

Long-Term Care Financing: Models and Issues

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Introduction

As the population of the United States ages, policymakers are devoting more attention to ways of strengthening the financing of long-term care for the elderly and disabled. While much of the current discussion focuses on the pressures that demographic change will place on the system, there are also concerns that people currently in need do not have uniform access to care that will promote autonomy and maintain quality of life. Many other developed countries are farther along the aging curve than the United States and have already responded with systematic reforms. There have also been innovative programs within the United States that have sought to promote consumer autonomy, service flexibility, support for informal caregiving, and improved integration of medical and social services.

Each local or national model reflects a series of choices on multiple dimensions of financing: sources of funds, mix of public and private responsibility, eligibility for benefits, and the nature and extent of covered services. This paper provides an overview of some of the basic policy choices to be made in designing a financing system; gives examples, drawn from experience in the US and elsewhere, of the possible approaches in each issue area; and summarizes equity issues or other policy concerns raised by the options. Each topic to be addressed is highly complex, and most are the subject of a large literature; a paper as brief as this one can offer only the most superficial coverage. The aim is simply to lay out the key issues and provide a starting point for further discussion and analysis.

While every effort has been made to obtain current information on each country's program, readily available source materials in English are sometimes several years old and may not reflect recent policy developments. The examples cited here should be taken as illustrations of policy options, rather than as up-to-date descriptions of national systems. Finally, most of the illustrations presented are drawn from programs serving the elderly, in part because of a lack of published sources comparing systems for the nonelderly disabled. At least some countries serve both populations under the same systems, and the basic policy issues considered here are likely to be similar for the elderly and nonelderly.

Sources of Funds

Public programs

In discussing public health or welfare programs, it is common to distinguish between social insurance programs, which cover most or all of the population and have a dedicated funding source, and social assistance programs, which are means-tested and are financed from general revenues. While these terms will be used here, some long-term care systems are more complex and may not fit neatly into one of the two categories. This section considers four key dimensions of public programs: universality versus means-testing, entitlement versus budgeting, source of funds, and division of national and local responsibility.

Universal or means-tested program

A public long-term care program can cover most or all of the population, providing benefits to anyone meeting functional disability tests or other eligibility standards, or it can serve only people whose income (and sometimes assets) are below specified levels.

Universal systems. In Germany, nearly everyone participates in a social insurance program for long-term care operated through quasi-public sickness funds. (People in the highest-income 10% of the population may opt out if they can show equivalent private long-term care coverage.) Participants make fixed contributions to a sickness fund, with matching contributions from employers (or from pension funds in the case of pensioners). Fixed benefits are available, regardless of income, to participants meeting disability and need standards.

In Japan, everyone aged 40 and over participates in a social insurance program operated by municipalities. This program, also funded through employer and employee contributions and deductions from pensions, provides disability-based benefits to all participants (except that those aged 40 to 64 are covered only for disability resulting from aging-related conditions such as Alzheimer's or stroke).

In Sweden and Denmark, everyone of all ages is entitled to receive long-term care services through municipal programs funded through general revenues. This approach is sometimes referred to as the "social democratic" model, in contrast to the contributory social insurance models of Germany or Japan.

Means-tested systems. In the United States, a few services on the border of acute and long-term care (care in skilled nursing facilities and home health care for people requiring skilled services) are covered by the universal Medicare program. But most public long-term care funding is through the joint federal/state Medicaid program, funded through general revenues, which covers only people meeting stringent income and asset standards. Similarly, in the United Kingdom, the universal National Health Service covers medical home health care, but personal and social services are furnished by localities on a means-tested basis.

Hybrids. A simple dichotomy between universal programs and programs aimed at the poor may not adequately characterize some systems. A universal program can cover everybody but vary benefits according to income.¹ France’s new *allocation personnalisée d’autonomie* (APA) provides disability-based cash payments to be used for long-term care services for people aged 60 and over. While there is a single maximum benefit amount for a person with a given level of disability, participants must pay coinsurance of up to 90%, on a sliding scale based on income. As table 1 shows, the effect is a universal entitlement with benefits based on a disability/income grid.

Table 1. Maximum Monthly Payment by Income and Disability, French APA Program, 2003

Monthly income (euros)	Disability level			
	4	3	2	1
623	474	712	949	1,107
1,237	368	551	735	858
1,553	261	391	522	609
2,167	154	231	308	360
2,483	47	71	95	111

Source: Author’s calculations from Kerjose.

Conversely, a means-tested program may have income standards so generous that much of the population is eligible. Israel’s social insurance program provides full benefits to aged people who meet disability tests and whose income is no higher than the average wage (or, for a couple, 1.5 times the average wage) – a test likely to be met by many pensioners. Benefits are then phased down, so that a single person with income equal to 1.5 times the average

¹ Outside the realm of long-term care, the new Medicare prescription drug benefit will also provide a hybrid universal/means-tested benefit, with some coverage for everyone but fuller coverage for low-income beneficiaries.

wage (2.25 times for a couple) gets 50% of the maximum benefit. People with income above this level receive no benefits (Brodsky, Habib, and Mizrahi).

Finally, a number of countries have both a universal social insurance program and a means-tested social assistance program. In Germany, people who cannot meet cost-sharing requirements under the social insurance program for nursing home care are helped by local means-tested programs. There are similar systems in Austria and Belgium. (OECD)

If resources are not unlimited, is it preferable to give some form of benefit to everyone or to focus resources on the people least able to pay for their own care?

There are several arguments for a universal program. The first is familiar: a universal program is more likely to have enduring political support than a program targeted at the low-income population. That nearly every state has responded to recent budgetary pressures by cutting Medicaid reimbursement, eligibility, or benefits is a reminder of the fragility of means-tested programs (Smith et al.). Second, the need for costly long-term care, like the need for health care, is a life risk for everyone in the society. At least for the elderly and the long-term disabled, we have universal social insurance for medical care. Why should we treat long-term care as a welfare issue? Finally, the disparate treatment of medical and long-term care complicates efforts to coordinate services across the whole spectrum.

The basic argument for means testing is that, if there is a limit to the resources the society is prepared to devote to a program, assistance should be targeted to the people who need it most. Some analysts contend that countries with universal programs may tend to give some amount of service to a great many people but fail to meet all the needs of people with no other financial resources (Brodsky, Habib, and Mizrahi). Critics of this argument suggest that a program serving the non-poor as well as the poor may mobilize greater resources per person overall, so there might actually be more available for the poor than in a lower-funded program for the poor only. (Brodsky et al.)

One other common argument for means-testing is that providing long-term care benefits to higher income people amounts to estate protection, allowing them to pass along assets to heirs instead of using them for care.² One possible response is Medicare also protects assets; no one suggests that wealthy

² This argument was the basis for the current restrictions on expansion of the state partnership programs, which offer some asset protection to people who buy private LTC insurance and then need Medicaid when the benefits run out. Concerns about transfers of wealth may carry less weight with a Congress that has temporarily repealed the estate tax.

beneficiaries should pay for their own liver transplants. But long-term care might be perceived differently, especially if a program provided cash benefits in lieu of services (this option is discussed below).

