if acute care overruns its budget. Third, long-term care may become overmedicalized and services less consumer-directed because the balance of power will shift from the individual client and her chosen provider to HMOs, insurance companies, or other administrative entities.

Expand Home and Community-Based Services

Although the expansion of Medicaid home and community-based long-term care services has focused largely on the younger population with disabilities, expanding home and community-based services for older adults is a cost-saving strategy advocated by many. Many states, including Oregon, New York, and Texas, are attempting to create a more balanced delivery system by providing a wide range of home and community-based services. In addition to Medicaid home care expenditures for the elderly (over $3 billion in 1995), $1.2 billion was spent on home and community-based services for older persons through programs funded only with state funds in 1997, most notably in Illinois, Massachusetts, California, and Pennsylvania.[12]

Most states have obtained Medicaid home and community-based service waivers in an attempt to expand noninstitutional services. Regulatory changes implemented by the Clinton administration have made obtaining waivers fairly routine in recent years. Using these waivers, states can cover a wide range of nonmedical long-term care services, including personal care services, adult day care, rehabilitation, and respite care. States must target people at high risk of institutionalization and assure HCFA that, on average, the cost of providing services with the waiver will not exceed the cost without the waiver. States may provide these services only to a preapproved number of people, limiting the potential financial liability that would

accompany an entitlement benefit. After a relatively slow start in the early 1980s, home and community-based waiver expenditures (for the elderly and young people with disabilities) have increased rapidly, from $0.7 billion in 1988 to $4.6 billion in 1995.

Although states hope to save money by substituting lower-cost home and community-based care for more expensive nursing home care, most research suggests that expanding home care is more likely to increase rather than decrease total long-term care costs. The primary reason for this result is what many call the "woodwork effect." While many older persons would forgo paid long-term care services if given only the option of nursing home care, many of these same individuals would use home care services if given the choice. Thus, the costs associated with large increases in home care use could more than offset the relatively small reductions in nursing home use.

Some recent research is more encouraging about the potential cost-effectiveness of home and community-based care. For instance, a 1996 study of Washington, Oregon, and Colorado concluded that the expansion of home and community-based services was a cost-effective alternative to institutional care in these states.[13] A 1994 study drew similar conclusions about the expansion of home and community-based services in Washington, Oregon, and Wisconsin.[14]

Strategies to Control Spending: Cuts in Eligibility, Reimbursement, Services, and Quality

If states do not succeed in substantially reducing the rate of increase in long-term care expenditures through increasing outside resources or through delivery system reform, states can still use a number of more conventional mechanisms such as cuts in eligibility, reimbursement, and covered services. Existing federal law gives states considerable flexibility in these areas, including setting reimbursement rates and controlling the supply of nursing home beds.

Table 3
Average Medicaid Rates for Nursing Facility Reimbursement by State, 1995

State	Per Diem Rates	State	Per Diem Rates
Alabama	$71.91	Nebraska	$62.03
Alaska	315.20	Nevada	67.21
Arizona	NA	New Hampshire	98.74
Arkansas	58.02	New Jersey	114.64
California	88.99	New Mexico	79.10
Colorado	78.08	New York	157.25
Connecticut	125.00	North Carolina	79.91
Delaware	87.35	North Dakota	76.27
Florida	83.54	Ohio	86.55
Georgia	71.11	Oklahoma	52.50
Hawaii	134.82	Oregon	76.00
Idaho	73.24	Pennsylvania	76.09
Illinois	70.41	Rhode Island	94.00
Indiana	64.93	South Carolina	68.78
Iowa	60.12	South Dakota	68.46
Kansas	60.08	Tennessee	49.97
Kentucky	69.24	Texas	56.17
Louisiana	71.24	Utah	74.24
Maine	96.30	Vermont	92.24
Maryland	78.10	Virginia	63.57
Massachusetts	94.25	Washington	92.35
Michigan	67.54	Washington, D.C.	125.46
Minnesota	88.21	West Virginia	76.97
Mississippi	59.01	Wisconsin	85.73
Missouri	58.57	Wyoming	73.31
Montana	79.57	**U.S. Average**	**$85.05**

Source: HCFA Office of Long-Term Care, Medicaid Bureau. Rates as of 3/31/95.

Cut Reimbursement Rates

Since the Omnibus Reconciliation Act of 1980, the "Boren Amendment" governed how states have reimbursed nursing homes until its recent repeal. This amendment required that rates be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards." As can be seen in table 3, there is considerable variation in how much states pay for nursing home reimbursement. (An important caveat in comparing state rates is whether or not they include ancillary services, such as physical therapy.) While some of this variation reflects different levels of service provision, it might also indicate real differences in how generous (or frugal) states are in nursing home reimbursement.

With repeal of the Boren Amendment as part of the Balanced Budget Act of 1997, states will have almost complete freedom in setting nursing home payment rates. Opponents of the Boren Amendment argued that courts forced the states to spend too much on nursing home care and to go far beyond the minimal standard embodied in the statute. However, even with the repeal of the Boren Amendment, the political power of the nursing home lobby at the state level may prevent rates from being reduced very much.

The problem with repealing the reimbursement standards is that Medicaid nursing home payment rates are already fairly low in most states, especially in comparison to Medicare and private pay rates. Not surprisingly, nursing homes often prefer higher-paying private pay to Medicaid residents, which can result in problems of access for Medicaid

beneficiaries. To the extent that states cut Medicaid reimbursement rates and the payment differential between private pay and Medicaid patients widens, access problems could worsen for Medicaid beneficiaries. However, there is a limit to how much nursing homes can avoid Medicaid residents, since Medicaid represents such a large portion of most nursing home budgets. In addition, while there is little evidence of a simple relationship between cost and quality, some are concerned that repeal of the Boren Amendment could result in payment rates below the level necessary to maintain adequate quality of care in nursing homes.

Stop New Construction of Nursing Home Beds

Another strategy for controlling Medicaid costs is to prohibit new construction of nursing home beds on the assumption that they would likely be filled with Medicaid residents. As of 1995, 17 states had such a moratorium on new construction of nursing homes. However, there are three problems with this strategy. First, the care needs of the elderly do not disappear just because there are no nursing home beds available. To the extent that these needs are met by home care and other services, Medicaid savings will be reduced. Second, nursing home bed/population ratios have already fallen substantially. The number of nursing home beds per 1,000 elderly 85 and over fell by 18 percent between 1978 and 1994, although the situation varies across the states.[15] It is unclear how far supply levels can fall without causing hospital backlogs and other problems. Third, the strategy of freezing bed supply does not address the underlying demographic reality that the United States is an aging society. Limiting the supply of nursing home beds might have value in the short term but could cause other problems as a long-term strategy.

Conclusions

Although the rate of growth for Medicaid long-term care expenditures for the elderly has slowed since 1993, spending on these services still represents a substantial proportion of total Medicaid expenditures. And the aging of the population guarantees greater future need for long-term care. For both these reasons, state policymakers have sought to reduce the rate of growth in these expenditures through reform in the organization and delivery of long-term care services as well as through coverage and benefit decisions.

In the short run, states are likely to turn to more traditional strategies to reduce spending such as reducing reimbursement rates to nursing homes, especially with repeal of the Boren Amendment. Although states have considerable flexibility to reduce long-term care spending through rate cuts, eligibility determinations, and benefit decisions, these cuts could potentially have a negative impact on quality of care and access to long-term care services for the elderly. If states maintain current levels of access and quality, they eventually will need to utilize other cost-saving strategies, such as increasing the amount of outside resources used to finance Medicaid long-term care, coordinating acute and long-term care through use of managed care, and expanding home and community-based care. It is uncertain how much reforms could reduce spending in the short or long term, but there are some encouraging developments in the integration of acute and long-term care and in creative home and community-based programs. States will seek to build on the promise of these findings as they attempt to reform Medicaid long-term care and to contain spending.

Notes

1. Katharine Levit et al. "DataView: National Health Expenditures, 1995." *Health Care Financing Review*, vol. 18, Fall 1996, pp. 175–214.

2. Joshua Wiener, Laurel Hixon Illston, and Raymond Hanley. *Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance* (Washington, D.C.: The Brookings Institution, 1994).

3. American Health Care Association. *Facts and Trends: The Nursing Facility Sourcebook, 1997* (Washington, D.C.: American Health Care Association, 1997).

4. *Ibid.*

5. Kenneth Manton, Larry Corder, and Eric Stallard. "Chronic Disability Trends in Elderly United States Populations: 1982–1994." *Proceedings of the National Academy of Sciences*, vol. 94, March 1997, pp. 2593–2598.

6. Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy. *Cost Estimates for the Long-Term Care Provisions under the Health Security Act* (Washington, D.C.: U.S. Department of Health and Human Services, March 1994).

7. Susan Coronel and Craig Caplan. *Long-Term Care Insurance in 1994* (Washington, D.C.: Health Insurance Association of America, 1996).

8. U.S. General Accounting Office. *Medicaid Estate Planning*. GAO/HRD-93-29R (Washington, D.C.: U.S. GAO, 1993).

9. Joshua Wiener, Raymond Hanley, and Katherine Harris. *The Economic Status of Elderly Nursing Home Users* (Washington, D.C.: The Brookings Institution, 1994).

10. Erica Wood and Charles Sabatino. "Medicaid Estate Recovery and the Poor: Restitution or Retribution?" *Generations*, vol. 20, Fall 1996, pp. 84–87.

11. Genevieve Kenney, Shruti Rajan, and Stephanie Soscia. *Interactions between the Medicare and Medicaid Home Care Programs: Insights from the States* (Washington, D.C.: The Urban Institute, November 1996).

12. Enid Kassner and Loretta Williams. *Taking Care of Their Own: State-Funded Home and Community-Based Care Programs for Older Persons* (Washington, D.C.: American Association of Retired Persons, 1997).

13. Lisa Maria B. Alecxih, Steven Lutzky, and John Corea. *Estimated Savings from the Use of Home and Community-Based Alternatives to Nursing Facility Care in Three States* (Washington, D.C.: American Association of Retired Persons, 1996).

14. U.S. General Accounting Office. *Medicaid and Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs* (Washington, D.C.: U.S. GAO, 1994).

15. Charlene Harrington et al. *State Data Book on Long-Term Care Program and Market Characteristics* (San Francisco: The University of California, San Francisco, 1995).

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Repeal of the "Boren Amendment": Implications for Quality of Care in Nursing Homes

Joshua M. Wiener and David G. Stevenson

From 1980 to 1997, federal law directly linked Medicaid nursing home rates with minimum federal and state quality of care standards. As part of the Omnibus Reconciliation Act of 1980, the "Boren amendment" required that Medicaid nursing home rates be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards" (Section 1902(a)(13) of the Social Security Act). State Medicaid officials overwhelmingly came to oppose the amendment as impossible to operationalize, believing that they were forced by the courts to spend too much on nursing homes at the expense of other services.

As states gain freedom to cut nursing home reimbursement, it becomes more important to understand whether and how these changes might affect quality of care in nursing homes.

The federal Balanced Budget Act of 1997 repealed the Boren amendment, giving states far greater freedom in setting nursing home payment rates. The nursing home industry warned that Medicaid reimbursement levels already are too low, and that further reductions would adversely affect quality of care. Indeed, poor-quality nursing home care is gaining increasing attention. For example, in response to a recent General Accounting Office report identifying glaring quality of care deficiencies in California nursing homes, the U.S. Senate Special Committee on Aging held critical hearings on nursing homes and their regulators, and President Clinton unveiled tougher enforcement standards.[1]

Despite nursing home industry claims that low payment rates inhibit quality of care, Medicaid rates for nursing facility care are a logical target for states trying to reduce the growth rate of long-term care expenditures. Nursing home care accounted for 20 percent of Medicaid expenditures in 1996. Whereas the financial effect of reforms such as expanding home and community-based services and integrating acute and long-term care is uncertain, with savings likely to occur some time in the future, the impact of nursing home rate reductions on state budgets is predictable, immediate, and potentially large. Similarly, with nearly 70 percent of nursing home residents dependent on Medicaid to pay for their care, it is hard to overstate the importance of Medicaid to the nursing home industry.[2]

As states gain freedom to cut nursing home reimbursement, it becomes more important to understand whether and how these changes might affect quality of care in nursing homes.

