NATIONAL ACADEMY OF SOCIAL INSURANCE

Long-Term Services and Supports: Meeting the Needs of Elders, Families and the Workforce Through Social Insurance

A Working Paper by Weiwen Ng
May 2010

Weiwen Ng is a recent MPH from the University of Michigan's School of Public Health. He was a 2010 Visiting Scholar at NASI where he focused on long-term services and supports policy.

Long-Term Services and Supports: Meeting the Needs of Elders, Families and the Workforce Through Social Insurance

By Weiwen Ng

Summary

The Community Living Assistance Supports and Services (CLASS) program, recently enacted as part of the national health reform law, is a major change in U.S. long-term care financing. This new social insurance program relies on behavioral economics principles to maximize voluntary enrollment, rather than mandating participation. By paying benefits in cash, it provides flexibility to disabled people and their caregivers. If it presents a compelling value relative to private insurance, it could enable many Americans to insure themselves against the risk of needing long-term care at home during their working lives as well as in their retirement years. However, experts say that the CLASS program's lack of underwriting places it at considerable risk of adverse selection, which will drive premiums up and reduce participation. The program will require a sustained marketing campaign to attract participation. Policy makers will need to make improvements that properly balance the long-term care needs of Americans with affordability and program solvency.

Introduction

In January, 2010, *Washington Post* writer Sara Mansfield Taber wrote about her experience caring for her aging mother, who had heart disease, two hip replacements and depression. Taber described how her mother kept her shoes on all day in the months before her death, because she was too weak to remove them. Taber and her siblings lived and worked in other cities, and her mother never got sufficient personal help. Taber's mother would only have received the formal social services she needed if she were rich enough to buy them herself, or if she were poor enough to qualify for Medicaid.

Taber interviewed two of her friends who had experience providing long-term care to family members needing care, one from Britain and the other from France. Both countries' long-term care services are far from perfect[i]. However, the social services that Taber's friends received made all the difference to them. Both of her friends' families received cash allowances and home visits from doctors to care for their disabled parents. Both families either hired a direct-care worker or had one provided by an agency. Both of Taber's friends still had to work very hard to care for their parents, but the social services they received enabled their parents to stay in their own homes and to have a much higher quality of life. Those services also provided some support to Taber's friends, enabling them to discharge their responsibilities to their parents better. Taber had no such help.

Ironically, if Taber's mother had been poor enough to qualify for Maryland's Medicaid program, she might have been eligible for home and community based services, which would have provided the social services that she needed. If she were in a state with a Cash and Counseling demonstration project, she would have

received a small cash allowance, which she could have used to pay aides or a family member. She would also have received guidance on how to access and use long-term care resources and to budget for their services. Cash and Counseling is considered to be one of the more successful Medicaid demonstration projects (Brown et al, 2007).

The Patient Protection and Affordable Care Act (H.R. 3590, 2010) contains a provision called the Community Living Assistance Services and Supports (CLASS) Act. This provision would create a voluntary social insurance program covering long-term services and supports. Regardless of their means, beneficiaries who had paid into the program for 5 years would be eligible to receive a cash benefit of at least $50 per day if they were disabled enough to meet the specifications in the bill. The late Senator Edward Kennedy and Constance Garner, his Policy Director for Disability and Special Populations, were the architects of the proposal, and it represents a potentially enormous change in the way we pay for long-term care in the U.S.

Who Gets Long-Term Care in the United States?

Long-term care needs are typically measured by the number of Activities of Daily Living (ADLs) Instrumental Activities of Daily Living (IADLs) that a person cannot perform on their own. The ADLs include bathing, dressing, transferring from bed or chair, eating, using the toilet and continence, all of which are activities that are critical to day-to-day living. IADLs such as shopping and answering the telephone are central to living independently.

In 2007, an estimated 7.2 million people over 65 lived in the community with an ADL or IADL disability. A further 1.2 to 1.5 million people over 65 are estimated to reside in nursing homes (Kaye, Harrington and LaPlante, 2010, Johnson, Toohey and Wiener, 2007). In other words, there are 6 or more community residents with ADL and/or IADL disabilities for every nursing home resident among people over 65. Using the higher estimate, 30.3% of the population over 65 has some long-term care needs. Kaye et al estimate a further 5.0 million people under 65 with ADL or IADL disabilities living in the community, and 250,000 living in nursing homes.

Of this population, about 1.6 million community residents over age 65, 1.3 million community residents from ages 18 to 64, and 300,000 community residents under age 18 received help in two or more ADLs (author's calculation from the 2008 National Health Interview Survey). People with this level of disability are considered to require an institutional level of care.

Who Pays for and Delivers Long-Term Care Services?