Entitlement or budgeted program

A public program can be an entitlement, providing a defined set of benefits to everyone meeting eligibility standards and involving an open-ended financial commitment.³ Or it can operate on a fixed budget, staying within the budget by adjusting eligibility thresholds, limiting services, or establishing waiting lists.

Entitlement systems. The broadest possible entitlement would provide all necessary services to everyone who needed them. Some of the Scandinavian systems nominally do so. Under Sweden's Social Services Act, for example, individuals have a right to services if "the needs cannot be met in any other way." In practice, the long-term care program is operated by local governments that may adjust the definition of need to fit available finances. (Trydegård) It does not appear that there is any nation offering a public long-term care program that provides an unlimited entitlement to a package of direct services, in the way that some health insurance plans offer nearly unlimited benefits.

Germany and Japan provide services (or, in Germany, an optional cash alternative) up to a fixed periodic per capita amount based on level of disability. These programs are *limited* entitlements whose costs are fairly predictable, at least over the near term. They may face budget overruns if estimates of prevalence of disability or benefit take-up are incorrect, but not because people use more services or more costly services than expected.

France's new autonomy pension system, initiated in January 2002, is an example of a limited entitlement that actually did face budget overruns because of unexpectedly high participation. Costs were nearly half again as high as initially estimated (€3.7 billion instead of €2.5); the government has already responded by tightening eligibility and lengthening the delay before benefits are available (Morel).

³ The Congressional Budget Office (CBO 2003) defines an entitlement as a "legal obligation of the federal government to make payments to a person, group of persons, business, unit of government, or similar entity that is not controlled by the level of budget authority provided in an appropriation act. The Congress generally controls spending for entitlement programs by setting eligibility criteria and benefit or payment rules." Entitlement programs thus involve defining both a covered population and the nature or amount of the benefits to be provided.

Budgeted systems. In the US, the Medicaid home and community-based services (HCBS) waiver programs operate on a prospective budget. A waiver program (a state may have several) serves a specified maximum number of individuals who meet specified financial and disability standards. Waiting lists are used if there are too many qualified applicants. Each program is expected to cost, in the aggregate, no more than would have been spent to serve the same individuals in nursing facilities or ICFs-MR. Although states are not penalized after the fact for exceeding this limit, they must show in advance that their programs are likely to comply. Some programs cap spending for each participant, while others allow higher spending for some individuals so long as the aggregate is not exceeded (LeBlanc, Tonner, and Harrington).

The long-term care component of the 1993 Clinton health care proposal would have provided fixed grants to states to furnish a state-defined package of long-term care services to people with limitations in 3 or more activities of daily living (ADLs) or severe cognitive disability, regardless of income. States would not have been permitted to impose additional participation standards or use means-testing, but would apparently have been permitted to use waiting lists or limited services to stay within the budgeted amounts.

Both the existing HCBS programs and the Clinton proposal might be thought of as quasi-entitlements: while the number of participants is limited, eligibility standards and benefits are fixed. Participants have an enforceable right to specified services, and applicants who meet eligibility standards have a right to a place on the waiting list. Budgeted systems may instead ration more informally. In England, for example, where localities provide services under fixed allocations from the central government, there are no formal eligibility or benefit standards. Needs are assessed and services doled out on an ad hoc basis; people cannot be certain what kind of help they might be eligible for (Royal Commission).

The apparent advantage of a budgeted program is that its costs are entirely predictable. At a time when the nation has not resolved how to sustain the Social Security and Medicare programs, it may be hard to make a case for an open-ended “third pillar” of social protection. But a budgeted program may not be workable for very long. Under the Clinton plan, for example, it would have been possible for some people to receive extensive services while other people with identical resources and needs received nothing at all. Critics of the scheme argued that there would inevitably have been pressure to expand the scheme to reach every eligible person (Fuchs and Merlis).

An entitlement program, while it may be fairer, is likely to be designed to achieve some desired spending level. Given limited funds, an entitlement may

wind up providing too little assistance to everybody. As will be seen, some systems pay considerably less than the expected costs of needed services. These shortfalls are partly deliberate; people are expected to draw on their own resources to some extent. But some people will inevitably have unmet needs.

A final concern about an entitlement is, of course, that people feel entitled to it, making it difficult to cut or even modify the benefits over time. This may be especially true if the program provides cash benefits; it might be easier to tinker with a service benefit package than to reduce a cash allowance. (However, cash allowances can be effectively “cut” over time by failing to provide for automatic inflation increases. In Germany’s program, any benefit increase must be legislated; Cuellar and Wiener)

Dedicated or general funds

A public long-term care program can be funded through a dedicated revenue source – premiums or an earmarked tax – or through general revenues. While social insurance is commonly associated with dedicated funding and social assistance with general funding, the relation is not so firm in long-term care programs. Several universal plans are funded through general revenues or a combination of premiums and general funds. On the other hand, no means tested plan has a dedicated revenue source, presumably because it is politically impossible to impose a visible tax on people who have no chance of qualifying for benefits.

Germany’s program is funded through a premium, effectively a payroll tax of 1.7% of wages, shared equally by employers and employees. Retirees pay a similar premium, shared equally by retirees and pension funds. In the Netherlands, the extraordinary medical expenses scheme (AWBZ) is funded through a tax equal to 9.6% of wages up to about \$25,000 (in 1998 dollars); people with higher earnings pay a flat rate. This tax is included in the overall income tax withheld from wages and is thus more or less invisible (Huijbers and Martin).

Payroll taxes in Japan are about 0.9% of income for workers aged 40-64, again split equally between employers and employees. People aged 65 and over pay a sliding scale premium that averaged \$26 a month in 2000. Dedicated taxes and premiums cover only half the cost of Japan’s program; the rest is covered through general funds – 25% national and 12.5% each from the prefecture and

the municipality (Campbell and Ikegami).⁴ The universal programs in Austria and France are entirely paid from general funds.

In the current budgetary environment, a program financed through a dedicated revenue stream may seem more attractive than one that places additional strains on general funds. Whether a new tax is salable may depend on whether the people who pay it think they're buying some tangible benefit. Strikingly, while private long-term care insurance depends on an accumulation of premium funds over many years to pay for a risk late in life, the public long-term care systems that use premiums all operate on a pay-as-you-go basis. Current workers are paying for current service use and are not pre-funding their own services. Younger workers may already feel that they are paying into social insurance systems from which they might never benefit and may resent an additional levy, particularly as they may have difficulty imagining that they will ever need long-term care. Japan's system provides a partial solution by taxing only people aged 40 and over, who may be more conscious of their own long-term care risks and the needs of their aging parents, and who are also likely to be more able to pay.