The question for state policymakers is whether and to what extent goals of quality assurance and cost control are compatible. In particular, can states reduce Medicaid nursing home payment rates without jeopardizing quality? To aid policymakers faced with this decision, this policy brief reviews the research literature (most of which is very old) pertaining to the relationship between financing and the quality of long-term care.

Reimbursement and Quality

Research on reimbursement and its potential impact on quality of care generally focuses on two broad areas of concern. First, what is the relationship between the costs of long-term care and quality of care? This policy question is motivated largely by the arguably low rates paid by Medicaid. Like most other areas of Medicaid policy, nursing home reimbursement levels and methods vary dramatically by state (table 1). Average Medicaid nursing home reimbursement rates for 1998 vary from a low of $62.58 per day in Nebraska to a high of $329.62 per day in Alaska. Second, does the method of payment (e.g., flat rate, prospective payment, casemix adjustment), independent of its level, affect quality of care? This question is potentially very important because government policymakers have considerable control over these policy levers.

Level of Cost, Payment, and Quality

Although measuring cost and payment levels is comparatively straightforward, measuring quality of care is not, and how it is assessed can significantly affect the results of studies examining the relationship between the two. Most studies have analyzed the relationship between cost (or payment) and quality by using some form of input (e.g., staffing levels) or process indicator as the measure of quality. Using 1995–96 On-Line Survey Certification and Reporting (OSCAR) system data, Harrington et al. found a small but positive relationship between the amount of Medicaid reimbursement and nurse staffing levels (except for nurse assistants). Facilities with higher staffing levels also had fewer certification deficiencies.[3] However, using structural measures of quality can be problematic because increased inputs imply, almost by definition, higher costs. That is, a positive relationship between inputs and costs is likely, regardless of whether there is a relationship between costs and "quality." Several studies have found that higher reimbursement was associated with higher staffing but failed to find a significant relationship for other measures of quality.[4] For instance, Zinn found that higher reimbursement was associated not only with higher registered nurse staffing, but, surprisingly, also with more use of restraints and a greater proportion of residents who were not toileted.

Only a few studies have examined the relationship between facility costs and quality using outcomes-based quality measures, and these have been quite limited. Using 1983 data from Iowa, Nyman found that costs were not significantly greater in nursing homes with higher quality as measured by various outcomes (including residents wearing clean clothing, being fully dressed, and having clean hair).[5] At the same time, these outcome measures of quality were found to be associated with nursing time per patient. Similarly, using 1987 National Medical Expenditure Survey data, Cohen and Spector did not find a statistically significant relationship between reimbursement level and outcomes-based quality measures (including mortality, change in functional status, and presence of decubitus ulcers), but did find a positive relationship between reimbursement level and staffing intensity.[6] Many aspects of quality care (e.g., staff attitude and administrative philosophy) apparently do not require large expenditures and are not significantly related to facility costs.[7] Thus, improved quality might not necessarily imply higher costs, and poor quality might not simply be a result of inadequate resources.

These results illustrate the complexity of the relationship among costs, inputs, and outcomes and the dilemma for states in trying to establish payment rates adequate to produce quality care. Both analyses found a relationship between cost/reimbursement level and staffing intensity, and both analyses found that professional staffing had a positive and significant relationship to quality of care in terms of outcomes.[8] However, the effects of higher cost/reimbursement on staffing and of staffing on outcomes were not large enough for cost/reimbursement to have a statistically significant impact on quality as measured by outcomes.

Method of Reimbursement and Quality

Setting Medicaid reimbursement rates for long-term care is one way states control expenditures and shape the long-term care market. To achieve savings, states focus not only on the overall level of reimbursement but also on the payment methodology used to pay long-term care providers. These policies differ most fundamentally on two levels: whether they base payment on facility-specific costs or on a set of flat rates (set independently of an individual facility's costs) and whether rates are set retrospectively or prospectively.

Facility-specific rates (set either prospectively or retrospectively) are based on an individual facility's costs, usually up to some ceiling. Under this type of payment, higher-cost facilities receive higher payments than lower-cost facilities. Under flat rates, nursing homes are paid a rate that is not based on the individual facility's costs. Typically, flat rates are based on the cost experience of all facilities in an area (sometimes adjusted for facility or patient characteristics such as the casemix of a nursing home).

Under retrospective payment, nursing homes receive a facility-specific interim payment rate based on costs for some base year, with adjustment for inflation. If the actual costs (usually up to some ceiling) are different from the interim rate, either the state pays the facility or the facility pays the state the difference. This methodology encourages facilities to spend more (perhaps improving quality) because they can be reimbursed for their expenses, although ceilings on allowable costs and lags in altering rates apply a brake on the incentive for facilities to increase spending.

Almost all states use prospective payment systems to pay nursing homes. Under prospective payment, providers receive a rate set in advance for a bundle

Table 1
Nursing Home Reimbursement across 50 States and the District of Columbia, 1998

	Per Diem Rate[a]	Method of Reimbursement[b]	Casemix Adjusted[b]	Ancillaries Included[b,c]
Alabama	$98.96	prospective facility-specific	no	basic
Alaska	329.62	prospective facility-specific	no	1
Arizona	97.39	prospective facility-specific	yes	1, 2
Arkansas	63.99	prospective patient-specific	yes	1, 2
California	83.04	prospective flat-rate	no	basic
Colorado	98.00	prospective facility-specific	no	1, 2
Connecticut	130.00	prospective facility-specific	no	1, 2
Delaware	97.00	prospective patient-specific	yes	1, 2, 3[d]
District of Columbia	210.35	prospective facility-specific	no	1, 2
Florida	94.38	prospective flat-rate	no	1
Georgia	75.26	prospective facility-specific	no	1, 2
Hawaii	150.00	prospective facility-specific	no	basic
Idaho	94.20	prospective facility-specific	no	1, 2
Illinois	77.63	prospective facility-specific	yes	1, 2
Indiana	86.43	prospective facility-specific	no	1
Iowa	69.50	prospective facility-specific	no	2
Kansas	78.11	prospective facility-specific	yes	1, 2
Kentucky	83.42	prospective facility-specific	yes	1
Louisiana	65.24	prospective flat-rate	no	2
Maine	105.85[b]	prospective facility-specific	yes	2
Maryland	106.62	prospective patient/facility-specific	yes	1
Massachusetts	109.52	prospective patient/facility-specific	yes	basic
Michigan	95.00	prospective facility-specific	no	2
Minnesota	101.71	prospective patient/facility-specific	yes	2
Mississippi	79.85	prospective facility-specific	yes	2
Missouri	86.00	prospective facility-specific	no	1, 2
Montana	87.54	prospective facility-specific	yes	basic
Nebraska	62.58	retrospective facility-specific	yes	basic
Nevada	110.51	prospective facility-specific	yes	basic
New Hampshire	111.94	prospective facility-specific	no	1, 2
New Jersey	104.93	prospective facility-specific	yes	1, 2
New Mexico	92.10	prospective facility-specific	no	1
New York	165.80	prospective facility-specific	yes	1, 2, 3
North Carolina	95.12	combination facility-specific	no	1, 2
North Dakota	94.00	prospective facility-specific	yes	1, 2
Ohio	107.00	prospective facility-specific	yes	1, 2
Oklahoma	64.20	prospective flat-rate	no	1, 2
Oregon	89.05	prospective facility-specific	no	1
Pennsylvania	114.12	retrospective	yes	1, 2
Rhode Island	125.86	prospective facility-specific	no	1
South Carolina	84.04	prospective facility-specific	yes	1
South Dakota	79.93	prospective facility-specific	yes	1, 2, 3
Tennessee	77.91[b]	combination facility-specific	no	1
Texas	75.40	prospective patient-specific	yes	1, 2
Utah	80.60	prospective facility-specific	no	1, 2
Vermont	94.24[b]	prospective facility-specific	yes	1
Virginia	78.12	combination facility-specific	yes	1
Washington	114.31	prospective facility-specific	no[e]	1
West Virginia	97.00	prospective facility-specific	yes	1
Wisconsin	91.00	prospective facility-specific	yes	2
Wyoming	93.84	prospective facility-specific	no	1, 2

Sources:

a. American Health Care Association. *Nursing Facility Sourcebook: Facts and Trends, 1998.*

b. C. Harrington et al. *1996 State Data Book on Long-Term Care Program and Market Characteristics.*

c. Most states include ancillary services such as nonprescription drugs and medical supplies in their rates. States vary more widely in their inclusion of the following ancillary services in the calculation of rates:
   1 = physical, occupational, speech, or respiratory therapy
   2 = durable medical equipment
   3 = prescription drugs
   "basic" does not include 1, 2, or 3

d. In Delaware, these ancillary services are only included in the rate for public facilities (3 of the 35 facilities in the state).

e. Washington recently adopted a patient-specific casemix reimbursement system.

of services, without adjustment for actual costs. As with a capitated payment for managed care, providers are at financial risk if facility costs exceed payments; alternately, providers can keep the surplus as profits should payments exceed their costs. Facility-specific prospective and flat-rate systems provide greater incentives for facilities to be efficient than retrospective systems do, because nursing home profits are the difference between their payment and their expenses. To the extent that facilities make money by curtailing services, quality may be adversely affected, which theoretically should be more of a problem for flat-rate systems because there is no relationship between an individual facility's costs and its reimbursement. In contrast, facility-specific prospective payment systems periodically recalculate a facility's costs. Thus, if a facility dramatically reduced its costs, its future rate would also be reduced, limiting the extent to which reducing costs is in the nursing home's interest.

Empirical studies tend to support these theoretical expectations. Using cost report data from eight states from 1978 to 1980, Holahan and Cohen found strong evidence that the cost-containment incentives in state reimbursement systems appeared to have a real impact on cost increases: Prospective and flat-rate systems generally reduced cost growth more than retrospective payment.[9] Aggressive cost-control strategies were also found to have a constraining effect on spending for patient-related services (and therefore might adversely affect patient care).[10] Patient-related costs were constrained more than nonpatient-related costs in reimbursement systems with stronger cost-controlling incentives. At least in the short term, cost-containment measures did not negatively affect access for Medicaid patients. In light of their findings, Holahan and Cohen recommended that states separate costs into three components—patient-care-related, noncare-related, and capital—to identify and more readily eliminate "unnecessary" cost growth.

Using 1981 Medicare and Medicaid Automated Certification Survey files and Medicare cost reports, Cohen and Dubay found that as cost-containment incentives (e.g., the use of flat-rate payments) became stronger, nursing homes responded by decreasing the severity of their casemix (e.g., by limiting access for heavy care patients) and decreasing staffing levels.[11] Nursing homes in states that paid flat rates had fewer nurses per bed than similar homes in cost-based reimbursement states. In addition, access for Medicaid patients was worse in states with flat-rate reimbursement and better in states with prospective reimbursement. Finally, prospectively paid nursing facilities did not have costs significantly different from retrospectively paid facilities. However, facilities that were paid flat rates under Medicaid did have significantly lower costs.

Prospective payment also can affect patient care services differently, depending on the bundle of services included in the unit of payment. For example, prospective payment may or may not include ancillary services such as prescription drugs and therapy services. In a study of five states that used the 1996 nursing home minimum data set, Moore and White compared New York—which includes prescription drugs in its prospective payments for nursing homes—with four states that reimburse prescription drugs on a fee-for-service basis (i.e., separate from the prospective rate).[12] The study found that prescription drug utilization for the treatment of selected medical conditions was significantly lower in New York than in the comparison states, suggesting that nursing homes responded to financial incentives of the fixed payment.