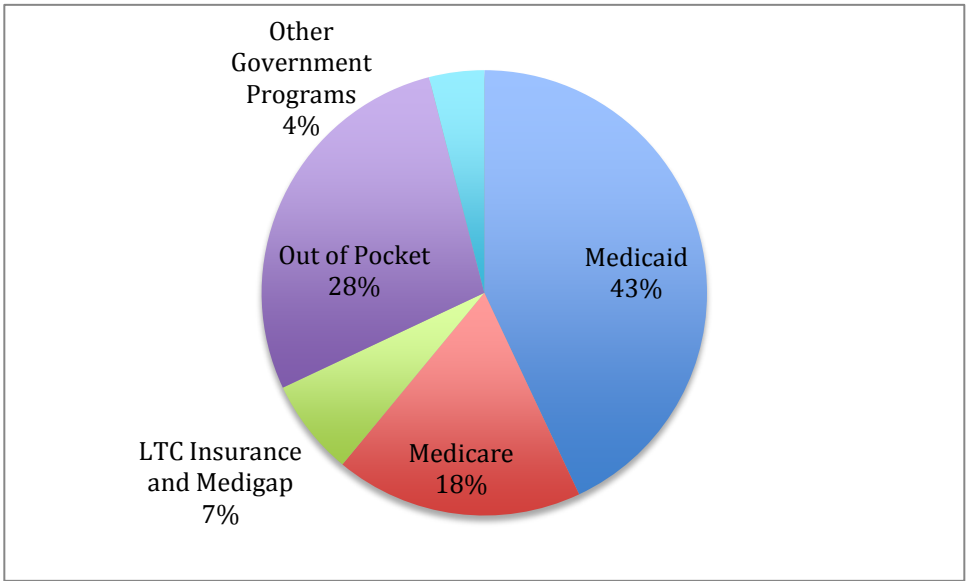
Most people receiving long-term care in the community have their needs met by family members or friends who give unpaid care. Kaye and colleagues (2010) estimate that only 13% of people living in the community with disabilities receive any help from paid providers. Of all the community residents with any IADL or ADL

disability, 87% receive only unpaid help. Most people with paid care also receive some informal care.

A survey by the National Alliance for Caregiving and the AARP (2009) provides detail on caregivers. Women account for 66% of all caregivers, and female caregivers spend significantly more time on caregiving than male caregivers,. Women average 21.4 hours per week on caregiving, versus 17.4 hours per week for men. The National Alliance for Caregiving (2009) estimated that as many as 61.8 million adults in the U.S. were giving care to their elders in 2009. Houser and Gibson, writing for AARP (2008), estimated that the replacement value of unpaid long-term care provided to people of all ages was $375 billion in 2007. In other words, if family members had to hire home care aides to perform the tasks they did, they would have spent $375 billion in 2007 to pay those aides.

Direct-care workers deliver most paid long-term care services. Despite the fact that they provide a vital service to families and that many more of them are going to be needed in the future, their wages are low. (Paraprofessional Healthcare Institute, 2009). The Bureau of Labor Statistics (2009) estimates that the 2010 median wages of personal and home care aides are only $9.22 per hour. Additionally, they are not covered by the Fair Labor Standards Act, which mandates overtime pay, a minimum wage and other labor protections (Paraprofessional Healthcare Institute, 2010). Furthermore, part-time work and irregular hours are normal in this profession. Fewer home care workers have employer-sponsored health insurance than in other industries. The emotional demands of the job and risk of physical injury are high. All these factors contribute to high turnover. BLS also projects that this will be one of the fastest-growing professions in the next 10 years, and that in fact there is likely to be a large shortage of workers (Paraprofessional Healthcare Institute, 2008).

Who Paid for Long-Term Care in 2006



Total Payments for Nursing Home, Assisted Living Facility and Community-Based Care in 2006
Source: Avalere Health (2009).

In contrast, the nation spent $231 billion on long-term care in the community, in assisted living facilities and in nursing homes – less than the estimated value of unpaid care. Medicaid was the largest single payer, paying for 40% of all long-term care services, or about $92 billion (Avalere Health, 2009). Individuals paid for a total $81 billion of services, or 31% of the total; most of this was spent out of pocket, but some was reimbursed by long-term care insurance. The chart above depicts sources of payment for long-term care services. The value of unpaid care is significantly larger than what we spend on paid care.