One drawback to a dedicated tax is that it may be difficult to modify benefits in the future if people feel that they have already paid for them – even if, as in the case of Medicare, their contributions cover a fraction of the cost (Brodsky et al.). One reason France could make rapid and fairly drastic benefit cuts in a universal entitlement program was that the program used general funds; no one had “earned” the original benefits (Morel).

All of the existing long-term care taxes or premiums are regressive for current workers, as they are imposed on wages and not on investment earnings or other income sources. (Note, however, that most of the systems – unlike Medicare part A – do require ongoing payments by people who are already retired and have pension income.) Because the recently enacted programs partially replace existing systems that were financed through general funds, they have to some extent shifted the burden of public long-term care financing from higher-income to lower-income people. The extent to which this is true depends on how progressive the general revenue system is. In the US, current Medicaid funding for long-term care is largely drawn from progressive federal taxes (although the state share is derived from tax systems that are often highly regressive). A payroll-tax funded universal long-term care program that

⁴The retiree premiums are set by each locality, with the other funding components, including distributions from the national pool of payroll taxes, provided at fixed ratios to the local premium receipts. This places municipalities at some degree of risk; Campbell and Ikegami.

replaced Medicaid might mean a transfer of funds from lower to higher-income people.

Division of national and local responsibility

In most countries, public long-term care programs are operated by some level of local government or there is some mix of local and national programs. There are several different ways of distributing financial responsibility.

In the countries that maintain both social insurance and means-tested social assistance programs (Austria, Belgium, Germany) the social insurance is national and the supplemental social assistance is local. This reflects the fact that the social insurance has been recently grafted onto systems that previously offered only local means-tested coverage. Alternatively, national and local programs can cover different long-term care services. In Australia, for example, nursing home care is federally funded, while home care is provided by state programs with partial federal funding.

In some countries, localities operate the long-term care program with some central government contribution. This is true of Medicaid in the US and of the means-tested social assistance program in the United Kingdom. However, the universal programs in Scandinavia are also locally operated. In Finland, Norway, and Sweden, localities receive block grants; the grants cover 30% of costs in Finland and only 15% in Sweden (OECD). While coverage is universal, benefits or required cost-sharing may vary according to local ability to raise funds. Differences in the proportion of the population served and in local charges has been especially high in Sweden; some attempt to reduce variation was initiated in 2002 (Trydegård).

In Denmark, municipalities provide long-term care with no central government contribution. As in Sweden, the result is substantial variation in spending per elderly individual. One study has found that, while local spending levels generally rise with the prevalence of disability in a municipality, spending per elderly person goes down when the ratio of elderly people to the total population increases – presumably because municipalities with high dependency ratios cannot raise adequate resources on their own. (Hansen) Canadian provinces also provide long-term care with no earmarked federal contribution (a single population-based block grant is meant to cover medical care, long-term care, education, and social assistance), with similar results (Canada Senate).

There are advantages in the continued use of localities to administer long-term care services even if a new national public program were developed. States

have established provider networks and assessment and case management. They are also better positioned to coordinate long-term care with the variety of other social services and supports dependent people may need. However, eligibility for services and the scope of benefits are likely to vary according to where someone happens to live. One recent study compared how several states' Medicaid programs would treat illustrative hypothetical cases of elderly and nonelderly people with specified needs. There was considerable variation in the nature and quantity of services that states would offer, waiting lists for services, and actual supply of providers for services nominally covered (Summer).

It would be possible to subject local long-term care programs to some national standards; Medicaid has such standards for medical care, but generally not for long-term care. However, to the extent that current local variation reflects different revenue capacity, uniform standards might need to be accompanied by a better system to redistribute funds according to local needs.⁵

Private funds

Private insurance

Growing numbers of Americans are purchasing private long-term care insurance. Cumulatively, nearly 8.3 million policies had been sold through 2001, of which 1.4 million were sold in 2000 and 2001; how many of these policies are still in force is not known (Health Insurance Association of America). Unlike private health insurance, which operates on a pay-as-you-go basis, private long-term care insurance—like life insurance—relies on the accumulation and investment of premiums over a long period. It is therefore less costly for younger purchasers, for whom the risk of needing services is many years away.

Private long-term care insurance is quite rare in other countries. In Germany, the 10% of the population that is exempt from the compulsory social insurance scheme must either participate voluntarily or purchase equivalent private coverage. There is also a small market for supplemental policies that make up for some the payment shortfalls in the public program. About 0.8% of the population had such policies as of 2001 (Hurst et al.). A private supplemental insurance market has also developed in Sweden in response to cutbacks in public services and increases in user fees (Pacolet et al.). The possible role of supplemental policies in complementing a public program will be

⁵ The current Medicaid formula, based solely on states' per capita income, has long been criticized for failing to take into account differences in states' fiscal capacity and need for services. But proposals to revise the formula have been stymied because it is politically difficult to redistribute funds among states.

considered later in this paper; the following discussion considers only insurance meant to serve as the primary payment source for long-term care.

There are several ways of promoting greater reliance on private long-term care insurance. As in Germany, people above a given income level could be required to obtain some amount of coverage. But, because people's incomes fluctuate, this could mean that many people would shift in and out of private coverage every year. This may be workable in Germany because people can buy long-term care coverage through the sickness funds, which operate on a pay-as-you-go basis. However, long-term care insurance in the US works on an investment model, with participants' premiums accumulating over time to cover expected ultimate utilization. This might not be feasible if people were churning in and out of the coverage.

Voluntary purchase of long-term care insurance could be promoted through tax incentives. Long-term care insurance premiums for policies meeting certain standards are currently deductible, but only for taxpayers who itemize deductions, and only to the extent that the sum of premiums and other medical expenses exceeds 7.5% of adjusted gross income. The Bush Administration has proposed an "above the line" deduction, which would be available to non-itemizers and without regard to the 7.5% threshold; similar proposals have attracted considerable support in Congress.

Supporters of expanded tax preferences argue that promoting the purchase of long-term care insurance will both protect consumers against possible catastrophic losses and ultimately save the federal and state governments by reducing future Medicaid outlays. Opponents contend that much of any new tax expenditure might go to people who would have bought long-term care insurance anyway, and that long-term care insurance will remain a "niche" product, attractive chiefly to wealthier people at or near retirement age. The dynamic might change if the tax preference took the form of a tax credit or a refundable credit rather than a deduction, which provides greater assistance to higher-income people.

One could conceive of a system that would provide the largest tax benefit to lower-bracket taxpayers and then phase out with higher incomes. However, given that most middle-income workers are not making adequate provision for retirement or other more immediate insurance needs, it may be unrealistic to expect that even generous subsidies would encourage very many to voluntarily purchase long-term care insurance (Merlis 2003). Older people would likely be more interested but, because they face much higher premiums, considerably larger subsidies might be needed.