Casemix Reimbursement. One variation of flat-rate reimbursement that many states have adopted is casemix reimbursement. An undesirable incentive of pure flat-rate payments (and to a lesser extent, of facility-specific methodologies) is for nursing homes to avoid patients who are severely disabled, as reimbursement is no greater for patients with heavy care needs than for patients with light care needs. Casemix reimbursement systems are designed to mitigate the effects of these perverse incentives by matching the payment level to an individual's care needs. Under casemix reimbursement, nursing homes receive higher reimbursement when individuals require more services. The major theoretical strength of casemix reimbursement is that it should make nursing homes indifferent to the relative care needs of the individuals they admit.

Despite these advantages, casemix reimbursement also creates disincentives for nursing homes to rehabilitate patients (because they are paid more for more disabled residents) or to provide services that diminish their profits (because profits are the difference between reimbursement and expenditures). These systems also have incentives to misreport resident conditions or services received. In their analysis of 1987 data from six states, Butler and Schlenker found some evidence that these problems did in fact occur and concluded that casemix reimbursement systems must include explicit ways to measure and ensure quality of care.[13] In their review of the casemix reimbursement literature, Weissert and Musliner concluded that casemix payment by itself generally did little to improve quality of care.[14] Disappointingly, higher casemix payments were not necessarily used to increase nursing home staffing levels. In contrast, the research is more positive on the use of casemix systems to improve access to care, although improving access for heavy care patients can create access difficulties for light care residents (who arguably should be served outside nursing homes).

Reimbursement Incentives to Improve Quality of Care. Some researchers have proposed that reimbursement be linked directly to quality of care. Because nursing homes respond to cost-containment mechanisms of differing reimbursement systems, Zinn reasoned they would respond similarly if quality indicators were linked to payment.[15] Pointing out that reimbursement and quality assurance are typically defined by independent systems with separate objectives, Shaughnessy and Kurowski explored the theoretical dimensions of linking reimbursement and quality assurance and detailed several areas of research that need to be addressed before this linkage is possible, including the development of better process and outcome measures, identification of quality norms, and development of incentives to change provider behavior.[16] Although this article was written 16 years

ago, most of the same limitations in the research base still remain today.

There have been some experiments with outcomes-based incentives. A demonstration in San Diego in the early 1980s tested the effectiveness of monetary incentives on improving the health of nursing home residents and reducing Medicaid expenditures. These incentives for improved outcomes had beneficial effects on quality, access, and number of hospital transfers.[17] Other initiatives in Illinois, Connecticut, and Michigan have not been evaluated.

Limited Nursing Home Bed Supply and Quality of Care

Several studies done in the 1970s and early 1980s found a strong relationship between poor quality and a high percentage of Medicaid residents in nursing homes.[18] These results are often interpreted as evidence that Medicaid nursing home reimbursement rates were too low to provide good-quality care. If that were the case, the quality of care problem could be alleviated simply by raising Medicaid reimbursement rates.

An alternative explanation is that the relationship between low quality and homes that are heavily dependent on Medicaid is attributable to an insufficient supply of nursing home beds available for Medicaid residents (i.e., excess demand), which means that facilities need not compete by providing high-quality care.[19] Excess demand exists when not enough beds are available for patients demanding care at a given market price, a condition that may be optimal for both the state and the nursing homes, if not for residents. Nursing homes typically charge two different rates—one for Medicaid residents and a higher one for private-pay residents (Minnesota and North Dakota require that nursing homes charge the same rate to private and Medicaid patients). Because private-pay rates are almost always higher than Medicaid reimbursement levels, profit-maximizing nursing homes would rather admit a private-paying individual over an individual supported by Medicaid. In an analysis of data from 43 states for 1969–73, Scanlon found that excess demand resulted in a segmented nursing home market, with private-paying residents obtaining all desired care and public-paying residents filling any remaining beds.[20] If excess demand exists for nursing home beds, it is excess Medicaid demand. Studies done of Wisconsin and the 10 national long-term care channeling demonstration sites in the early 1980s also found evidence of excess demand.[21]

Under excess demand, nursing homes can attract as many Medicaid patients as they want, regardless of quality. Although Medicaid residents prefer higher quality of care, they cannot exercise these preferences under excess demand and must instead choose among the limited number of available beds. Hence, high-quality care is necessary only to attract more private-paying nursing home residents. In a market with a surplus of nursing home beds, however, nursing homes cannot act on their preference to admit private-paying patients over Medicaid-subsidized patients—they will accept either type of patient in order to fill their beds. In this environment, both private- and Medicaid-paying residents would be able to exercise their preference for high-quality care. Consequently, nursing homes should increase quality to attract patients.

Using 1978–79 and 1983 data from Wisconsin, Nyman found evidence to support his theory that excess demand was responsible for lower-quality nursing home care.[22] He found that the low-quality–high-Medicaid relationship was stronger under conditions of excess demand. In addition, Nyman found that nursing homes in counties with a surplus bed supply spent more on patient care per empty bed than counties with a tight bed supply. Nyman posited that this evidence cast doubt on the assumption that the high-Medicaid–low-quality relationship resulted simply from lower Medicaid payments. On the basis of a 1987 nursing home survey and certification data, Zinn reached similar conclusions.[23]

In addition to quality, the presence of excess demand in the nursing home market creates concern about access to nursing home care, especially for Medicaid patients. Private demand should not be affected by Medicaid demand or bed supply because private-pay patients will always have admission preference. Using 1982–84 data from the National Long-Term Care Survey and Area Resource data, Ettner found that Medicaid patients had worse access to nursing homes on average, and that this situation seemed to exist mainly in areas in which bed supply was low or private competition for beds was greater.[24] In addition, some nursing homes (e.g., Vencor, Inc.) have begun to focus on the private-pay and Medicare market to the exclusion of the Medicaid market.[25] Few facilities, however, can afford to exclude Medicaid residents completely because Medicaid pays for the majority of nursing home residents.

There is some evidence that excess demand has declined in recent years. In an evaluation of 1988 data from Wisconsin, Minnesota, and Oregon, Nyman found no evidence of excess demand (this finding for Wisconsin contrasted with his previous analysis of 1983 data).[26] In addition, national nursing home occupancy rates declined from 92 percent in 1985 to 88 percent in 1995.[27] This decline is particularly remarkable because the ratio of nursing home beds per 1,000 elderly persons aged 85 and over declined by 21 percent between 1978 and 1996.[28] Nonetheless, there remains an extremely strong relationship between nursing home bed supply and utilization, leading most states to fear that a higher number of nursing home beds will result in higher Medicaid expenditures.[29] As a result, most states control the supply of nursing homes through certificate-of-need programs or moratoriums on new construction or certification for Medicaid.

State efforts to shift the balance of the long-term care system from institutional-based to home and community-based care by expanding home care services and using case management and preadmission screening efforts to encourage placement in settings other than nursing homes may also reduce excess demand. In all but a few states, however, home and community-based services are only a small proportion of Medicaid long-term care expenditures for the elderly. In addition, Medicare home health expenditures have skyrocketed since 1989, and the benefit

has become more long-term-care–oriented. As the availability of home and community-based services increases, nursing homes will have to compete more actively with other types of long-term care providers, such as assisted living facilities and home health agencies, as well as with other nursing homes.

Conclusion

The repeal of federal minimum standards for Medicaid nursing home reimbursement gives states additional flexibility in determining how to set payment rates but, by itself, does not alter state policy. Instead, the impact of the repeal will depend on how much states choose to alter nursing home payment in the changed statutory environment. So far, a booming economy and a low rate of increase in Medicaid expenditures have meant that few states have needed to find large Medicaid savings. Although the nursing home industry is politically powerful in most states and may succeed in blocking substantial rate reductions in the future, nursing homes and some resident advocates across the country are still concerned that the Boren amendment's repeal will ultimately result in reimbursement rate cuts that adversely affect quality of care. Moreover, any Medicaid payment reductions will be in addition to the Medicare skilled nursing facility cuts and reimbursement changes enacted as part of the Balanced Budget Act of 1997.[30] Reimbursement reductions are of considerable concern because there is already evidence of significant quality of care problems in nursing homes.

The impact of potential financing changes on the quality of long-term care is difficult to assess. Almost all the research literature on the relationship between financing and quality of nursing homes is based on very old data and does not reflect the regulatory changes required by the Omnibus Budget Reconciliation Act of 1987. Most studies on the topic were published in the mid- to late 1980s and relied on data from the late 1970s and early 1980s. Moreover, several studies discussed in this brief focused on data from one or a few states, making it hard to generalize to the nation as a whole. In addition, the measures of quality in most of these studies were quite rudimentary, especially in terms of outcomes.

For states seeking Medicaid savings by lowering nursing home rates, the available research does not offer conclusive evidence about the level of reimbursement needed to provide adequate quality of care. Logic dictates that there is some minimal level of reimbursement below which it is impossible—or at least unacceptably difficult—to provide good-quality care. That assumption was the premise of the Boren amendment; the problem was that nobody could ever specify in any scientific way what that level of reimbursement was.

Nursing homes often complain that current Medicaid rates are too low to provide high-quality care and that reduced payments will adversely affect quality. A dilemma for policymakers is that a dollar's worth of increased Medicaid reimbursement will generate less than a dollar's worth of quality improvement. Higher rates might be diluted in ways—including administrative expenses, profits, and inefficiency—that do not improve resident outcomes. And while it seems intuitive that it should cost more to provide higher quality of care, this is not necessarily the case. Higher-cost facilities generally have higher levels of inputs, but many elements of "quality" are costless. Instead of hoping to achieve quality indirectly through more generous reimbursement, a more effective way to improve quality of care may be through a regulatory approach that requires increased care inputs (e.g., staffing). Fairness, however, requires that states be willing to pay for the cost of new regulatory requirements.

Beyond the level of reimbursement, state choices in method of reimbursement are likely to affect quality of care. Patient care is particularly vulnerable to reimbursement-focused cost-containment efforts such as flat rates, suggesting that states should separate out those elements for more generous treatment. Casemix reimbursement is becoming increasingly popular among states and may improve access for heavy care patients, but it seems to have little positive impact on quality of care. Although casemix systems better match payment with resident needs, they provide little incentive for improved outcomes: Nursing homes receive higher reimbursement for more severely disabled residents, but they are not required to spend additional funds to provide care. Finally, although linking payment and quality of care would seem conceptually desirable, the technology to implement such systems at the state level is not currently available.

State policymakers also need to be cognizant of the effects that the long-term care market can have on quality of care and its relation to Medicaid reimbursement. Diminished competition as a result of excess demand seems to have a negative impact on quality of care, but the extent to which excess demand still exists in the long-term care market is unclear. States can lower excess demand by increasing the supply of nursing homes and by expanding the supply of home and community-based services, but these changes also would increase the total cost of the long-term care system, implying a cost/quality tradeoff. Moreover, the expansion of nursing home alternatives raises a host of other issues related to quality of care in these settings.

In sum, because quality of care in nursing homes is already problematic, states looking to cut nursing home rates need to be cautious in their quest for Medicaid savings. Though it does seem true that higher rates are not necessarily used to improve patient care and that many elements of quality care do not require higher costs, direct patient care expenditures are particularly vulnerable to rate-reduction initiatives. Lowering Medicaid nursing home reimbursement rates may be especially problematic in states with high levels of excess demand, as nursing homes in those states do not have to compete for patients on the basis of quality. Reducing excess demand would lower the quality risks of reducing reimbursement rates but probably would result in higher Medicaid expenditures as well.