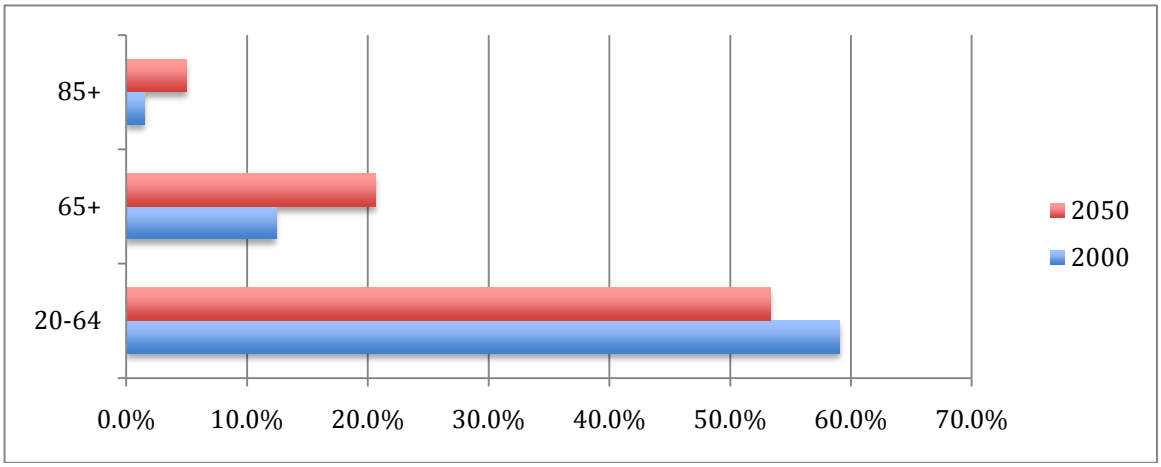
Private long-term care insurance is available. However, only about 10% of people over age 65 and 6% of people from ages 50-64 purchase it (Komisar, 2009). The 7% of long-term care expenses that private insurance paid in 2006 includes payments by Medigap policies for skilled nursing facilities. The majority of respondents in an AARP survey in 2006 incorrectly believed that Medicare would pay for extended nursing home stays or assisted living stays (GfK NOP Roper Public Affairs and Media, 2006). Some economists (Brown and Finkelstein, 2004) argue that the existence of Medicaid crowds out the purchase of private insurance, since Medicaid covers most long-term care services for people who exhaust their assets. In other words, it does not make financial sense for people to buy private insurance because they are already covered by Medicaid, albeit they will need to exhaust their assets first. However, private long-term care insurance is simply not affordable to most adults (Wiener, Illston and Hanley, 1994, Kim, 2009).

How Many People Will Need Long-Term Care in the Future?

The growth rate in the retired and elderly population will outpace general population growth within the next 50 years. Long-term care needs are closely linked

to age, and demand for long-term care services and supports will increase dramatically in the years to come. Unfortunately, there will also be fewer working adults to support the aged, especially those over age 85.

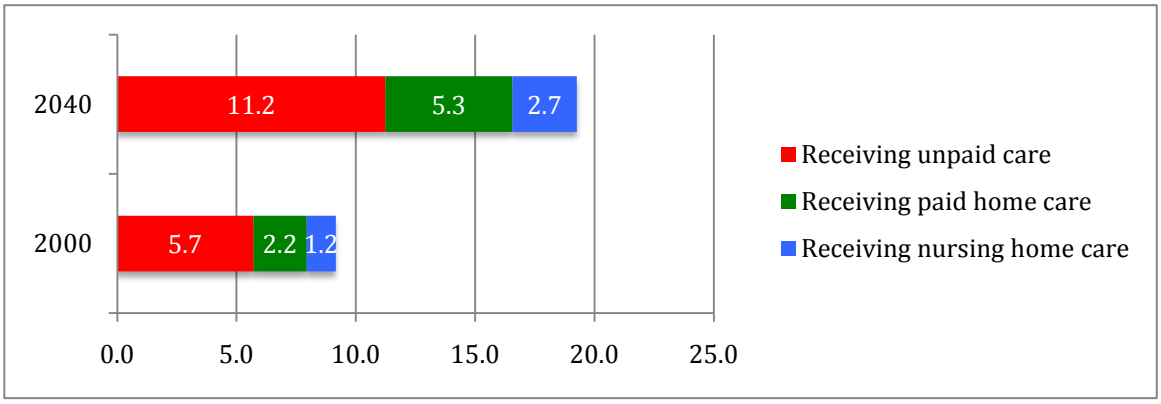
Population Distribution of the United States, 2000 and 2050



Source: Author's calculations from Census Bureau population projections.

Over age 85, needs for long-term care increase dramatically. By 2040, the share of people over age 85 will increase by over two and a half times (Johnson, Toohey and Wiener, 2004). At the same time, family sizes will be smaller than they are today, and fewer seniors will be married in 2040. This decreases the total resources available to elders who need long-term care. As the graph below shows, this will cause a greater reliance on paid care in the future, which will further affect the economic security of elders and their families.

How Many People Receive Unpaid Care, Paid Care and Nursing Home Care 2000 and 2040



Source: Johnson, Toohey and Wiener, (2007). This projection is based on the intermediate case discussed in the paper, which assumes that inherent disability levels remain roughly constant.