Private income and savings

Currently in the US, private resources (other than insurance) are the second largest source of payment for home health and nursing home care.⁶ There are several options for increasing the resources that might be available to individuals, or better drawing on existing resources, to pay for long-term care.

First, there could be some form of tax-favored savings for long-term care expenses. The Medicare prescription drug law enacted in 2003 provides for health savings accounts (HSAs), under which an individual buys a high-deductible medical insurance plan and can set aside funds to pay that deductible or to buy non-covered medical services. One allowable use of the HSA is to pay long-term care insurance premiums (U.S. Internal Revenue Service). In addition, the funds can be accumulated over time and could ultimately be used for direct long-term care spending.⁷ However, the amounts that can be set aside are sharply limited, the participant must switch to a high-deductible medical plan, and no further deposits are permitted once the participant receives Medicare. A program specifically aimed at long-term care might do without these restrictions and could still be cost-effective if use of the savings delayed reliance on public funds. However, because long-term care is very costly and not everyone will ultimately require it, it makes more sense to pool savings through insurance than to promote individual savings.

An alternative considered by the American Academy of Actuaries (1999) would have allowed people to pay into a public or private savings program during their working lives. As they neared retirement age, they would decide whether to take the proceeds in the form of insurance or in the form of a retirement annuity. The major potential problem with allowing this kind of deferred decision-making is adverse selection at the time the decision is finally made. One solution explored by Warshawsky, Spillman, and Murtaugh. would allow people with accumulated savings at retirement age to buy a single product that includes both an annuity and some amount of long-term care protection.

⁶ Out-of-pocket payments for nursing home and home health care in 2002 were \$32 billion, compared to \$59 billion by Medicaid and \$24 billion by Medicare (CMS). Note that nursing home payments made using Social Security benefits are included in the private out-of-pocket figure. In some other countries, comparable pensions are paid directly to the nursing home, or are suspended for people receiving public LTC benefits. This accounts for some of the disparity in "private" shares of LTC spending in the US and other countries.

⁷ HSAs resemble the existing Archer medical savings accounts (MSAs). However, previous law allowed only 750,000 Archer MSAs and had a sunset provision, possibly discouraging insurers from offering the product; the HSAs have no such limits.

Home equity is an important component of the wealth of most elderly households and could be a larger source of funding for long-term care in the community. Reverse mortgages, under which a lender advances money to an elderly person in return for a future claim on the home, have been available since the 1960s but remain very rare; only 18,000 new federally insured reverse mortgages were written in 2003 (National Reverse Mortgage Lenders Association). Some of the borrowers are presumably using the proceeds to pay health or long-term care costs, and Connecticut has a state-run reverse mortgage program specifically for homeowners with long-term care needs. Reverse mortgages are costly, and a borrower with extensive needs might quickly exhaust available equity. Better protection might be provided if borrowers pooled their risks through the purchase of long-term care insurance. However, as one recent study points out, reverse mortgages offer higher payouts to older borrowers, while long-term care insurance is most affordable for younger purchasers (Ahlstrom, Tumlinson, and Lambrew). Some form of hybrid product might be needed to resolve this conflict.

Family resources

While the role of family members in providing informal care to disabled people living in the community has been widely discussed, there has been less attention to their role in financing formal services. At one time, most countries assumed that families would have the primary responsibility for paying for long-term care, with public assistance targeted at people with no available family support. In the US and in other countries with means-tested social assistance programs, income and resources of spouses are commonly considered in determining eligibility. A few countries also consider the availability of support from children or more distant relatives. “Filial obligation” laws in Austria, France, and Germany apply to social assistance but not to social insurance benefits (Jenson and Jacobzone). Countries that do not have specific rules on this subject but that have subjective processes for determining benefit eligibility (such as the “holistic” assessments in the Netherlands; see below) might also consider family supports (Brodsky, Habib, and Mizrahi).

A few US states have adopted filial obligation laws, but these have been unpopular, vaguely worded, and difficult to enforce. State Medicaid programs are required under certain conditions to seek recovery from the estates of beneficiaries who received long-term care; this may have the effect of depriving relatives of bequests they might otherwise have received. France has recently repealed similar requirements (Morel).

Families undoubtedly contribute to long-term care costs voluntarily, without any legal obligation. (The extent to which disabled people rely on family resources in the US is unknown.⁸) Families may also supplement expenditures under public programs to fill gaps or to obtain higher-quality care. In the United Kingdom, for example, relatives of nursing home residents commonly make extra payments to obtain better accommodations (Pacolet et al.). This supplementation is explicitly forbidden under US Medicaid law, for fear that facilities will extort extra payments from families having difficulty locating a nursing home placement.

US tax law provides a limited credit for taxpayers who have paid for services for a disabled dependent. The dependent must live with the taxpayer and the care provided must be necessary to allow the taxpayer to work or look for work.⁹

The Public/Private Mix

In the US, most people are expected to pay for long-term care services on their own or with private insurance unless their income and assets are within Medicaid limits.¹⁰ People whose resources are above the Medicaid standard in their state spend their savings until their assets are below the limit—\$2,000 for an elderly individual and \$3,000 for a couple.¹¹ In 35 states and the District of Columbia, people who meet the resource limit but not the income limit can spend down by using their excess income to pay for medical and long-term care (Schneider et al.). Someone in a nursing home spends all her income except a small personal needs allowance; if this is insufficient to pay her bill, Medicaid kicks in. Someone receiving home care spends down to the applicable income limit, retaining the rest to meet living expenses. Medicaid eligibility in most states thus has a durational component—people remain in private-pay status

⁸ In the US, surveys that include information on sources of payment, such as the National Nursing Home Survey and the National Home and Hospice Care Survey, do not distinguish between payments from the patient's own resources and payments by relatives.

⁹ This credit should not be confused with fixed tax credits proposed by both the Clinton and Bush administrations for families with members needing LTC. The proposed credits, which would be available whether or not any services were actually purchased, are discussed in the section on caregiver support, below.

¹⁰ Some alternative programs are available for specific populations. For example, the Department of Veterans Affairs has been providing an expanding range of long-term care services as World War II veterans enter their seventies and eighties.

¹¹ Larger amounts of resources can be retained by the community spouse of a beneficiary in a nursing home.

until they have exhausted their assets – and a form of cost-sharing, under which part of people’s income goes to pay for services.¹²

There are at least three other ways in which public and private financing responsibility could be divided:

- Public and private resources might be used at different points in the life course of a disabled person.
- For both institutional and home care, cost-sharing could be restructured in ways familiar from the medical care sector: deductibles, coinsurance, or fixed copayments.

Coverage by duration of care

In the US, a number of schemes have been advanced under which people would use their own resources or private insurance to pay for long-term care for a fixed time period, after which a public program would assume responsibility. There have also been proposals to do the reverse: provide public coverage at the onset of disability and then at some point require use of personal resources. It is not clear that anything comparable has been considered in other countries, although some programs do have waiting periods for benefits similar to those imposed by private long-term care policies in the US. For example, the French autonomy pension begins no less than two months after the filing of a complete application.