Notes

1. U.S. General Accounting Office, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight.* Washington, DC: GAO/HEHS-98-202, 1998.

2. American Health Care Association, *Nursing Facility Sourcebook: Facts and Trends, 1997*. Washington, DC: American Health Care Association, 1998.

3. Harrington, C., J. Mullen, and H. Carillo, *Predicting Nurse Staffing in Nursing Facilities in the U.S.*, San Francisco: University of California, 1998b; Harrington, C., et al., *Nursing Home Staffing and Its Relationship to Deficiencies*, San Francisco: University of California, 1998c.

4. Nyman, J.A., "Improving the Quality of Nursing Home Outcomes: Are Adequacy- or Incentive-Oriented Policies More Effective?" *Medical Care*, vol. 26, no. 12 (1988b): 1158–1171; Zinn, J.S., "Market Competition and the Quality of Nursing Home Care," *Journal of Health Politics, Policy, and Law*, vol. 19, no. 3 (1994): 555–582; Cohen, J.W., and W.D. Spector, "The Effect of Medicaid Reimbursement on Quality of Care in Nursing Homes," *Journal of Health Economics*, vol. 15 (1996): 23–48.

5. Nyman, J.A., 1988b.

6. Cohen, J.W., and W.D. Spector, 1996.

7. Nyman, J.A., 1988b; Ullman, S.G., "Ownership, Regulation, Quality Assessment, and Performance in the Long-Term Health Care Industry," *Gerontologist*, vol. 27, no. 2 (1987): 233–239.

8. According to a 1996 Institute of Medicine review, "The preponderance of evidence, from a number of studies using different types of quality measures, shows a positive relationship between nursing staff levels and quality of nursing home care...." (Wunderlich, G.S., F.A. Sloan, and C.K. Davis, eds. *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* Washington, DC: National Academy of Sciences, 1996).

9. Holahan, J.F., and J.W. Cohen, "Nursing Home Reimbursement: Implications for Cost Containment, Access, and Quality," *Milbank Quarterly*, vol. 65, no. 1 (1987): 112–147.

10. Holahan and Cohen categorized the eight study states according to the relative stringency of their reimbursement systems by considering the use of flat rates, adjustment for inflation, efficiency bonuses, and relative payment ceilings.

11. Cohen, J.W., and L.C. Dubay, "The Effects of Medicaid Reimbursement Method and Ownership on Nursing Home Costs, Case-Mix, and Staffing," *Inquiry*, vol. 27 (Summer 1990): 183–200.

12. Moore, T., and A. White, *Drug Utilization and MDS-Based Outcomes for Elderly Nursing Home Residents*. Briefing paper. Cambridge, MA: Abt Associates, 1998.

13. Butler, P.A., and R.E. Schlenker, "Case-Mix Reimbursement for Nursing Homes: Objectives and Achievements," *Milbank Quarterly*, vol. 67, no. 1 (1989): 103–136.

14. Weissert, W.G., and M.C. Musliner, "Case-Mix Adjusted Nursing Home Reimbursement: A Critical Review of the Evidence," *Milbank Quarterly*, vol. 70, no. 3 (1992): 455–490.

15. Zinn, J.S., 1994.

16. Shaughnessy, P.W., and B. Kurowski, "Quality Assurance through Reimbursement," *Health Services Research*, vol. 17, no. 2 (1982): 157–183.

17. Norton, E., "Incentive Regulation of Nursing Homes," *Journal of Health Economics*, vol. 11 (1992): 105–128.

18. Anderson, N., et al., *Nursing Home Care: A Minnesota Analysis*, Minneapolis: American Rehabilitation Foundation, 1968; Kosberg, J., and S.S. Tobin, "Variability among Nursing Homes," *Gerontologist*, vol. 12 (1972): 214–219; Gottesman, L.E., "Nursing Home Performance as Related to Resident Traits, Ownership, Size, and Source of Payment," *American Journal of Public Health*, vol. 64, no. 3 (1974): 269–276; Fottler, M.D., H.L. Smith, and W.L. James, "Profits and Patient Care Quality in Nursing Homes: Are They Compatible?" *Gerontologist*, vol. 21, no. 5 (1981): 532–538; Lewis, M.A., et al., "The Immediate and Subsequent Outcomes of Nursing Home Care," *American Journal of Public Health*, vol. 75, no. 7 (1985): 758–762; Weissert, W., and W.J. Scanlon, "Determinants of Nursing Home Discharge Status," *Medical Care*, vol. 23, no. 4 (1985): 333–343.

19. Nyman, J.A., "The Effect of Competition on Nursing Home Expenditures under Prospective Reimbursement," *Health Services Research*, vol. 23 (1988a): 555–574; Nyman, J.A., 1988b; Nyman, J.A., "Excess Demand, the Percentage of Medicaid Patients, and the Quality of Nursing Home Care," *Journal of Human Resources*, vol. 23, no. 1 (1988c): 76–92; Nyman J.A., "Testing for Excess Demand in Nursing Home Care Markets," *Medical Care*, vol. 31 (1993): 680–693.

20. Scanlon, W.J., "A Theory of the Nursing Home Market," *Inquiry*, vol. 17 (Spring 1980): 25–41.

21. Nyman, J.A., "Prospective and 'Cost-Plus' Medicaid Reimbursement, Excess Medicaid Demand, and the Quality of Nursing Home Care," *Journal of Health Economics*, vol. 4 (1985): 237–259; Nyman, J.A., 1988a, 1988c.

22. Nyman, J.A., 1985, 1988a, 1988c.

23. Zinn, J.S., 1994.

24. Ettner, S.L., "Do Elderly Medicaid Patients Experience Reduced Access to Nursing Home Care?" *Journal of Health Economics*, vol. 12 (1993): 259–280.

25. Moss, M., and C. Adams, "Industry Focus: For Medicaid Patients, Doors Slam Closed; Citing Finances, Nursing Home Evicts the Needy," *Wall Street Journal*, 7 April 1998, B1.

26. Nyman, J.A., 1993.

27. Strahan, G.W., "An Overview of National Nursing Homes and Their Current Residents: Data from the 1995 National Nursing Home Survey," *Advance Data from Vital and Health Statistics*. Hyattsville, MD: National Center for Health Statistics, 1997.

28. Harrington, C., et al., *1996 State Data Book on Long-Term Care Program and Market Characteristics*. San Francisco: University of California, 1998a.

29. Wiener, J.M., D.G. Stevenson, and S.M. Goldenson, *Controlling the Supply of Long-Term Care Providers at the State Level*, Occasional Paper No. 22, *Assessing the New Federalism*. Washington, DC: Urban Institute, forthcoming.

30. The Balanced Budget Act of 1997 established a casemix-adjusted prospective payment system for Medicare skilled nursing facilities (effective July 1998) that is projected to save almost $10 billion between 1998 and 2002.

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PUBLIC POLICIES ON MEDICAID ASSET TRANSFER AND ESTATE RECOVERY: HOW MUCH MONEY TO BE SAVED?

BY JOSHUA M. WIENER

In 1995 Congress passed legislation that would have converted Medicaid from an open-ended entitlement program with a number of federal requirements to a block grant with few national standards. Moreover, federal expenditures for Medicaid would have been capped and indexed at far below the expected rate of growth under current law. For his part, President Clinton has proposed establishing per beneficiary limits on the growth of federal expenditures, while giving states somewhat greater flexibility in contracting with managed care organizations, setting reimbursement rates, and organizing long-term-care services. Savings, while significant, would be much less than under the congressional plan.

If states are to control Medicaid expenditures, they will have to confront the issue of services for the elderly and people with disabilities. Although about three-quarters of Medicaid beneficiaries are children and nonelderly, nondisabled adults, they account for only about a third of expenditures (Holahan and Liska, 1995). Older people and people with disabilities account for two-thirds of Medicaid expenditures. Moreover, in 1995, 33 percent of Medicaid expenditures were for long-term-care services—nursing facilities, personal care, home health, intermediate care facilities for the mentally retarded, and home and community-based services (Burwell, 1996). Approximately three-fifths of Medicaid long-term-care expenditures are for the elderly (Kaiser Commission on the Future of Medicaid, 1995). Medicaid is the dominant source of public funding for long-term care for the elderly, accounting for 62 percent of government spending for nursing home and home care in 1993 (Wiener, Illston, and Hanley, 1994). Most Medicaid long-term-care spending for the elderly goes for nursing home care, where 68 percent of residents in 1992 had their care at least partly financed by the program (Liu and Moon, 1995).

The issues go beyond whether substantial Medicaid savings can be achieved by being 'tougher.'

Advocates of block grants and large reductions in the rate of growth of Medicaid spending argue that substantial program savings can be achieved by (1) allowing states to be tougher on nursing home residents who qualify for Medicaid by transferring assets in order to appear poor and (2) more aggressively recovering Medicaid expenditures from the estates of deceased Medicaid nursing home residents. While some savings are surely possible through these practices, the amounts are not likely to be large, and such strategies raise a number of public policy issues.

BACKGROUND

Medicaid is a means-tested welfare program. In general, unmarried people may not retain more than $2,000 in assets, generally not counting the value of the home. The asset limits for married couples, one of whom still lives at home, were substantially liberalized by the Medicare Catastrophic Coverage Act of 1988. Meeting the asset limits by transferring assets to other parties at less than market value is prohibited for thirty-six

months prior to applying for Medicaid. Under provisions of the Omnibus Budget Reconciliation Act of 1993, states are required to recover the cost of institutional care from the estates of deceased Medicaid beneficiaries.

Nursing home residents who meet the asset test must contribute all of their income toward the cost of care, after deducting a small allowance (usually $30 a month) to pay for personal items. Again, community-based spouses may retain substantially higher amounts of the couple's income. Only if the contribution toward the cost of care is inadequate to meet the expense of nursing home care will Medicaid then pay the residual cost.

Preventing Transfer of Assets

Over the last several years, policy makers and the media have focused attention on middle- and upper-class elderly people who transfer, shelter, and underreport assets in order to meet Medicaid asset eligibility requirements so that they can qualify for aid in paying for nursing home care (Burwell and Crown, 1995; Gray, 1992; Bates, 1992). Congress legislated against these activities, often referred to as "Medicaid estate planning," in the Tax Equity and Fiscal Responsibility Act of 1982, the Medicare Catastrophic Coverage Act of 1988, and the Omnibus Budget Reconciliation Act of 1993. While the practice of transferring assets to qualify for Medicaid has been going on for many years, some observers argue that the legislative prohibitions are easy to circumvent and that its prevalence has increased dramatically in recent years (Serafini, 1995; Moses, 1994; Moses, 1995a; Moses, 1995b). (See the paper by Brian Burwell and William Crown in this issue for a description of some of the techniques that can be used.) Speaker Newt Gingrich alleged that transfer of assets by "millionaires" to gain Medicaid eligibility is a "very common problem" (Schmidt and Rich, 1995). Moreover, according to some estimates, as much as $5 billion a year—roughly 20 percent of Medicaid nursing home expenditures—could be saved by reducing Medicaid estate planning (Cantwell, 1995).

No other long-term-care policy issue is argued with greater passion. Opponents of transfers contend that Medicaid is meant only for those who really need it and that manipulating loopholes to gain eligibility is a perversion of the program's intent (Moses, 1990). Moreover, they argue that money that goes to support artificially eligible nursing home residents is money that cannot be spent on Medicaid services for low-income children and nonelderly adults. Some observers also worry that the publicity about asset transfers will negatively affect the "moral color" of the debate about long-term-care reform. After all, if long-term-care reform is only about protecting the assets of the well-to-do, then there is not likely to be much of a constituency for change.