Medicaid has become the default source of coverage for long-term care. While many states have made tremendous advances in making home- and community-based

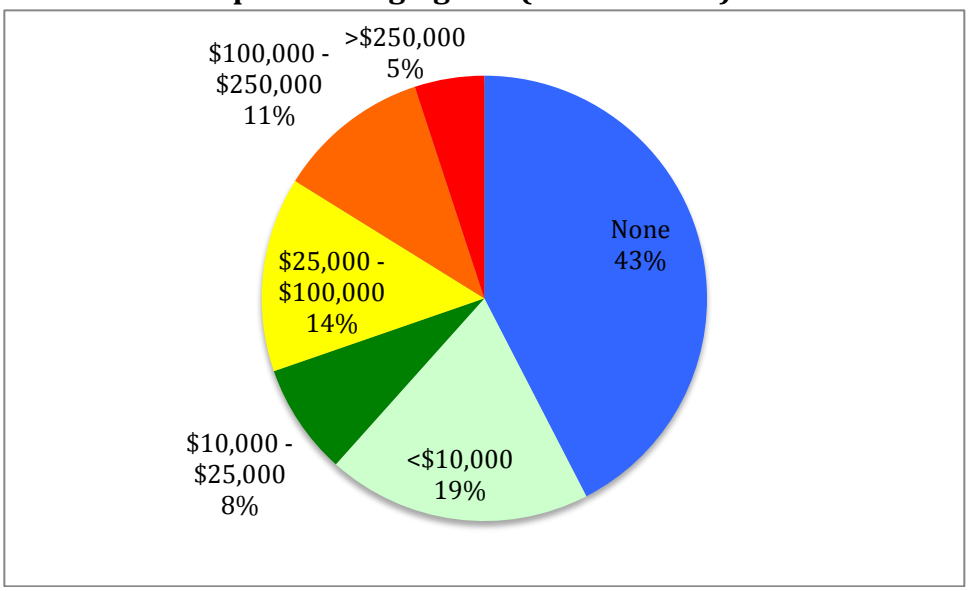
services (HCBS) available to beneficiaries, the program is still biased towards nursing home care (Scheppach, 2009), since coverage for nursing home is mandatory and HCBS programs are optional. Furthermore, unlike the Federal government, states must maintain balanced budgets, and states have little choice but to cut optional services to contain costs. In this recession, some 24 states and the District of Columbia have made cuts to optional elder services (Johnson, Oliff and Williams, 2010). State revenue growth out of recessions typically lags general economic recovery (Patton, 2002), so it may be some time before states can restore their previous service levels.

Over the last decade, the National Governors Association has made the case for increased federal and personal financing of long-term care (Scheppach, 2009 and Patton, 2002). This situation will worsen as the Baby Boomers and the following cohorts age.

Long-Term Care Impairs Economic Security

Long-term care is costly, and it is a fairly common risk. Kemper and co-authors (Kemper, Komisar and Alexcih, 2005) estimated that 69% of people turning 65 in 2005 would need some long-term care before they died. While people need an average of 3 years of long-term care, 31% do not require any, 20% require 2-5 years, and another 20% require over 5 years of long-term care. Johnson, Mermin and Uccello (2006) find that experiencing severe ADL disabilities or cognitive impairment sharply reduces wealth even if the person does not enter a nursing home.

Estimated Present Discounted Value of Lifetime Spending on Long-Term Care Services for People Turning Age 65 (2005 dollars)



Source: Kemper, Komisar and Alecxih (2005)

Long-term care expenditures are also widely distributed. Kemper, Komisar and Alecxih (2005) estimated that 42% of people turning 65 in 2005 would not spend anything on long-term care, meaning that they will be able to get by with help from family caregivers only and will not need to rely on Medicaid. However, 5% of then would spend over $250,000. MetLife's 2009 annual survey of long-term care costs found that the average annual cost for a semi-private nursing home room was $72,300 (MetLife, 2009). The average annual cost for an assisted living facility room was $37,600. The average person living in the community with disability in two or more ADLs, which is considered an institutional level of need, would spend around $13,000 annually in home care aide services in addition to unpaid care from friends and family (author's calculation from data from Stallard, 2008). Because long-term care is an unpredictable and catastrophic risk, most experts believe that it is better handled through insurance rather than through savings.

Providing care to aging parents causes caregivers to curtail their paid work hours somewhat, which affects their own economic security. Johnson and Lo Sasso estimate from the Health and Retirement study that both male and female family caregivers in 1994 reduced their paid hours by an average of nearly 9 hours a week (2006), or approximately $7,800 per year, which would also have reduced their retirement and Social Security benefits. Additionally, by the middle of the century, family sizes will decline. Caregivers will have fewer siblings to share their burdens with, which will probably translate to bigger burdens on each caregiver.

The CLASS Act as a Voluntary Social Insurance Solution

Social insurance programs are government-sponsored insurance programs that meet needs that are essential to society, such as health care, disability insurance and old age insurance. These needs are often not fully met by a solely private, voluntary insurance framework. Social insurance programs are usually mandatory, which eliminates the problem of adverse selection. One of the greatest strengths of social insurance programs is that everybody pays in and everybody benefits at some point, regardless of their socioeconomic status or any other factor. This leads to far more political support than means-tested or welfare programs.