The one durational system actually in operation is the set of Partnership for Long Term Care projects initially sponsored by the Robert Wood Johnson Foundation. Under these arrangements, currently approved in four states, individuals buy long-term care insurance policies meeting specified minimum standards. If the policyholder receives long-term care and exhausts the benefits available under the private coverage, he or she can then obtain Medicaid under more liberal eligibility policies that protect a larger share of assets. For example, if someone’s long-term care insurance policy has paid \$50,000 toward that person’s care, the person can retain \$50,000 in savings, rather than the \$2,000 maximum usually permitted under Medicaid.¹³

¹² In the 16 states without this medically needy option, people with income above the limits theoretically receive no assistance regardless of service need; in practice, the limits can be bypassed through mechanisms known as “Miller trusts.”

¹³ This is the model used in California and Connecticut; programs in New York and Indiana work somewhat differently (Meiners).

These programs are potentially a winning proposition for the policyholder and are designed to be at least budget neutral for Medicaid. However, Medicaid law limits expansion by providing that, in any new program not already approved as of the date of enactment, Medicaid must retain the right to recover any long-term care expenditures from the policyholder's estate, including the assets that were theoretically sheltered. Congress acted on the view that public dollars should not be used to protect private inheritances. As a result, some states that were preparing to replicate the partnership programs have abandoned their efforts. The original programs continue to operate, and there is some evidence that they have attracted buyers who would otherwise not have purchased insurance. Because few participants have yet reached the point of needing services, it may be many years before the cost-effectiveness of the projects can be evaluated (Meiners, McKay, and Mahoney).

The 1990 US Bipartisan Commission on Comprehensive Health Care (the Pepper Commission) considered a variety of options for "front-end" and "back-end" public coverage of nursing home stays. Estimates of the proportion of elderly nursing home entrants covered were as shown in table 2. The front-end options protect the resources of people who are able to return home after a short stay, but people who stay longer risk impoverishment. The back-end options cover fewer entrants but preserve the life savings of residents with very long stays – *if* they have sufficient funds to carry them through the deductible period. Under these options some people who might have returned home could impoverish themselves before gaining coverage. The Commission ultimately chose a combination of three months of federally funded front-end coverage for everyone and a federal/state program for longer stays that would have protected much higher amounts of non-housing assets than Medicaid does.¹⁴

Table 2. Coverage of Nursing Home Entrants Under Proposals Considered by the Pepper Commission

	Percent of elderly	
	Covered	Covered for full length of stay
Cover from admission ("front-end") through--		
Third month	100%	42%
Sixth month	100%	50%
Cover whole stay ("back-end") after--		
Two months	67%	0%
Two years	25%	0%

¹⁴ Asset limits would have been \$30,000 for an individual and \$60,000 for a couple, compared to Medicaid's \$2,000/\$4,000.

Source: Based on U.S. Bipartisan Commission.

Cost-sharing

Most countries impose some form of cost-sharing for both home care and institutional care. Cost-sharing tends to be larger for institutional care, partly because people in institutions have fewer other demands on their resources.

Home care

Table 3 shows cost-sharing requirements in selected countries for “home help,” roughly equivalent to what would be called personal care in the US. As in the US, more skilled home care, or “district nursing,” is usually covered under medical insurance. Most of the countries shown impose some form of fixed payment per visit, subject to income-based exemptions or sliding scales. The percentages shown are the average share of cost covered by copayments; this tends to be in the 10% to 15% range. France’s disability-based cash allowances are reduced by a fixed amount based on income; this financial participation is not linked to service use or expense.

Table 3. Cost-sharing for Home Help, Selected Countries

Country	Individual share
Austria	None (up to budgeted limit)
Belgium	Income-related, average 14%-20% of cost, depending on location
Denmark	None
Finland	0%-13% of cost, depending on income
France	Income- and disability-related fixed contribution
Germany	None (up to budgeted limit)
Japan	10% coinsurance
Netherlands	Copayment per hour of care, reduced for low-income, average 12%
Sweden	Income-related, average 8%, varies by area
United Kingdom	0%-10% of cost, depending on income

Source: Pacolet et al., except Austria, Germany, Japan, Netherlands (Brodsky, Habib, and Mizrahi), France (Kerjosse)

Austria and Germany, with their fixed monthly cash allowances (or, in Germany, the option of a monthly service budget), do not impose copayments. However, someone who requires services that cost more than the allowed amount will have to pay for them out of pocket. As table 4 shows, Germany’s allowance for the lowest care level (“substantial care dependency”) is set at an amount expected to be sufficient to cover 33 minutes of care a day, while

participants are expected to need 90 minutes. The difference may be thought of as an implicit coinsurance requirement. Israel’s system has similar shortfalls, while Austria’s (at least for the care level illustrated) funds sufficient care to meet expected need.

Table 4. Expected Need and Service Funding, 3 Countries

Care level	Needed	Funded
Germany, substantial care dependency	90 minutes/day	33 minutes/day
Israel, first level	17.5 hours/week	10 hours/week
Austria, first level	8 hours home help and 4 hours nursing/week	50 hours of care/month

Source: Based on Brodsky, Habib, and Mizrahi 2000.

Either explicit or implicit cost-sharing not only reduces the government share of costs for each service but also deters utilization. The deterrent effect, which would be expected to be largest for low-income people, is somewhat mitigated by income-based reductions. However, one study in Sweden found that some municipalities had deliberately raised fees to reduce use of “minor” home help; one in six people aged 75 or older had gone without services for financial reasons (Trydegård).

As was noted earlier, cost-sharing requirements and/or other care limits in Germany and Sweden have led to the emergence of a market for private supplemental insurance. To the extent that cost sharing is intended to control utilization, there is a question of whether supplemental insurance should be encouraged or restricted. The new Medicare prescription drug law prohibits Medicare supplemental (Medigap) plans from covering cost-sharing under the drug benefit and, in response to findings that Medigap raises general use of Medicare services, provides for new plan models with reduced coverage of cost-sharing. On the other hand, if the chief goal of cost-sharing is to limit the overall public share of spending, one could conceive of a system that imposed progressive cost-sharing with the expectation that higher-income people would obtain private insurance or self insure.

Institutional care

As table 5 shows, some systems have spend-down regimes for nursing home care comparable to that in the US or have cost-sharing that consumes nearly as much of income (Belgium, Finland, Sweden). In Austria and Germany,

social insurance payments are applied to the cost of care, but residents may also have to draw on pension income and, if this is insufficient, fall back on means-tested social assistance.