Defenders of the practice insist that transferring or sheltering assets to qualify for Medicaid is morally indistinguishable from using the tax code to avoid paying estate taxes. Both are legal and both cost the government money. Moreover, it is politically naive and mistaken to think that lower Medicaid long-term-care expenditures will automatically mean higher amounts spent on the nonelderly poor. Finally, few alternatives exist for the disabled elderly who do not want their life savings totally destroyed by the costs of long-term care and who want to leave some inheritance to their spouse and children.

While it seems likely that an increasing number of people are transferring their assets, the very limited available evidence suggests that the numbers are much smaller than is commonly thought. The only direct evidence is from a U.S. General Accounting Office (1993) study of applicants for Medicaid nursing home care in Massachusetts, a state chosen in part because asset transfer was believed to be common there. Of the 403 Massachusetts Medicaid applicants reviewed, forty-nine applicants had transferred assets, and three-quarters of these shifted less than $50,000 in resources. Twenty-six of the forty-nine applicants were either denied eligibility or withdrew their application. Six of the seven applicants who transferred more than $100,000 were denied eligibility. Thus, although some clients did transfer assets, existing rules kept most off the Medicaid rolls.

Beyond this direct evidence, more indirect data also suggest that the incidence of asset transfer is low. First, logically, older people cannot transfer large amounts of assets if they do not have large amounts of assets. Existing data suggest that very elderly disabled widows, who account for the vast bulk of nursing home patients, have quite low income and assets. As shown on Table 1, Wiener, Hanley, and Harris (1994) found that about two-thirds of disabled elderly who were admitted to nursing homes between 1982 and 1984 had incomes below 150 percent of the federal poverty line in 1982; about a third had incomes below the poverty line. Furthermore, based on a synthetic estimate using data on the noninstitutionalized elderly population from the Survey of Income and Program Participation, they calculated that about three-quarters of nursing home patients had less than $50,000 in nonhousing assets (in 1989 dollars) at the time of their admission to the nursing home; almost half had less than $10,000 in nonhousing assets (Table 2). In contrast, only about 11 percent had the level of assets ($100,000 or more) considered typical of estate planners' clients. Of this more wealthy population, about half have enough annual income to pay for nursing home care without recourse to any assets. Thus, this group has no incentive to engage in Medicaid estate planning because they can pay for nursing home care out of current income.

Second, if a large and rapidly increasing number of the elderly are transferring their assets, then the number of Medicaid nursing home beneficiaries should be rising rapidly. In fact, as shown on Table 3, the number of Medicaid nursing home beneficiaries is increasing slowly and only

slightly faster than the number of nursing home beds. Between 1990 and 1993, the average annual compound rate of increase in Medicaid nursing home beneficiaries was 3.3 percent a year, while the increase in the number of nursing home beds was 1.5 percent a year. All of the rate of increase in Medicaid beneficiaries in excess of the rate of increase in beds is due to a relatively large rise in the number of Medicaid nursing home residents in one year—1992.

Table 1

Distribution of Income of Disabled Elderly Admitted to a Nursing Home, 1982–1984

Income in 1982 as a Percentage of Federal Poverty Level	
Less than 100%	35.3%
100%–149%	31.4%
150%–199%	15.0%
200%–299%	11.0%
300% +	6.7%
	100.0%

Source: Brookings Institution. Analysis of 1982–84 National Long-Term Care Survey.

Table 2

Estimated Income and Personal Net Worth of Nursing Home Population, 1989

		Personal Net Worth (Nonhousing Assets)			
Income	Total	0–$9,999	$10,000–49,999	$50,000–99,999	$100,000 +
		Percentage of Population			
$7,499 or less	44	34	8	2	0
$7,500–14,999	36	12	14	8	2
$15,000–29,999	15	2	4	4	6
$30,000 +	5	0	1	0	3
Total	100	48	27	14	11

Source: Brookings Institution. Estimates based on Survey of Income and Program Participation.

Table 3

Number of Medicaid Nursing Home Beneficiaries and Nursing Home Beds, 1990–1993 (in thousands)

Year	Medicaid Recipients	Beds
1990	1,461	1,660
1991	1,490	1,685
1992	1,573	1,734
1993	1,610	1,768
Annual Compound Rate of Growth	3.3%	1.5%

Source: "Statistical Supplement, 1995," *Health Care Financing Review,* and Harrington, C., University of California at San Francisco, personal communication, October 11, 1995.

Third, in an exercise that combined an estimate of the available assets of the nursing home population and the growth in the number of Medicaid beneficiaries, Liu and Moon (1995) estimated the maximum potential loss due to the increase in asset transfer between 1988 and 1992. They began by noting that the proportion of nursing home residents covered by Medicaid increased from 66 percent in 1988 to 68 percent in 1992. This 2 percentage point increase translates into 30,000 people a year and represents a maximum estimate of the potential increase in the number of people who might have transferred assets to become eligible for Medicaid. As Liu and Moon note, this estimate is almost certainly too high because it assumes that all of the increase is due to asset transfer, but the spousal impoverishment provisions of the Medicaid Catastrophic Coverage Act of 1988 dramatically eased Medicaid nursing home eligibility requirements for married couples. They then multiplied 30,000 people by the average nonhousing assets ($36,000) for people over age 80 who lived alone and had incomes of less than $40,000, a group they defined as likely to have an incentive to transfer assets. People with incomes above $40,000 have little incentive to divest assets because their incomes are so high that they can pay for nursing home care out of current income without recourse to any assets at all. As a result, Liu and Moon calculate that if every penny of assets that the elderly had *was* transferred, the amount equals $1.1 billion, representing only about 4 percent of Medicaid nursing home expenditures.

Expanding Estate Recovery

In general, while single individuals generally are limited to $2,000 in fi-

nancial assets, a home of unlimited value is an excluded asset in determining financial eligibility for Medicaid. However, for a long time states had the option of recovering Medicaid expenditures for nursing home care from the estates of deceased Medicaid beneficiaries, principally from the sale of the house. As of 1993, twenty-four states operated estate recovery programs (Office of the Inspector General, 1994). Although the Omnibus Budget Reconciliation Act of 1993 mandates states to operate such programs, some states have refused to do so because these initiatives are politically unpopular.

Advocates of aggressive estate recovery argue that when determining how much an individual may retain and still be eligible for Medicaid, it makes little sense to maintain the current distinction between financial and housing assets. An asset is an asset and should be counted accordingly. Given that Medicaid is supposed to be for people with little or no assets, it makes perfect sense to recover the cost of caring for residents from their estate after they die (with proper protections for the spouse and minor and disabled children).

Opponents of estate recovery contend that a person's home has a very different ethical and moral meaning than do stocks and bonds, for example. The home has an almost mythic quality in American society and is deeply intertwined with the meaning of people's lives. Thus, Medicaid nursing home residents should be able to pass on their home to their family just like people who are not Medicaid beneficiaries. Moreover, the opponents argue that estate recovery puts the government in the unsavory position of a vulture circling dying patients, just waiting for the opportunity to get its money back.

It is likely that a significant proportion of elderly people discharged from nursing homes own their homes. In an analysis of the 1982–84 National Long-Term Care Survey, Wiener, Hanley, and Harris (1994) found that 55 percent of disabled elderly people entering nursing homes owned a home, a percentage that is well below the 75 percent of all elderly who are homeowners, but still substantial. Sheiner and Weil (1992) found that only 42 percent of all elderly households will leave behind a house when the last member dies. However, the proportion of deceased Medicaid nursing home residents who leave behind houses is probably much smaller because an unknown proportion sell their homes in order to help pay for their nursing home care or for other reasons. In an analysis in eight states in 1985, the U.S. General Accounting Office found that only 14 percent of Medicaid nursing home residents owned a home at the time of application for Medicaid (General Accounting Office, 1989).

In an effort to calculate the maximum that states could recover from estates, Liu and Moon (1995) estimated the housing wealth available for estate recovery from deceased Medicaid-eligible nursing home patients. They calculated that about 56,000 Medicaid nursing home residents died annually, were not married, and owned a home when they died. With $37,000 the average housing equity eligible for recovery, the total amount is about $2 billion, about 8 percent of Medicaid nursing home expenditures.

Experience with currently operating estate recovery programs suggests that they are likely to recoup only a small proportion of this amount. As a percentage of Medicaid nursing home expenditures, the amount recovered from the estates of deceased Medicaid beneficiaries averaged 1.03 percent in 1993 for the top ten states, falling rapidly from a high of 2.51 percent in Oregon to 0.53 percent in Wisconsin (Table 4). Because of the already significant effort underway in many states, additional savings are likely to be limited to those states not currently operating estate recovery programs. Thus, to achieve the maximum estimated savings, all states would have to achieve recovery rates seven times as high as the current average for the ten best states and nearly three times as high as the most successful state (Liu and Moon, 1995). Although this might be possible, it seems unlikely.

Table 4

Top Ten Medicaid Estate Recovery Programs, 1993

State	Money Recovered as Percentage of Nursing Home Expenditures
Oregon	2.51
New Hampshire	1.36
California	1.16
Massachusetts	1.00
Minnesota	0.91
North Dakota	0.87
Idaho	0.85
Illinois	0.57
Utah	0.57
Wisconsin	0.53

Source: Office of Inspector General, 1994.

Conclusions

Perhaps more than ever before, state initiatives in long-term care are focusing on ways to save money. Preventing asset transfer and aggressively pursuing estate recovery are two strategies that are under consideration to achieve savings without directly hurting low- and moderate-income older people with severe disabilities. Although limited, the available evidence suggests that savings would not be high. In addition, these savings would be at least somewhat offset by substantial administrative costs.

Beyond the issue of cost savings, asset transfer and estate recovery raise at least three broad public policy concerns. The first is whether the financing of long-term care is primarily a public or private responsibility. Some people believe that the primary responsibility for the financing and care of people with disabilities belongs with individuals and their families with government acting only as a payer of last resort for those unable to

provide for themselves. Under this approach, the fact that some middle-class nursing home residents transfer assets in order to obtain Medicaid benefits and that Medicaid beneficiaries can pass on to their heirs a house worth tens of thousands of dollars is a moral affront that violates the notion that Medicaid should be limited to the truly needy.

Others believe that the government should take the lead in ensuring care for all disabled people, regardless of financial status. In this view, the need for long-term care is a normal risk of living and of growing old that the vast majority of people cannot protect themselves against. Good quality private long-term-care insurance, for example, is simply too expensive for the vast majority of elderly (Wiener, Illston, and Hanley, 1994). In contrast to Medicaid, they note, nobody cares whether terminally ill Medicare beneficiaries give gifts to their children and grandchildren, and no one has proposed recovering the costs of healthcare from the estates of deceased Medicare beneficiaries. The reliance on a means-tested program to finance what is a normal risk of life and of growing old creates a perverse incentive for good people to manipulate the system in order to appear poor.

Closely related to this policy issue is the fact that the amount of income and assets that Medicaid nursing home residents are allowed to retain is very low and requires an extreme level of impoverishment. Thus, it would be possible to make the amount of income and assets that residents are allowed to retain less penurious without abandoning the principle of means-tested long-term-care financing. This would also make asset transfer less likely because residents would be able to retain larger sums of money, rather than losing everything. For example, raising the personal needs allowance to $100 a month and permitting residents to retain $30,000 in nonhousing assets would have increased the number of Medicaid nursing home beneficiaries by only 7 percent in 1993 but would have made their lives more comfortable (Wiener, Illston, and Hanley, 1994). To do so, however, would have increased Medicaid expenditures by $4.0 billion (Wiener, Illston, and Hanley, 1994).

Finally, Americans are deeply ambivalent about the intergenerational transfer of wealth. Many people consider it extremely unfair that nursing home residents should have to lose their entire life savings simply because they were unlucky enough to develop Alzheimer's disease and, through no fault of their own, require institutionalization. While granting problems with the current system, others question whether protecting financial estates to be passed on to adult children is an appropriate public policy goal because such transfers further inequality and are not based on the merits of the heirs. People who want to protect their assets, it is argued, should purchase private long-term-care insurance. Furthermore, what are personal savings for, they ask, if not for needed care toward the end of life?