Before the recession, a poll commissioned by the National Academy of Social Insurance found that most Boomers and seniors were concerned about their inability to pay for long-term care if they needed a significant amount of it (Peter D. Hart Research Associates and American Viewpoint, 2005). In 2009, a poll commissioned by the SCAN Foundation showed that Americans were more likely to favor health reform if it improved coverage for long-term care, especially care based in the community (Lake Research Partners, 2009). Furthermore, while the NASI poll showed that Americans did not necessarily favor the government taking on full responsibility for long-term care, more than 70% of respondents said that the long-term care system needed major improvements or a complete overhaul, and 70% of respondents said the government should do more to pay for long-term care. A previous poll by the AARP (Gibson, 2003) found that the majority of people with disabilities prefer to manage their own personal care services and/or to receive benefits in cash, rather than have agencies direct and provide such services.

The CLASS program is a potential solution to some of our long-term care insurance problems. It was designed as a voluntary program before health reform. It uses subsidies and automatic enrollment to "nudge" people into participating, which is a novel approach in usually mandatory social insurance.

The CLASS program would provide a cash benefit of an average of $50 per day to people who had significant disabilities in the Activities of Daily Living, or who had significant cognitive impairment. While the maximum daily benefit for the CLASS Act is much lower than private long-term care insurance contracts, it is still sufficient to cover a substantial amount of the home and community-based care that people require. Furthermore, it was designed with the hope that because of the lower benefit values, the premiums could be significantly cheaper than private insurance contracts, which have daily benefits averaging significantly over $100 (LifePlans, 2007). Garner (2009) indicated that the intent was to be able to have premiums as low at $65 per month. At that rate, she felt that young adults were likely to participate, citing several focus groups among college students that her office had facilitated. The Moran Company (2007) predicted that a mandatory program with a $75 benefit, which was similar to the initial benefit specified by the CLASS Act, would have premiums of around $75 a month. Under the law, the Secretary of the Department of Health and Human Services has wide latitude to implement higher tiers of benefits for higher levels of disability. The CLASS Act

would offer benefits as long as a beneficiary was disabled, unlike most commercial plans, which are time-limited.

Cash benefits are more flexible than private long-term care insurance plans. Beneficiaries could use them to purchase services from any providers they choose, as opposed to agency providers dictated by a Medicaid agency or insurance provider. Beneficiaries could purchase durable medical equipment or home modifications that are often not covered by Medicaid or private insurance. Ultimately, beneficiaries could compensate their family members who are caregivers (Stone, 2001). Rachel Silverman, writing for the Wall Street Journal (2006, 2009), reports that a small but increasing number of families are using formal caregiving contracts. While estate planning is one major concern driving these contracts, several of Silverman's interviewees also identified the need to balance work and caregiving as another factor. One interviewee said that "if I can't work because I'm busy taking care of him, which I'm very willing to do, I need to be compensated. I'm not a saint." Many middle- and working-class family members cannot afford to take unpaid leave to care for their parents. However, the CLASS Act could enable them to do so.

The Secretary of Health and Human Services is directed to set the premiums so that the fund is solvent for 75 years. The premiums will be age rated, meaning that younger participants pay lower premiums than older ones. Furthermore, full-time students and people under 100% of the Federal Poverty Limit will receive heavily subsidized premiums. Individuals will pay the same premium throughout their lives and this premium will be set at the year they enter the program.

Risks to the CLASS Act

Unlike other social insurance programs, participation in the CLASS Act is voluntary. Normally, private long-term care insurance programs medically underwrite their applicants, but the CLASS Act does not. Instead, it attempts to use the behavioral economics principle of automatic enrollment to encourage participation and attract a diverse pool of healthy and less healthy people. Furthermore, the age rating provisions will further decrease premiums for younger adults.

The lack of underwriting places the CLASS program at risk of adverse selection: people who have existing disabilities, cognitive impairments or chronic conditions, and who would normally be excluded from private insurance, would be able to enroll in the CLASS program as long as they were actively at work. These individuals would then be able to receive lifetime benefits if their diseases progressed sufficiently. If the CLASS Act attracts a population that is significantly sicker than private insurers, it will have to raise its premiums to cover its expected costs, which will make it increasingly unattractive to young and healthy individuals. In lieu of underwriting, the CLASS Act has a requirement that enrollees be actively at work, but this may not be sufficient to keep the program viable (Foster, 2010). Furthermore, there is the possibility that beneficiaries could game the program by

paying premiums for five years, then withdrawing, then re-entering the program when they were older and anticipated they would soon need long-term care. The CLASS Act would allow this, albeit it would impose a modest penalty and require people to pay premiums for two years before receiving benefits regardless of whether they had met the vesting period. In contrast, private insurance programs would underwrite again if a lapsed enrollee tried to re-enroll.