Table 5. Cost-sharing for Nursing Home Care, Selected Countries

Country	Individual share
Austria	80% of cash benefit, plus part of pension
Belgium	56% of total cost
Denmark	15% of income for rent, fees for heating, electrical, other services
Finland	Lesser of 80% of income or income minus personal need allowance
Germany	100% of hotel, at least 25% of total cost
Italy	100% of hotel
Japan	10% copayment plus \$200 month food charge
Netherlands	11% of income up to monthly maximum
Sweden	70% of income
United Kingdom	100% until spend-down to income/asset limit

Source: Pacolet et al., except Austria, Japan, Netherlands (Brodsky, Habib, and Mizrahi), Finland (European Commission), Germany (Cuellar and Wiener)

Many countries, in reimbursing for nursing home or other institutional services, distinguish between “hotel” costs – rent, meals, utilities, housekeeping, laundry, and other ordinary expenses of living – and costs for nursing and personal care. Residents are expected to cover the hotel costs from their pension income, as they would cover similar expenses if they had remained at home, while the long-term care program covers the costs of care. As one study of the Danish system puts it, the principle is that “even elderly people in nursing homes should be considered as tenants. The general rule now is that the economic situation of elderly people is the same irrespective of the type of housing they live in.” (Hansen)

Eligibility

Evaluating need

Both public long-term care programs and private insurance must have some method for determining who is sufficiently disabled or otherwise in need to qualify for benefits. Some systems use specific criteria, such as requiring assistance with a given number of ADLs or instrumental activities of daily living (IADLs), or needing a given number of hours of care.

Other systems rely on more subjective assessments. For example, eligibility in the Netherlands is determined through “holistic” evaluations by teams that may include nurses, social workers, and other professionals. The team considers level of disability, the home and environment, current availability of informal care, and likelihood that this care will continue. There is no uniform instrument for these assessments, and teams have a high degree of professional discretion (Brodsky, Habib, and Mizrahi).

Entitlement programs tend to use objective criteria, while budgeted programs may be more likely to use subjective assessments, which allow more or less restriction on program entry as needed to meet funding targets. Medicaid HCBS programs are about equally divided among those with a strict assessment instrument or ADL/IADL threshold and those using more subjective evaluations. (Lutzky et al.)

Objective standards have the advantage of transparency and the disadvantage of rigidity. For example, a system that uses ADLs as its sole measure of disability may exclude many people who clearly need assistance. Kassner and Jackson (1998) found that people who required assistance with no ADL or only one ADL, but with five or more IADLs, needed as many hours of care as people requiring assistance with two ADLs.

This problem can be addressed at the price of greater complexity. Japan uses an automated program that considers 73 individual characteristics (ADLs, IADLs, cognitive and other scales) to accept or reject applicants and classify them into level of care categories. But even this system does a better job of predicting need for institutional than of predicting need for home care (Okamoto 2000).

Subjective evaluations may be better able to account for individual needs and circumstances, but are unlikely to be politically acceptable in the context of a universal program. One option, adopted in Germany, is to have strict criteria for benefits under the social insurance plan and provide means-tested social assistance to people who have clear needs but fail to qualify under those criteria (European Commission).

Targeting and restricting coverage

As table 6 shows, systems using fixed criteria vary considerably in the share of the elderly population potentially eligible for long-term care coverage. Austria and Japan offer some minimal benefit to a large number of elderly people, while Belgium and Germany use much stricter criteria. In the United States, the standard for federally qualified private long-term care insurance policies established by the Health Insurance Portability and Accountability Act

(HIPAA) is near the stricter end of the spectrum: the policyholder must need assistance with 2 ADLs out of a list of 5. (In the U.S. and at least some other countries, benefits are also allowed for people with severe cognitive impairment but no ADL limitations; these standards are not shown in the table.)

Table 6. Functional Disability or Care Need Standard for Long-Term Care

Country	Minimum eligibility standard	Percent of elderly eligible
Austria	1 ADL + needs 50 hours of care per month	21% of 65+
Belgium	3 ADLs	5.5% of 65+
Denmark	1 ADL + 4 IADLs	10% of 70+
France	3 ADLs	NA
Germany	2 ADLs + needs 90 minutes help/day	5.6% of 60-80, 18% of 80+
Japan	Needs 25-29 minutes care/day, meets other specified criteria	14% of 65+
US HIPAA	2 ADLs	7%-8% of 65+

Source: Pacolet et al., except Austria (Ministry of Labor, Health, and Social Affairs), France (Kerjosse), Japan (Okamoto 2000), US (author's estimate based on 2001 National Health Interview Survey and Jones 2002)

Decisions about qualifying disability levels are driven in part by budgetary concerns but may also reflect different and sometimes conflicting goals for long-term care programs – especially programs focused on home care. On the one hand, furnishing supportive services to less disabled people may slow deterioration and prevent premature institutionalization (Schneider). Japan established its lowest eligible care group, the “borderline” disabled, specifically to provide aid for “preventive” services (Campbell and Ikegami). On the other hand, broader eligibility standards not only increase the population to be assisted but may also be more likely to result in replacement of existing informal care. Even programs narrowly focused on people whose impairments are severe enough to qualify them for nursing home admission (such as most HCBS programs for the elderly) have suffered from the “woodwork effect”: many people participate who would not in fact have entered a nursing home in the absence of the program (Doty).

One way of resolving this conflict is to combine disability standards with some consideration of the availability of family supports. Someone who is highly disabled but living with family members might require services only intermittently, while someone living alone might need help even with less severe disability. Taking account of informal supports may not be possible in a system

using objective criteria, because assessing how much support the family can provide is inherently subjective (Brodsky et al.). Moreover, in social insurance programs, considering family circumstances may be seen as incompatible with insurance concept (Cuellar and Wiener). Finally, budgetary pressures may result in simply shifting burdens to caregivers. In Sweden, for example, municipalities rarely furnish assistance to elderly women who are left with the burden of caring for their husbands (Trydegård). Efforts in US HCBS programs to control the “woodwork effect” by using double screens – disability plus some measure of actual risk of institutionalization – have similarly been criticized as unfairly penalizing family caregivers (Wiener and Stevenson).

Benefits

Home care

Form and management of benefit

Home care programs may be thought of as aligned on two dimensions, as shown in table 7. The first is the degree of consumer direction or autonomy, from systems in which an agency or care manager makes all care decisions to systems in which individuals decide what they need and how to get it. The second is the nature of the benefit, ranging from payment for formal services from recognized providers, through service budgets that may be used to pay formal and informal providers but may not be retained as income, to unrestricted cash grants.