In sum, the issues of transfer of assets and estate recovery go beyond the question of whether they can contribute materially to efforts to reduce the rate of increase in Medicaid expenditures. They crystallize many of the questions about the nature of the public and private responsibilities for long-term care. ∞

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REFERENCES

American Health Care Association. 1995. *Facts and Trends: The Nursing Facility Sourcebook, 1995.* Washington, D.C.

Bates, A. 1992. "Golden Girls." *New Republic (Feb.* 3): 17–18.

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

Burwell, B. 1996. "Medicaid Long-Term Care Expenditures in FY 1995." Cambridge, Mass.: The MEDSTAT Group.

Cantwell, J. R. 1995. "Solutions to the Medicaid Funding Problem." Dallas, Tex.: National Center for Policy Analysis.

Gray, J. 1992. "Governors Seek to Shed Burdens of Medicaid." *New York Times.* 4 Aug.4, p. A8.

Holahan, J., and Liska, D. 1995. "The Impact of the House and Senate Budget Committees' Proposal on Medicaid Expenditures." Washington, D.C: Kaiser Commission on the Future of Medicaid.

Kaiser Commission on the Future of Medicaid. 1995. "Medicaid and the Elderly." Washington, D.C.

Kosterlitz, J. 1991. "Middle Class Medicaid." *National Journal* 23(Nov. 9): 2,728–32.

Liu, K., and Moon, M. 1995. "Recovering Hidden Assets: The Magic Bullet for Medicaid Savings?" *The Urban Institute Policy Bites (*23).

Moses, S. A. 1990. "The Fallacy of Impoverishment." *Gerontologist* 30(1): 21–25.

Moses, S. A. 1994. "The Florida Fulcrum: A Cost Saving Strategy to Pay for Long-Term Care." Kirkland, Wash.: LTC, Inc.

Moses, S. A. 1995a. "The Long-Term Care Financing Crisis: Danger or Opportunity." Kirkland, Wash.: LTC, Inc.

Moses, S. A. 1995b. "The Magic Bullet: How to Pay for Universal Long-Term Care, A Case Study in Illinois." Kirkland, Wash.: LTC, Inc.

Office of the Inspector General. 1994. "Medicaid Estate Recovery Programs." OEI-07-92-00990. Washington, D.C: U.S. Department of Health and Human Services.

Schmidt, S., and Rich, S. 1995. "Democrats Counter GOP Medicare Cuts Without New Patient Costs." *The Washington Post,* Oct. 2, p. A7.

Serafini, M. W. 1995. "Plugging a Big Drain on Medicaid." *National Journal* 27(Mar. 18): 687.

Sheiner, L., and Weil, D. N. 1992. "The Housing Wealth of the Aged." Working Paper Number 4115. Cambridge, Mass.: National Bureau of Economic Research.

U.S. General Accounting Office. 1989. *Medicaid: Recoveries from Nursing Home Residents' Estates Could Offset Program Costs.* GAO/HRD-89-56, March. Washington, D.C.

U.S. General Accounting Office. 1993. *Medicaid Estate Planning.* GAO/HRD-93-29R, June. Washington, D.C.

Wiener, J. M., Hanley, R. J., and Harris, K. M. 1994. "The Economic Status of Elderly Nursing Home Users." Washington, D.C: Brookings Institution.

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

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Public and Private Responsibilities in Long-Term Care

Finding the Balance

EDITED BY

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CHAPTER 6

Jump Starting the Market

Public Subsidies for Private Long-Term Care Insurance

JOSHUA M. WIENER

This chapter provides an analysis of policy responses to the long-term care financing programs that rely on public subsidy models. Each of three major programs is assessed in terms of its capacity to address affordability barriers to long-term care insurance.

This chapter briefly describes the current limitations of the long-term care insurance market. The following three approaches to public subsidies for private long-term care insurance are presented, with advantages and impediments identified for each: (1) employer tax subsidies, (2) tax deductions or credits, and (3) waiver of some or all of the Medicaid asset depletion requirements for purchasers of qualified insurance policies. The chapter concludes with observations about the potential contributions of these strategies in making long-term care insurance more affordable.

Background

The current U.S. system of financing and delivering long-term care for the elderly and the younger disabled population is badly broken. At present, the United States does not have, in either the private or the public sectors, satisfactory mechanisms for helping people anticipate and pay for long-

term care. In particular, the disabled elderly and their families find, often to their astonishment, that the costs of nursing home and home care are not covered to any significant extent by either Medicare or their private insurance policies. Instead, the disabled elderly must rely on their own resources or, when those have been exhausted, turn to welfare in the form of Medicaid. Moreover, although the vast majority of disabled elderly live in the community, nearly two-thirds of public expenditures for long-term care for the elderly are for nursing home care (Wiener, Illston, & Hanley, 1994).

To address these problems, a small but growing private long-term care insurance market has developed over the past ten years. Although over 95 percent of the elderly have Medicare coverage and about 70 percent have supplemental private insurance policies, insurance against the potentially devastating costs of long-term care is relatively rare (Committee on Ways and Means, 1996). As of the end of 1993, approximately 3.8 million long-term care policies had been sold (although fewer were in force), overwhelmingly marketed to the elderly on an individual rather than group basis (Coronel & Fulton, 1995). Employer contributions toward the cost of long-term care insurance are uncommon.

By far, the greatest impediment is the high cost of good-quality policies. Despite the marked improvement in the financial position of the elderly over the past twenty years, long-term care insurance remains unaffordable for most. The average annual premium for policies covering three years of nursing home and home care with inflation protection in 1995 was over $2,000 a year if purchased at age sixty-eight and over $4,000 a year if purchased at age seventy-five (Lewin-VHI & The Brookings Institution, 1996).

The policies are expensive for two reasons: (1) nine out of ten are sold individually and, therefore, carry high administrative costs; and (2) most policies are bought by older people whose risk of needing long-term care is substantial. Consequently, most studies estimate that only 10 percent to 20 percent of the elderly can afford good-quality private long-term care insurance (Wiener, Illston, & Hanley, 1994; Crown, Capitman, & Leutz, 1992; Rivlin & Wiener, 1988). Other research has found the percentage of the elderly who can afford private insurance to be higher, but these studies have done so by assuming purchase of policies with limited coverage, by assuming the elderly would use their assets as well as income to pay premiums, or by excluding a large proportion of the elderly from the pool of people considered interested in purchasing insurance (Cohen et al., 1992; Cohen et al., 1987). Affordability is not likely to dramatically improve in the future (Wiener, Illston, & Hanley, 1994).

Given the limitations of the current market for private long-term care insurance, public subsidies to promote its purchase are frequently proposed. One approach is to provide employers with a tax subsidy for the purchase of long-term care insurance policies for their employees by allowing them to deduct insurance contributions as a business expense. A second strategy is to provide a tax deduction or credit to individuals for purchase of private long-term care insurance. Tax incentives for employers and individuals were part of the Health Insurance Portability and Accountability Act of 1996 (the Kassebaum-Kennedy bill). A final strategy is to waive some or all of the Medicaid asset depletion requirements for purchasers of qualified private long-term care insurance policies, an approach being tried in several states. The intent of these strategies is to induce more people to purchase policies by lowering premium costs through tax breaks or guaranteeing publicly funded coverage once privately purchased coverage is exhausted. Proponents argue that a key consequence of any of these actions is public endorsement of the importance and desirability of private long-term care insurance.

All of these options will, no doubt, promote the purchase of private long-term care insurance, but to what extent is unclear. Moreover, with the possible exception of easing access to Medicaid by persons who purchase private long-term care insurance, these strategies are not free to the government. All of these options could result in substantial loss of federal revenue, which is spending just as certainly as the direct expenditures of a public insurance program.

Employer-sponsored Market for Long-Term Care Insurance

Advantages and disadvantages

One approach to address the affordability problem is to encourage the purchase of private long-term care insurance at younger ages, especially through employers.

Theoretically, employer-sponsored plans offered to the nonelderly provide several advantages over those purchased individually. First, premiums for younger policyholders can be substantially lower than those for older policyholders because younger policyholders pay premiums over a longer period of time and because earnings on premium reserves have more time to build. For example, the premiums for a forty-two-year-old will be approximately one-quarter to one-third of the premiums for a sixty-seven-year-old (Wiener, Harris, & Hanley, 1990). Computer simulations suggest that purchase of long-term care insurance by the younger population could largely solve the affordability problem of private long-term care insurance, even without employer contributions (Wiener, Illston, & Hanley, 1994).

Although lower premiums are tied to the age of the purchaser and not necessarily to the fact that the policy is employer-sponsored, the nonelderly are easiest to reach through their place of employment. The workplace is where most health, life, and disability insurance is purchased and most retirement savings through pensions are established.

Lower administrative and marketing costs offer another potential source of savings over individual policies. Administrative and marketing costs are high in individual policies because sales have to be made one at a time. Group markets are able to achieve lower costs through economies of scale. Moreover, in group policies, employers bear many of the costs of administering the policy, such as collecting premium payments through payroll deductions. Employers may also elect to assume part of the costs of marketing the plan to their employees. However, informal discussions with insurance actuaries suggest that most assume only a 10 percentage point difference in the anticipated medical loss ratio between individual and group plans.[1] Thus, although the administrative savings of group policies are desirable and not trivial, they will not dramatically lower premiums.

Enrolling people at younger ages through the workplace also reduces the risk of adverse selection and therefore the need for medical underwriting. Disability is relatively rare at younger ages. The less frequent underwriting typical of employer-based policies is an improvement over the universally strict practices used for purchase of individual insurance policies. However, most younger persons with significant disabilities are not in the workforce and would not, therefore, be eligible for these policies.

Finally, advocates of employer-sponsored insurance argue that the quality of policies should improve through the involvement of company benefit managers. Large groups have more market power than individuals to negotiate with insurance carriers for less restrictive policies with richer benefits and lower prices. In general, the quality of policies in the employer market is quite good, especially in providing home care benefits. On the other hand, most employer-sponsored policies have grossly inadequate inflation protection. Under most policies, the insured must purchase

1. The loss ratio is the percentage of the premium that is for benefits rather than administrative and other overhead. Many companies assume a loss ratio of 60 percent for individual policies and 70 percent for group policies.

additional coverage from time to time to compensate for inflation, but at the new older age and therefore at a substantially higher premium.[2]

Despite the potential advantages of selling to the nonelderly population through employer groups, the employer-sponsored market for long-term care remains small and may not expand enough to play a significant role in financing long-term care. As of the end of 1994, a total of over 400,000 policies had been sold through 968 employers, although the number of policies in force is lower (Coronel & Caplan, 1996). In a key difference from acute care policies, where most employers pay a large proportion of the cost of insurance, most employer-sponsored long-term care policies are offered on an employee-pay-all basis (Coronel & Caplan, 1996).

Employers are reluctant to offer the policies, and employees are not rushing to purchase them. In particular, employers have been unwilling to contribute to the cost of policies.

Encouraging Employer Contribution through Tax Incentives

Employer sponsorship

Employer contributions could make long-term care insurance more affordable by reducing the amount that employees have to pay out of pocket and might give employees confidence in the product. Until passage of the Kassebaum-Kennedy bill in 1996, private long-term care insurance was not specifically recognized in the federal tax code. Because of its unique characteristics, long-term care insurance did not fit neatly into the existing tax models of health and accident, life, or disability insurance, pensions or private annuities. As a result, the tax status of employer contributions and insurance benefits was unclear, and this lack of clarity no doubt slowed the growth of long-term care insurance, at least to some extent. The Kassebaum-Kennedy bill clarified that contributions toward the cost of group long-term care insurance policies is a tax-deductible expense for employers (like health insurance) and that benefits (within limits) are not considered income for the insured.