In the past, many voluntary programs that attempt to avoid underwriting have failed. For example, Bartlett and colleagues (Bartlett, Klein and Russell, 1999) write that in the 1950s, the early Blue Cross plans charged only somewhat higher premiums to older applicants who would normally be covered by Medicare today. In contrast, commercial insurers were far more aggressive in using experience rating, or charging younger and healthier customers less. The commercial plans siphoned younger customers off, which caused the Blues Cross plans' risk pools to deteriorate. The Blue Cross plans had to adopt the same rating practices as the commercial plans to survive. The CLASS Act could suffer the same fate. The CMS Actuary, Richard Foster (2010), assumed that only 2% of workers would participate in CLASS and predicted severe problems due to adverse selection. He estimated that premiums would average $240.

However, Richard Frank, Deputy Assistant Secretary for the Office of Disability, Aging and Long-Term Care at the Department of Health and Human Services reported that his office had modeled the CLASS program extensively and was convinced that it was potentially viable (Frank, 2009). The CBO (2009) estimated that premiums would average a much lower $146. Paul Van de Water (2010) suggested some relatively minor legislative changes that could further strengthen the program, such as requiring a full 5 years of work during the vesting period, strengthening penalties for late or lapsed enrollment and indexing the premiums for inflation, rather than having participants pay a flat premium that is effectively front-loaded for inflation.

Conclusion: Possible Futures for the CLASS Act

If the projections by the CBO (2009) are correct, the CLASS Act would be programmatically sound, but it would not have a large impact on long-term care. Its premiums would be similar to commercial insurance, and few people would see it as a good value. It would extend coverage to those living with disabilities or chronic conditions who are normally excluded by underwriting, but this coverage will become expensive. The program would be seen as a special program for the old and and the disabled, and it would not receive the broad political support of a traditional social insurance program.

Furthermore, CLASS might crowd out some purchase of private insurance, leaving a net reduction in the amount of long-term care services financed by insurance. This could worsen the situation for state Medicaid programs and families.

However, the CBO and other parties could be pessimistic. No existing insurance program has offered steep subsidies to students and has required employers to automatically enroll their employees. The CBO likely had no precedent to simulate the effects of these provisions. Given the increasing use of employer-sponsored long-term care plans, many large employers might offer CLASS as an employee benefit. Higher participation among younger workers will probably lead to lower premiums for the program.

Several additional steps are probably needed to make the CLASS program live up to its full potential. A broad and sustained marketing campaign will be essential to convince people that they need to consider long-term care insurance and to build political support for the program. Additionally, the government will need to continue to invest in aging programs like the Aging and Disability Resource Centers and the Area Agencies on Aging to ensure that services and providers are available, and that families have guidance on how to access these resources and services. The government and the private sector will also have to take additional steps to ensure that the long-term care workforce is adequately trained and remunerated. Given the experience of the early Blue Cross Blue Shield plans, the government might also consider increased regulation of private long-term care insurance.

While the CLASS Act is an innovative first step towards solving our long-term care problems, the government might have to consider more drastic action. For example, Germany adopted mandatory social insurance for long-term care due to political pressure from their states, whose budgets were strained by means-tested long-term care services (Gibson and Redfoot, 2007). As with health insurance, such a step might be necessary to guarantee that long-term care insurance is available and affordable to everyone.

References

American Academy of Actuaries. (2008, July). Fundamentals of Insurance: Implications for Health Coverage. Retrieved 2/10/2010 from AAA website: http://www.actuary.org/pdf/health/coverage_ib_08.pdf

American Academy of Actuaries. (2009, July). *Re: Actuarial Issues and Policy Implications of a Federal Long-Term Care Insurance Program*. Retrieved 12/10/2009 from American Academy of Actuaries website: http://www.actuary.org/pdf/health/class_july09.pdf

Avalere Health. (2008, December). Long-Term Care: An Essential Element of Healthcare Reform. Retrieved 1/26/10 from Avalere Health Website: http://www.avalerehealth.net/research/docs/SCAN_Healthcare_Reform.pdf

Bartlett, Dwight K. Klein, Robert W. Russell, David T. (1999). Attempts to Socialize Insurance Costs in Voluntary Insurance Markets: The Historical Record. *Journal of Insurance Regulation*, Summer 1999, pgs 478-487.

Brown, Jeffrey R. Finkelstein, Amy. (December, 2004). *The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market.* National Bureau of Economic Research, Washington, DC.

Brown, R. Carlson, B.L. Dale, S. Foster, L. Phillips, B. Schore, J. (2007). Cash & Counseling: Improving the Lives of Medicaid Beneficiaries Who Need Personal Care or Home and Community-Based Services. Mathematica Policy Research Inc., Princeton, NJ.