Table 7. Autonomy and Nature of Benefits Under Home Care Programs

Management of benefit		Nature of benefit		
		Formal in-kind services	Service budget or cash that must be used for services	Unrestricted cash
Autonomy	Less ↑	Agency makes care plan, selects providers	United Kingdom, Netherlands	
	↓	Agency makes care plan, individual chooses among approved providers	Denmark, some Swedish municipalities, US non-waiver Medicaid and some HCBS	Japan, some US HCBS
	More ↓	Agency assesses need, individual makes care plan and hires providers		US cash-and-counseling, most US private long-term care insurance

Under traditional programs that pay for in-kind services, agency-selected providers furnish services under an agency-approved care plan; this can be true in a social assistance program (United Kingdom) or in a social insurance program (Netherlands). At the other extreme, represented by France’s APA, Germany’s cash option, and some private long-term care insurance policies, the individual receives funds which may be used to pay anyone for any service or may simply be retained as income. In between are a variety of programs that pay only for services but give the consumer some discretion in what services will be provided and by whom. HCBS waiver programs in the US include systems providing in-kind services (sometimes subject to an individual budget limit); systems that provide a fixed budget to an intermediary entity that buys services with more or less consumer input; and “cash-and-counseling” programs that allow participants to buy formal and informal services directly.

Cash options or programs with a high degree of consumer direction have several advantages. Consumers value autonomy and choice: one study found 95% satisfaction among private long-term care policyholders whose insurance provided cash benefits, compared to 60% among those with service-only policies (U.S. DHHS). It may be easier to set a budget than to specify an entitlement to a

particular scope of services, because long-term care needs are highly variable and diffuse (Brodsky et al.). Individual participants' needs may be met at lower cost, if consumers can pay family members or find other alternatives to formal agency services.

Note, however, that per capita savings may not translate into lower costs overall, because cash programs may have higher take-up rates than service programs. One reason Japan opted for budgeted service benefits rather than cash was to assure more gradual growth in program spending; Campbell and Ishegami. In the U.S., private policies with cash benefits tend to cost more than those with equivalent service benefits; this may be one reason that their market share is only about 10% (U.S. DHHS).

Allowing use of informal providers may raise concerns about quality, patient safety, or fraud and abuse (AARP). And some consumers – particularly those with cognitive impairments – may be unable or unwilling to manage their own benefits. A mixed cash/service program may be better equipped to address people's differing circumstances and preferences. Germany's system allows home care beneficiaries a choice between service benefits with a budget limit, a direct cash payment, or a combination of the two. The maximum cash payment is only about half the maximum allowable service budget for a participant with the same level of disability. When the program was first implemented in 1995, 83% of home care beneficiaries took cash only; this dropped to 72% by 1998 (Cuellar and Wiener). In addition, the likelihood of taking cash only dropped with increasing disability (Schneider).

Amount of benefit

Cash programs and programs, like Japan's, with fixed service budgets generally classify participants according to level of care need. The classification is established at the same time as the initial eligibility assessment and may be subject to periodic reassessment. Systems vary in the number of level-of-care tiers and in the range of benefit amounts they offer, as shown in table 8. Austria and Japan, with less restrictive participation standards, have more classes and a wider range of benefit levels than the systems that only serve the highly disabled.

Table 8. Levels of Care in Four Systems

Country	Number of levels of care	Ratio of highest to lowest benefit
Austria	7	10:1
France	4	2.33:1
Germany	3	4:1
Japan	6	6:1

Source: Brodsky, Habib, and Mizrahi; France: author's calculations from Kerjosse.

In the US, 35 states set individual budgets for participants in some or all of their HCBS waiver programs (LeBlanc, Tonner, and Harrington). Relatively few of these impose "hard" budgets, actually limiting services for specific individuals, and those that do often set limits well above average expected expenditures. Budgets may instead be used as benchmarks to track individual spending and possibly modify care plans (Wiener, Tilly, and Alexcih).

There are, however, instances in which a waiver program transfers a fixed budgeted amount per participant to an independent public or private agency; the agency is expected to cover most services using these bundled payments, which thus approach capitation. Vermont's program for the developmentally disabled sets the budgeted amount for new entrants at one of 10 flat rates (from \$7,191 to \$71,376 per year in 2000) based on the client's assessed service needs. Within the overall budget, the contracting agency develops and manages individual budgets in consultation with families or guardians (University of Minnesota). Michigan's program for the aged and disabled makes fixed daily payments to one of 23 regional "waiver agents." The payment in 2000 included \$32 per day for services and \$9 or \$10 for administration. The agency is at risk if average service costs for all clients exceed the allowance; there is an exceptions process under which an agency can obtain additional funding for clients whose services cost more than \$96 per day (Tilly and Kasten).

One alternative to fixed per capita budgets is a fixed ceiling on the number of visits or hours of care a beneficiary may receive. Such limits are reportedly fairly uncommon in HCBS programs (LeBlanc, Tonner, and Harrington). However, some systems elsewhere do use them. For example, the program in the Netherlands allows a maximum of 3 hours of nursing care per day, and a home help program named Alpha Care allows no more than 16 hours per week (Brodsky, Habib, and Mizrahi). More commonly, individual service allotments are established as part of initial care planning; the Scandinavian systems generally approve fixed hours of units of care for each participant. While these allotments are nominally based on needs assessment, they are also a

tool for budgeting. Local authorities in Denmark have reportedly made sharp cutbacks in hours and frequency of services for participants with IADL needs in order to fund more services for people with ADL needs (Hansen).

Finally, there can be implicit rationing if services are covered but unobtainable. At the start-up of the German program, 30% of the home care budget could not be spent, because there was no one to provide care; the supply has since improved (Schneider). Similar problems were predicted when the Japanese system was implemented. Shortages did not in fact materialize – not because service supply grew, but because fewer people than expected initially sought benefits (Okamoto 2001). Long-term care workforce issues are beyond the scope of this paper. However, it is at least worth noting that the Departments of Labor and Health and Human Services (2003) project that demand for long-term care workers will grow by 200% to 242% between now and 2050, while the supply of workers who have traditionally filled these jobs will grow only slightly.

Residential care

There is a range of housing options for elderly people who cannot or do not wish to remain in their own homes but who do not require the level of care furnished by certified nursing facilities. In the US, there are congregate housing communities, assisted living facilities, and board and care or old age homes, as well as continuing care communities that combine several levels of housing (such as individual apartments, assisted living, and nursing facility). None of these terms has a very clear definition, and each embraces a wide variety of very different facilities. For example, assisted living facilities may offer individual apartments or may have semiprivate rooms or wards resembling those in nursing homes; they may provide minimal services or may offer help for people with multiple ADL limitations (Hawes, Rose, and Phillips).

Some people may receive assistance with at least part of the cost of alternative living arrangements:

- About 1.5 million low-income elderly people receive federal rental assistance; at least some of these are in developments that are targeted at the elderly and disabled and that may offer some amenities or services, such as transportation or housekeeping assistance (US DHUD). In addition, there is a federal tax credit for developers of low-income housing; some of these developments also offer supportive services.