2. For example, if a person buys a policy at age forty-two that pays $60 a day in nursing home benefits and if inflation is 33 percent during the next five years, then the insured can buy additional coverage of $20 a day to compensate for the inflation but at the price charged forty-seven-year-olds, not forty-two-year-olds. We estimate that to retain purchasing power, the inflation-adjusted premium at age eighty-two would be approximately ten times what it was at age forty-two. This is because nursing home use is exponential by age.

A persistent problem with tax incentives is the probability that most of the tax expenditures will be for people who would have purchased policies anyway. As a result, tax subsidies can be very costly ways of promoting private insurance. For example, Wiener, Illston, and Hanley (1994) estimate that if the federal government allowed employers to deduct the cost of their contribution to private long-term care insurance, the lost revenue would be $7,900 to $11,300 per year per additional policy sold.

These tax benefits are also not free to the federal government, producing potentially substantial tax losses. Some advocates argue that reductions in government expenditures for Medicaid nursing home and home care will offset the tax loss because some people who will buy private insurance would otherwise be eligible for Medicaid. At least for a long time period, these offsets are unlikely to occur due to an imbalance in timing that guarantees short-term tax losses. The tax loss happens immediately, since the revenue loss is linked to premium payments, while the savings (if any) will not occur until the benefits are used, typically many years into the future. Using a computer simulation model, Wiener, Illston, and Hanley (1994) estimate that it could take twenty-five years before the annual tax loss approximately equals the annual Medicaid savings.

While the uncertain tax status of long-term care insurance has no doubt prevented some employers from offering long-term care insurance policies to their employees, these factors are likely to be overwhelmed by the financial problems facing employer-sponsored acute health insurance benefits for retired employees that supplement the Medicare program. Unlike pensions, virtually all corporations offering postretirement health benefits have financed them on a pay-as-you-go basis rather than prefunding them. Prodded by accounting rules established by the Financial Accounting Standards Board that require companies to disclose their future financial liability for these benefits, corporations are now aware that, collectively, they have an estimated $187 billion to $400 billion in mostly unfunded liabilities (U.S. General Accounting Office, 1989, 1993; Warshawsky, 1992).

As a result, large numbers of employers, concerned about health care costs for both their active employees and retirees, are cutting back on retiree benefits, making retirees pay a greater part of the cost or dropping that coverage altogether. For example, data from Foster Higgins' annual survey of mostly large employers found a drop in retiree health benefits between 1988 and 1992 (Foster Higgins, 1993). In 1988, 55 percent of responding firms offered retiree health benefits to Medicare-eligible retirees; by 1992, only 46 percent of responding firms did so. The percentage of full-time workers in state and local governments with retiree health benefits declined between 1990 and 1992 from 58 percent to 50 percent

(U.S. Department of Labor, 1994, 1991). A recent study of fifty of the largest companies showed that thirty-one reported increases in retiree cost sharing for medical benefits in 1994 (Watson Wyatt Worldwide, 1995). In this environment, it seems unlikely that many additional employers will want to contribute to a new, potentially expensive insurance plan that will primarily benefit retirees twenty years to thirty years after they have left the company. Indeed, employers are trying to distance themselves as much as possible from such benefits.

Limited employee demand

To date, employee demand has been limited and therefore has not played a large role in the decision of companies to add long-term care insurance to their benefit package. The desire to maintain a company's image as a leader in employee benefits and a personal sensitivity by a senior officer or employee benefit manager to the problem have been larger factors. Nonetheless, surveys of large employers suggest the possibility of a large increase in the number of companies offering policies, if not paying for them.

Employees also have been reluctant to purchase insurance. The Health Insurance Association of America estimates that, depending on how the universe of eligibles is defined, only 5.3 percent to 8.8 percent of those offered employer-sponsored long-term care insurance have purchased policies (Coronel, 1993).

Several factors limit employee demand. First, although premiums for policies without inflation adjustment are quite low at younger ages, they cost more than many people are willing to pay voluntarily. Moreover, a high-quality long-term care insurance policy with a level premium, inflation protection, and nonforfeiture benefits purchased at age fifty can cost more than $1,000 a year (Wiener, Harris & Hanley, 1990). In a survey of nonpurchasers of employer-sponsored policies offered by two major insurers, LifePlans, Inc. reported that 82 percent of respondents felt that the fact that "the policy costs too much" was either "very important" or "important" in their decision not to purchase a policy (LifePlans, 1992). Even though economists contend that increased employer contributions for fringe benefits are mostly offset by reduced wages, 90 percent of respondents in this survey said that they would be more willing to purchase a policy if their employer contributed to the cost.

In addition, middle-age workers usually must contend with other, more immediate expenses, such as child care, mortgage payments, and college education for their children. In the LifePlans, Inc. (1992) survey, 80 percent of nonpurchasers stated that "more important things to spend money on at this time" was either "very important" or "important" in their decision not to purchase a policy. The risk of needing long-term care is too distant to galvanize many people into buying insurance.

Finally, selling to the nonelderly population raises difficult considerations of pricing and product design. An actuary pricing a private long-term care insurance product for a forty-five-year-old must predict what is going to happen forty years into the future, when the insured is age eighty-five. To say the least, this is difficult. Ironically, although one of the advantages commonly claimed for private insurance is its flexibility in responding to the needs and wants of consumers, policyholders who buy insurance at younger ages could be locked into the existing model of service delivery decades before they use services. Who knows what the optimal delivery system will be a half century from now?

Encouraging Individual Purchase of Private Insurance through Tax Incentives

Another set of options would improve the affordability of private long-term care insurance by offering direct tax incentives to individuals who purchase policies. For example, the Kassebaum-Kennedy legislation allows individuals to count private long-term care insurance premiums as a health expense.[3] Health care expenses in excess of 7.5 percent of adjusted gross income are tax-deductible. As a result of the ability to deduct part of the cost of private long-term care insurance, the net price of insurance policies will be reduced. Some insurance advocates argue that providing a tax benefit will have a "sentinel" effect, promoting insurance beyond merely reducing the price. A tax incentive, they contend, will signal potential purchasers that the government thinks private long-term care insurance is a worthwhile product.

The type of tax chosen to provide the tax subsidy defines the scope of who can benefit. Allowing taxpayers to deduct all or part of the cost of a private long-term care insurance policy would provide a premium subsidy valued at the marginal tax rate of the household. Since upper-income taxpayers have higher marginal tax rates than lower-income taxpayers, deductions are regressive in nature. That is, they are worth more

3. The level of private long-term care insurance that can be included varies by age. For 1997, it was limited to $200 for persons age forty and younger; for persons age seventy and older, it was limited to $2,500.

to upper-income people than to lower-income people. However, for the 72 percent of taxpayers in the 15 percent tax bracket in 1993, this type of tax subsidy reduces the cost of obtaining long-term care insurance by only about one-seventh, probably not enough to motivate very many additional people to purchase policies (Cruciano & Strudler, 1996). The other major drawback is that relatively few taxpayers itemize their deductions. In 1993, only 29 percent of all tax returns included itemized deductions; only 4 percent claimed a deduction for medical expenses (Internal Revenue Service, 1996).

The other broad approach is to provide a tax credit, which is a direct reduction in the amount of tax owed, for purchase of policies. In theory, tax credits need not be as regressive as deductions. However, as a practical matter, moderate- and low-income taxpayers may not have the cash on hand to pay premiums during the year so as to be able to claim a tax credit in the following year. The other problem is that, unless the credit is refundable, it is an ineffective policy for people who do not have a tax liability. This is especially a problem for the elderly, only about half of whom have any federal income tax liability (Committee on Ways and Means, 1996).

As with tax subsidies for employer contributions to private long-term care insurance, the key issue is whether tax incentives are an effective and efficient way to promote the purchase of private long-term care insurance, and thereby, the reform of nursing home and home care financing. For example, estimating the effect of an income-related tax credit for the purchase of private long-term care insurance, Wiener, Illston, and Hanley (1994) calculated the cost per additional policy induced by the tax benefit at between $1,700 and $1,900 per year. Similarly, they estimate that the tax loss per year through 2018 will be at least four times the Medicaid savings.

Public-Private Partnerships

While changing the tax code is the most commonly proposed way of publicly subsidizing private long-term care insurance, the initiatives by Connecticut, Indiana, California, Iowa, and New York take a substantially different approach. Commonly referred to as the Robert Wood Johnson Public-Private Partnerships (for the foundation that promoted this strategy), these states provide easier access to Medicaid for persons who purchase a state-approved private long-term care insurance policy. (See Chapter 5 in this volume for a more detailed description and an alternative perspective.) In essence, these states allow nursing home patients with private long-term care insurance to be Medicaid-eligible with substantially

higher levels of assets than is normally allowed.[4] At present, Medicaid only allows unmarried nursing home patients to retain $2,000 in assets (excluding the home). While employer-paid plans and tax incentives seek to reduce the net cost of insurance, this public-private partnership does the reverse by trying to increase the amount of benefits received per dollar spent.

There are two models for linking Medicaid and private insurance.[5] In both cases, Medicaid acts as reinsurance for persons with limited private long-term care insurance. In one model used by Connecticut, California, Indiana, and Iowa, the level of Medicaid-protected assets is tied to the amount that the private insurance policy pays out. For example, if a person buys a policy that pays $100,000 in long-term care benefits, then that individual can keep $100,000 in assets and still be eligible for Medicaid. Consumers are able to purchase insurance equivalent to the amount of assets they wish to preserve, potentially reducing the amount of insurance individuals need to buy.

The other model, used by New York, provides protection of an unlimited amount of assets if an individual purchases a policy that meets state standards, including coverage of at least three years of a combination of nursing home and home care, with a minimum $100 per day indemnity payment. The rationale for not requiring an asset test for Medicaid coverage is that nursing home costs are so high in New York that few individuals can avoid Medicaid over an extended period of time.[6] Thus, New York is targeting a higher-income population with potentially more assets than are the other states.

The key observation supporting the public-private approaches is that long-term care insurance that covers shorter periods of nursing home and

4. Medicaid law allows states great flexibility in determining countable income and assets of medically needy patients—patients with high medical bills in relation to their income. In essence, states using this strategy exclude insurance-related assets from their definition of resources that must be counted in determining Medicaid eligibility. However, the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) severely restricts the ability of additional states to pursue this option by including the insurance-related protected assets in an individual's estate. OBRA 93 requires states to attempt to recover the cost of institutional care from the estates of Medicaid patients. Thus, patients may not be able to pass on these additional funds to their heirs, substantially lessening the appeal of this approach.

5. In both models, nursing home patients must still contribute all of their income toward the cost of care except for a small (usually $30 per month) personal needs allowance.

6. In 1993, the average Medicaid rate was $185 per day, compared with $88 for the United States as a whole (American Health Care Association, 1996).

home care is cheaper and more affordable than policies that cover longer periods of care.[7] The problem with the current system is that if an individual buys a policy that covers, for example, two years of nursing home care and ends up staying in a nursing home five years, then the insured's assets can still be lost. Thus, under these Medicaid initiatives, it is possible to obtain lifetime asset protection without having to buy an insurance policy that pays lifetime benefits. Proponents of this approach contend that the goal is not asset protection per se, but preservation of financial autonomy toward the end of life.

Supporters assert that by encouraging purchase of insurance, Medicaid long-term care expenditures will possibly be reduced or, at least, will not increase. This argument is probably stronger for the approach used by Connecticut, Indiana, Iowa, and California, where there is a dollar-for-dollar correspondence between the amount the insurance pays and the level of Medicaid-protected assets. In New York, the ability to protect potentially large amounts of assets makes this argument weaker, although still possible. To the extent that these systems are budget-neutral, these strategies will be a move toward what economists call Pareto optimality, that is, making some people better off without making anybody worse off. Insurance dollars are simply substituted for private asset dollars.