Bureau of Labor Statistics. (2009). Occupational Outlook Handbook, 2010-11 Edition: Home Health Aides and Personal and Home Care Aides. Retrieved 1/27/10 from BLS website: http://www.bls.gov/oco/ocos326.htm

Bureau of Labor Statistics. (2010). National Compensation Survey Databases. Retrieved 2/16/2010 from http://www.bls.gov/ncs/home.htm

Congressional Budget Office. (2009, November 25). *Additional Information on CLASS Program Proposals*. Washington, DC. Retrieved 4/30/2010 from http://www.cbo.gov/doc.cfm?index=10823

Frank, Richard. (2009). Untitled Presentation. Presented at *The Sleeper in Health Reform: Long-Term Care and the CLASS Act*. Kaiser Family Foundation, Washington, DC. October 20, 2009.

Foster, Richard. (2010). Estimated Financial Effects of the "Patient Protection and Affordable Care Act," As Amended. Centers for Medicare and Medicaid Services, Baltimore, MD.

Garner, Constance. Untitled Presentation. Presented at *Long Term Care in America: The Agenda for Health Reform*. Health Affairs, Washington, DC. May 7, 2009.

GfK NOP Roper Public Affairs and Media. (2006). *The Costs of Long-Term Care: Public Perceptions Versus Reality in 2006*. AARP, Washington, DC.

Gibson, Mary Jo. (2003). *Beyond 50.03: A Report to the Nation on Independent Living and Disability*. AARP Public Policy Institute, Washington DC.

Gibson, Mary Jo. Gregory, Steven R. Pandya, Sheel M. (2003). *Long-Term Care in Developed Nations: A Brief Overview*. AARP Public Policy Institute, Washington, DC.

Gibson, Mary Jo. Redfoot, Donald L. (2007). *Comparing Long-Term Care in Germany and the United States: What Can We Learn From Each Other?* AARP Public Policy Institute, Washington, DC.

Gleckman, Howard. (2010). *How Does U.S. Long-Term Care Stack Up Against the Rest of the World?* Kaiser Health News. Retrieved 4/30/2010 from http://www.kaiserhealthnews.org/Columns/2010/January/011910Gleckman.aspx

Hart, Peter D., Research Associates. American Viewpoint. *Long-Term Care: The Public's View*. National Academy of Social Insurance, Washington, DC.

Houser, Ari. Gibson, Mary Jo. (2008). *Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update.* AARP Public Policy Institute, Washington, DC.

Johnson, Nicholas. Oliff, Phil. Williams, Erica. (2010). *An Update on State Budget Cuts: Governors Proposing a New Round of Cuts for 2011; At Least 45 States Have Already Imposed Cuts That Hurt Vulnerable Residents*. Center on Budget and Policy Priorities, Washington, DC.

Johnson, Richard. Lo Sasso, Anthony T. (2006). *Parental Care at Midlife: Balancing Work and Family Responsibilities near Retirement.* Urban Institute, Washington DC.

Johnson, Richard. Mermin, Gordon BT. Uccello, Cori. (2006). *When the Nest Egg Cracks: Financial Consequences of Health Problems, Marital Status Changes and Job Layoffs at Older Ages*. Urban Institute, Washington DC.

Johnson, Richard. Toohey, Desmond. Wiener, Joshua M. (2007). *Meeting the Long-Term Care Needs of the Baby Boomers: How Changing Families Will Affect Paid Helpers and Institutions.* Urban Institute, Washington, DC.

Kaye, H. Stephen. Harrington, Charlene. LaPlante, Mitchell P. (2010). Long-Term Care: Who Gets It, Who Provides It, Who Pays, And How Much? *Health Affairs*, 29(1): 11-21.

Kitchener, Martin. Ng, Terence. Miller, Nancy. Harrington, Charlene. (2005). Medicaid Home And Community-Based Services: National Program Trends. *Health Affairs*, 24(1), 206-212.

Kemper, Peter. Komisar, Harriet. Alexcih, Lisa. (2005). Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect? *Inquiry*, 42, pgs 335-350.

Kim, Nayoung. (2009). *Is Private Long-Term Care Insurance Affordable for Older Adults?* Unpublished doctoral dissertation, Wayne State University, Detroit, MI. Retrieved 2/10/2010 from http://www.econ.wayne.edu/p0708/nayoung/JMP_Nayoung Kim_Final_102009.pdf

Komisar, H. (2009). You Can Run, But You Can't Hide: Facing the Costs of Long-Term Care. Presentation to New York Institute of Technology Center for Gerontology and Geriatrics. Retrieved 1/10/2010 from http://www.nyit.edu/academics/LTC091007-Komisar.ppt

Lake Research Partners. (2009). *New Poll Shows Americans More Likely to Favor Health Care Reform if it Improves Coverage for Long-Term Care Services: Support for Improved Coverage Cuts Across Gender, Age, Income, and Party Lines*. Washington, DC.