- An increasing number of private LTC insurance policies include a benefit for assisted living; the daily benefit may be the same as for nursing home care or a lower amount.
- State Medicaid programs may provide HCBS waiver services or non-waiver home and personal care to people in assisted living facilities or other non-nursing home settings; 34 States currently do so (AAHSA Medicaid). However, Medicaid law prohibits payment of room and board in facilities other than certified nursing homes; Medicaid can pay these facilities only for specific services that would also be covered if rendered in a beneficiary's own home. (In effect, Medicaid observes the hotel/care distinction discussed earlier.)

Still, most of the financing for residential alternatives comes from residents' own funds or those of their families. Some options may not be affordable for many older people. One recent study found that two-thirds of people aged 75 and older had incomes less than the most common monthly rate for assisted living facilities that provided little privacy and low service levels. Facilities that provided greater privacy and substantial services commonly charged about \$2,000 per month in 1999, or about two-thirds the cost of nursing home care.

Many other countries provide public support for care in alternative residential settings. As table 10 shows, some countries cover costs in old age homes (the nearest equivalent to US assisted living) to the same extent as in nursing homes, while others require that residents of old age homes pay a larger share of their costs.

Table 9. Percentage of Residential Facility Costs Paid by the Elderly and Their Relatives, Selected Countries

	Old age home	Nursing home
Austria	20%-30%	20%-30%
Finland	19%	12%
Netherlands	38%	11%
Spain	50%	20%
Sweden	12%	12%
United Kingdom	30%	30%

Source: Pacolet et al.

Should an LTC program in the US provide benefits for assisted living or other residential settings? One possible argument for doing so is that alternatives might provide less costly care for people who would otherwise require nursing home placement. However, it is uncertain to what extent

alternative settings substitute, or could substitute, for nursing home care. Estimates of the share of assisted living facility residents requiring assistance with 3 or more ADLs, a common threshold for nursing home entry, range from 24 to 42 percent; this compares to 74 percent in nursing homes (Redfoot and Pandya). Many facilities will not accept people with certain disabilities or with cognitive impairments, and some will not allow people whose disability progresses after admission to remain (Hawes, Rose, and Phillips).

Other types of community facilities may be even less likely to replace nursing home services. One recent study, using the Medicare Current Beneficiary Survey, examined Medicare beneficiaries in elderly group residential arrangements (EGRAs); the term embraces a variety of settings that are not formal long-term care facilities, including assisted living facilities, continuing care communities, health graded housing arrangements, retirement homes and apartments, elderly homes, and so on. Only 14 percent of EGRA residents needed help with 3 or more ADLs, while 39 percent required no assistance with any ADL or IADL (McCormick and Chulis).

A second possible argument for funding residential alternatives is to promote quality improvements. States vary in the extent to which they license facilities other than nursing homes and in the stringency of the standards they apply. There are particular concerns about the quality of board and care homes, small private facilities that are often unlicensed and that may serve as many as 600,000 to 1 million residents. Unlicensed facilities or those in states with loose requirements are likely to have untrained staff, lack of supportive aids, safety issues, and other problems (Hawes et al.). Public or private coverage could be linked to adoption of uniform standards. This is, in fact, why optional coverage of ICFs and ICFs-MR was added to Medicaid in the early 1970s; federal funds were a carrot to induce states to bring the facilities up to minimal standards. However, setting standards for new types of facilities may present difficult tradeoffs. Should residents enjoy fewer protections than are provided under current standards for nursing facilities? If equally stringent standards are adopted, will any cost advantages of alternative settings be reduced?

One drawback to coverage of assisted living or other alternative settings is the likelihood of a woodwork effect. While disabled people and their families may make considerable efforts to delay or avoid a nursing home admission, they may be more willing to consider placement in a facility that is less institutional and more attractive. Private long-term care policies that cover assisted living limit this effect by using the same coverage threshold (usually 2 ADLs or severe cognitive impairment) as for nursing home care.

Conclusion: Assessing Tradeoffs

Policymakers considering reforms in long-term care financing must seek a balance among a variety of competing goals and priorities. Some analyses of long-term care systems contend that there are really only a few basic models; once choices are made on one or two aspects of program design, decisions on other details are more or less automatic. For example, Brodsky et al. characterize systems as entitlement or non-entitlement and as universal or targeted at the poor. They find that systems in each of the resulting four categories have common features, as shown in table 10. (Some of the terminology has been changed to terms used in this report.)

Table 10. Alternative Strategies for Designing LTC Systems

Other design issues	Primary design issues			
	Target poor only		Target poor and non-poor	
	Non-entitlement	Entitlement	Non-entitlement	Entitlement
Revenue source	General revenue	General revenue	Premium or dedicated tax	General revenue
Eligibility				
Means-testing	Strict	Strict	Very rare	Liberal
Consideration of family support	Common	Rare	Rare	Common
Level of disability	Low	Medium	High	Medium
Flexible criteria	Yes	Yes	No	Yes
Benefits				
Level of benefits	High	High	Low/medium	Medium/high
Cash benefits	Rare	Rare	More common	Less common

Source: Based on Brodsky et al.

While it may be true that many systems can be characterized in this way, it is not clear that decisions on one or two policy dimensions really dictate other program features. In the U.S., for instance, the Medicaid home and community-based services program is a non-entitlement program for the poor, but it never considers availability of family caregivers, requires a high level of disability, usually has inflexible eligibility criteria, and sometimes provides cash benefits. This might simply mean that programs here are less coherent or more ad hoc than those developed in other countries. But it certainly suggests that there are more than four ways to build a system. This report has instead assumed that the various components of program design are puzzle pieces that can be put together in a large number of possible configurations.

Each of the individual elements or decision points discussed in this report may be seen as promoting or working against some possible objectives, including:

- Equity: similar treatment of similarly situated people;
- Efficiency: targeting resources to people in need and minimizing displacement of existing spending;
- Cost control: limiting costs to taxpayers and/or making future costs more predictable;
- Popular support: likelihood that a policy will have broad and sustained approval;
- Flexibility: ability to tailor services to individual needs and circumstances;
- Support for family caregivers; and
- Promotion of integration of medical and social services.

The potential trade-offs are perhaps most obvious for the broadest aspects of program design. A universal entitlement program may be most likely to promote equity and garner broad public support; but if cost control and targeting are priorities, these goals may be better achieved through a means-tested program operating on a fixed budget.

The potential effects of decisions on some of the second-order design questions are less certain. For example, a system that determined service eligibility through subjective evaluations rather than objective standards might be perceived by some of the public as unfair, while others might value flexibility and the potential for tailoring services. Providing cash instead of services might promote cost control because budgets can be fixed and consumers may be able to buy services at lower cost than an agency; but savings per participant might be offset by higher take-up of a cash benefit. And it is difficult to assess how different options might affect such priorities as supporting caregiving or promoting integration.

The list of policy goals is arbitrary, and the assessment of how each option relates to these objectives is subjective. The point is merely to emphasize that no one proposal for of long-term care financing is likely to be effective in addressing all the concerns that have sparked recent interest in program reform. The choice among models is necessarily tied to decisions about prioritizing basic objectives.

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