There are two other potential advantages to this approach. First, since only "approved" policies are eligible for the enhanced asset protection, state regulators can use the initiative as a carrot to induce insurance companies to upgrade the quality of their policies.[8] Second, by giving the elderly the alternative of protecting their assets by purchasing insurance, legal and illegal transfers of assets for the purpose of obtaining Medicaid eligibility may be reduced.

Despite these arguments, there are several concerns about the equity and efficiency of this option. The first concern is whether it is appropriate to use a means-tested welfare program—Medicaid—as a mechanism

7. For an individual who is age sixty-seven, a prototype individual private insurance policy costs $2,337 a year for a policy that covers four years of nursing home and home care, but $1,617 a year for a policy that covers only two years of nursing home and home care (Wiener, Harris, & Hanley, 1990).

8. For example, Connecticut mandates compound inflation adjustment of indemnity benefits. In addition, the state is requiring a type of nonforfeiture benefit that mandates companies to offer a policy with less extensive coverage to individuals who discontinue their premium payments and let their policy lapse. Connecticut has also mandated training for insurance agents selling certified policies and is requiring the distribution of a consumer booklet that compares insurance policies.

to protect the assets of upper-middle and upper-income elderly. Indeed, under this approach, it remains an open question how far down the income distribution insurance purchase will go. Computer simulations by Wiener, Illston, and Hanley (1994) suggest that the vast bulk of private insurance expenditures will be for the relatively well-to-do elderly.

The second concern is whether providing improved asset protection will actually induce substantial numbers of people to purchase long-term care insurance who would not otherwise have bought it. As of December 1995, participation in partnership plans had been disappointing, with only 11,399 policies in force, over half of which were in New York State (Laguna Research Associates, Inc., 1996). While it is difficult to precisely measure people's motivations for buying insurance, one study of purchasers found that only 23 percent of respondents listed protection of assets as the "most important" reason for buying insurance (LifePlans, 1995). Asset protection may have a narrow appeal because most elderly have relatively modest levels of financial wealth (Radner, 1993).

Politically, by emphasizing asset protection, advocates of this strategy lean heavily on a weak reed for public support for long-term care reform. If long-term care reform is primarily about ensuring the intergenerational transfer of wealth, then many people may ask what the public interest in such an initiative is.

Even more fundamentally, many elderly do not want easier access to Medicaid. Indeed, one of the major reasons people buy long-term care insurance is to avoid having to apply for welfare. One survey of insurance purchasers found that 91 percent of respondents reported that avoiding Medicaid was an "important" or "very important" reason for buying a policy (LifePlans, 1995). Medicaid's relatively low reimbursement rates have led to inadequate access and quality of care problems in nursing homes heavily dependent on Medicaid (Nyman, 1988; Institute of Medicine, 1986; Scanlon, 1980). In addition, upper-middle and upper-income elderly will probably find the $30 a month personal needs allowance of the Medicaid program to be inadequate. Therefore, they would use up at least some of their newly protected assets for daily living expenses. Avoiding Medicaid is also the principal argument that insurance agents use to market policies; the partnership plans require a radical revision in an agent's sales pitch. In sum, it is not clear that easier access to Medicaid will be enough of an inducement to get large numbers of additional elderly to purchase private long-term care insurance.

The third concern is whether the public-private partnership will be truly budget-neutral. After all, Medicaid benefits are being offered to

people who would otherwise not be eligible. Because most policies probably will be sold to healthy young elderly who are at least ten years to twenty years away from needing nursing home care, even fragmentary evidence as to the effect of the partnership on the public purse will not be available for a decade or two. If additional public expenditures should prove to be required, then one may well ask whether providing asset protection to relatively well-to-do elderly is the best place to put the next long-term care dollar.

It is also important to realize that an indispensable component for assessing the effect on the Medicaid budget is establishing a comparison level of expenditures. In a world with no private long-term care insurance at all, it is likely, although not certain, that the partnership would be budget-neutral. However, there is likely to be continuing modest growth in the number of private long-term care insurance policies sold. Compared to this scenario, if the partnership does not induce substantial numbers of additional insurance purchasers, then the partnership will require larger Medicaid expenditures than would otherwise be needed. This is because under current Medicaid rules purchasers of insurance who would have bought policies without the public-private partnership would have to spend down their assets after their insurance benefits have been exhausted before qualifying for Medicaid—something that they are not required to do under the partnership.

In addition, while supporters argue that the partnership offers persons a more appealing alternative to transferring assets as a way to avoid Medicaid's claim on these resources, it is conceivable that it will actually *increase* the level of premature asset transfer. Current rules prohibit the transfer of assets to other persons at less than fair market value for thirty-six months prior to application for Medicaid eligibility (Burwell & Crown, 1996). Once the partnership has encouraged the elderly to look to Medicaid as a way to protect their assets, some insurance purchasers may only buy the thirty-six months' worth of coverage required to comply with Medicaid rules and then legally transfer the remainder of their financial wealth upon entry into a nursing home. Others may calculate that they can transfer or shelter their assets and obtain Medicaid benefits without purchasing any long-term care insurance policy.

Conclusions

Limitations in the affordability of private long-term care insurance for the elderly and the lack of employer contributions in the group market have led to a range of proposals to provide public subsidies as a way to expand the market. This essay examined three broad options to jump start the private long-term care insurance market.

One strategy is to clarify the tax code in ways that encourage employers to contribute to the cost of private long-term care insurance for their employees. This strategy is contained in the Kassebaum-Kennedy law. However, even with tax incentives, most large corporations face a large unfunded liability for retiree acute care benefits and are unlikely to want to contribute to yet another benefit for retirees.

Another option would improve the affordability of private long-term care insurance by offering tax deductions or credits to individuals who purchase policies. Again, this strategy is contained in the Kassebaum-Kennedy law. This approach is likely to be highly inefficient, with most of the benefits going to persons who would have bought the policies without the subsidy. Moreover, at most levels of subsidy, this strategy is not likely to be able to reduce the price enough to significantly improve affordability for the elderly.

A final option would provide easier access to Medicaid for people who purchased approved private long-term care insurance policies. People who do so would be able to retain a higher level of assets than is normally permitted and still be Medicaid-eligible. This approach can provide a lifetime level of asset protection without requiring people to buy expensive policies with unlimited coverage. It is not clear, however, whether many people want easier access to Medicaid, which is, after all a welfare program, even if it allows greater asset protection. Moreover, the strong emphasis in this strategy on asset protection makes the appropriateness of government efforts to protect inheritances open to question.

In sum, common sense dictates that private insurance is more likely to be affordable with these types of public subsidies than without them. But such approaches are likely to be only modestly effective in improving the affordability of private long-term care insurance compared to the unsubsidized options; most people are unlikely to ever have private long-term care insurance. Two approaches described here (employer tax subsidies and tax deductions or credits for individual purchasers) will result in significant tax losses to the federal government, and the third (waiver of Medicaid asset depletion requirements for purchasers of qualified policies) might increase Medicaid spending. Thus, policymakers must decide whether they wish to put additional spending into direct funding of services or whether they want to put it into promoting private insurance.

References

American Health Care Association. (1996). *Facts and trends: The nursing facility sourcebook, 1996.* Washington, DC: American Health Care Association.

Burwell, B., & Crown, W. (1996). Medicaid eligibility policy and asset transfers: Does any of this make sense? *Generations, 20,* 78–83.

Cohen, M. A., Kumar, N., McGuire, T., & Wallack, S. S. (1992). Financing long-term care: A practical mix of public and private. *Journal of Health Politics, Policy and Law, 17,* 403–423.

Cohen, M. A., Tell, E. J., Greenberg, J. N., & Wallack, S. S. (1987). The financial capacity of the elderly to insure for long-term care. *Gerontologist, 27,* 494–502.

Committee on Ways and Means. (1996). *Overview of entitlement programs: Background material and data on programs within the jurisdiction of the Committee on Ways and Means, 1996.* U.S. House of Representatives. Washington, DC: U.S. Government Printing Office.

Coronel, S. (1993). *Long-term care insurance in 1991.* Washington, DC: Health Insurance Association of America.

Coronel, S., & Caplan, C. (1996). *Long-term care insurance in 1994.* Washington, DC: Health Insurance Association of America.

Coronel, S., & Fulton, D. (1995). *Long-term care insurance in 1993.* Washington, DC: Health Insurance Association of America.

Crown, W. H., Capitman, J., & Leutz, W. N. (1992). Economic rationality, the affordability of private long-term care insurance, and the role of public policy. *Gerontologist, 32,* 478–485.

Cruciano, T. M., & Strudler, M. (1996). Individual tax returns and tax shares, 1993. *SOI Bulletin, 16,* 7–35.

Employee Benefits Research Institute. (1989). Issues and trends in retiree health insurance benefits. *EBRI Issue Brief* (No. 89).

Foster Higgins, Inc. (1993). *Health Care Benefits Survey, 1992, Report 2: Retiree health care.* New York: Foster Higgins.

Institute of Medicine. (1986). *Improving the quality of care in nursing homes.* Washington, DC: National Academy Press.

Internal Revenue Service. (1996). Selected historical and other data. *SOI Bulletin, 16,* 126–128.

Laguna Research Associates. (1996). *Partnership for long-term care: National evaluation summary statistics as of December 31, 1995.* San Francisco, CA: Laguna Research Associates.

Lewin-VHI, Inc., & The Brookings Institution. (1996). *Key issues for long-term care insurance: Ensuring quality products, increasing access to coverage, and enabling consumer choice.* Fairfax, VA: Lewin-VHI.

LifePlans, Inc. (1992). *Who buys long-term care insurance.* Washington, DC: Health Insurance Association of America.

LifePlans, Inc. (1995). *Who buys long-term care insurance: 1994–95 Profiles and innovations in a dynamic market.* Washington, DC: Health Insurance Association of America.

Nyman, J. A. (1988). The effects of competition on nursing home expenditures under prospective payment. *Health Services Research, 23,* 555–574.

Radner, D. B. (1993). An assessment of the economic status of the aged. *Studies in Income Distribution* (No. 16). Washington, DC: Social Security Administration.

Rivlin, A., & Wiener, J. M. (1988). *Caring for the disabled elderly: Who will pay?* Washington, DC: The Brookings Institution.

Scanlon, W. J. (1980). A theory of the nursing home market. *Inquiry, 17,* 25–41.

U.S. Department of Labor. (1994, 1991). *Employee benefits in state and local governments, 1990 and 1992.* Washington, DC: U.S. Government Printing Office.

U.S. General Accounting Office. (1989). *Employee benefits: Companies' retiree health liabilities large, advance funding costly* (GAO/HRD-89-52). Washington, DC: U.S. General Accounting Office.

U.S. General Accounting Office. (1993). *Retiree health plans: Health benefits not secure under employer-based system* (GAO/HRD-93-125). Washington, DC: U.S. General Accounting Office.

Warshawsky, M. J. (1992). *The uncertain promise of retiree health benefits: An evaluation of corporate obligations.* Washington, DC: AEI Press.

Watson Wyatt Worldwide. (1995). *Top 50: A survey of retiree benefits provided by plans covering salaried employees of 50 large U.S. companies as of January 1, 1995.* New York: Watson Wyatt Worldwide.

Wiener, J. M., Harris, K. M., & Hanley, R. J. (1990). *Premium pricing of prototype private long-term care insurance policies.* Washington, DC: The Brookings Institution.

Wiener, J. M., Illston, L. H., & Hanley, R. J. (1994). *Sharing the burden: Strategies for public and private long-term care insurance.* Washington, DC: The Brookings Institution.