LifePlans, Inc. (2007). *Who Buys Long-Term Care Insurance?* America's Health Insurance Plans, Washington, DC.

Merlis, Mark. (2003). *Private Long-Term Care Insurance: Who Should Buy It and What Should They Buy?* Kaiser Family Foundation, Washington, DC.

MetLife Mature Market Institute. (2009). The 2009 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services and Home Care Costs. Retrieved 12/19/2009 from http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf

The Moran Company. (2007). *Modeling a New Long-Term Care Financing Plan*. Arlington, Virginia. Retrieved February 20, 2010 from http://www.thelongtermcaresolution.org/documents/moran_final.pdf

National Alliance for Caregiving and AARP. (2009). Caregiving in the U.S: 2009. Retrieved 12/21/2009 from National Alliance for Caregiving website: http://www.aarp.org/research/surveys/care/ltc/hc/articles/caregiving_09.html

OECD. (undated). *OECD population pyramids in 2000 and 2050*. Retrieved 3/9/2010 from http://www.oecd.org/LongAbstract/0,3425,en_2649_33933_38123086_1_1_1_1,00.html

Patient Protection and Affordable Care Act of 2010. H.R. 3590, 111th Congress.

Paraprofessional Healthcare Institute. (2010). Home Care Workers Deserve Minimum Wage Protection. Retrieved April 20, 2010 from PHI website: http://phinational.org/policy/home-care-workers-deserve-minimum-wage-protection/

Paraprofessional Healthcare Institute. (2009). Facts 3: Who Are Direct-Care Workers? Retrieved 1/27/10 from PHI National website: http://www.directcareclearinghouse.org/download/NCDCW Fact Sheet-1.pdf

Paraprofessional Healthcare Institute. (2008). Facts 1: Occupational Projections for Direct-Care Workers, 2006–2016. Retrieved 1/27/10 from PHI National website: http://www.directcareclearinghouse.org/download/BLSfactSheet4-10-08.pdf

Patton, Paul. (2002). March 21, 2002 testimony by Kentucky Governor Paul E. Patton before the Senate Special Committee on Aging on Broken and Unsustainable: The Cost Crisis of Long-term Care for Baby Boomers; and Medicaid: The Nation's Unintended Financier of Long-Term Care. Retrieved 4/30/10 from National Governors' Association website: http://www.nga.org/portal/site/nga/menuitem.0f8c660ba7cf98d18a278110501010a0/?vgnextoid=36de9e2f1b091010VgnVCM1000001a01010aRCRD

Tumlinson, Anne. Aguiar, Christine. O'Malley Watts, Molly. (2009). Closing the Long-Term Care Funding Gap: The Challenge of Private Long-Term Care Insurance. *Kaiser Commission on Medicaid and the Uninsured*.

Scheppach, Raymond. (2009). Written Testimony for the Subcommittee on Health of the Senate Finance Committee "The Role of Long-Term Care in Health Reform". Retrieved 4/30/10 from http://finance.senate.gov/imo/media/doc/032509rstest1.pdf

Silverman, Rachel Emma. (2009). Getting Paid to Take Care of Mom or Dad. Wall Street Journal, The Juggle Blog. Retrieved 5/1/2010 from http://blogs.wsj.com/juggle/2009/10/21/getting-paid-to-take-care-of-mom-or-dad/tab/article/

Silverman, Rachel Emma. (2006, September 7). Who Will Mind Mom? Check Her Contract. *The Wall Street Journal*, pg D1.

Stallard, E. (2008). Estimates of the Incidence, Prevalence, Duration, Intensity and Cost of Chronic Disability among the U.S. Elderly. Retrieved 12/20/2009 from http://www.soa.org/library/monographs/retirement-systems/living-to-100-and-beyond/2008/january/mono-li08-3b-stallard.pdf.

Stone, Robyn. (2001). Providing Long-Term Care Benefits In Cash: Moving To A Disability Model. *Health Affairs*, 20(6): 96-108

Van de Water, Paul. (2010). LASS: A New Voluntary Long-Term Care Insurance Program. Retrieved 4/30/2010 from Center on Budget and Policies website: http://www.cbpp.org/cms/index.cfm?fa=view&id=3156

Wiener, Joshua. Illston, Laurel Hixon. Hanley, Raymond. (1994) *Sharing the Burden: Strateges for Public and Private Long-Term Care Insurance.* Brookings Institution Press, Washington, DC.

[i] Readers should note that France and Britain are not perfect models, as Gleckman (2010) describes.

France phases out its long-term care insurance payout, called *Allocation personnalisée d'autonomie*, for people with higher incomes, and about one quarter of people over age 65 have purchased supplemental insurance. France has also struggled with high costs in its system.

Britain's long-term care services are, like the United States, organized in a welfare model, meaning that one has to be poor to qualify for benefits. Benefits can also vary substantially by area. The system has been disparaged as the "postcode lottery", which Taber's friend obviously won.