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INTRODUCTION

As President Barack Obama and Congress debate health care reform, it is important that long-term care be included.[1] While not central to providing basic health insurance to all Americans, long-term care should be part of efforts to improve health care for all Americans. Contrary to widespread belief that long-term care affects only a small minority of the population, 69 percent of people turning age 65 will need long-term care before they die and a third of the population will spend some time in a nursing home (Kemper, Komisar and Alecxih, 2005/2006).

In thinking about the place of long-term care in the health reform debate, four factors are important:

- With the aging of the population, the number of older people with disabilities is sure to grow substantially. According to one estimate, the number of older people with disabilities will approximately double between 2000 and 2030 (Johnson, Toomey, and Wiener, 2007). As a result, the relative financial and other burdens of long-term care will be greater in the future than they are now. Comprehensive reform will need to take into account both the number of people needing long-term care in the future and their characteristics, which may be very different than today.
- Federal and state governments spend substantial amounts of money on long-term care. In 2006, the public sector spent $150 billion on long-term care for people of all ages (Tumlinson and Aguiar, 2008). With the aging of the baby boom generation, it is highly likely that public spending for long-term care will increase significantly over the next 30–40 years. In addition, no other part of the health care system is as dependent on public financing as long-term care. In 2008, for example, 77 percent of nursing home residents had their care covered by either Medicare or Medicaid (American Health Care Association, 2008). As a result, government policy is especially important for long-term care providers and consumers.
- Not only do older people and younger adults with disabilities use expensive long-term care services, they have high acute care expenses related to their underlying chronic diseases. An analysis of the Medicare Current Beneficiary Survey by Avalere Health suggests that, in 2005, older people with problems performing at least one activity of daily living had average Medicare costs of $14,775 compared with $4,289 for beneficiaries with no problems with the activities of daily living (Tumlinson and Aguiar, 2008). One study estimated that disability-associated health and long-term care expenditures were $398 billion in 2006 (Anderson, Wiener, Finkelstein, and Armour, 2008).
- The current long-term care financing and delivery system is broken. The United States does not have, either in the public or private sectors, satisfactory mechanisms for helping people anticipate and pay for their long-term care. As a result of the lack of insurance coverage, long-term care expenses are the leading cause of catastrophic health care costs among older people. The disabled elderly and their families find, often to their surprise, that neither Medicare nor their private insurance covers the costs of nursing home care or home and

[1] This testimony primarily addresses long-term care for older people and younger adults with physical disabilities. The important topic of long-term care for people with intellectual disabilities or mental illness is not the main focus of the paper.

community-based services. Instead, people needing long-term care must rely on their own resources, or when those have been exhausted, must turn to welfare in the form of Medicaid. Despite the strong preference of people with disabilities for home and community-based services, the available financing is highly skewed toward institutional care. Moreover, the home and community-based services that are available do not necessarily meet the preferences of people with disabilities. Quality of care is often deficient and the workforce needed for high-quality care is lacking.

PROBLEMS OF THE CURRENT SYSTEM AND GOALS OF REFORM

The current system of financing and organizing long-term care satisfies almost no one. There are at least five goals that should be addressed by long-term care reform:

Treating the Risk of Long-Term Care as a Normal Life Risk

Although not often discussed, perhaps the most important goal of reform should be to treat long-term care as a normal risk of living and growing old. Fully 69 percent of people who turned age 65 in 2005 will have some long-term care needs before they die; among the 35 percent of older people who will spend some time in a nursing home before they die, about half will reside there for a year or longer (Kemper, Komisar, and Alecxih, 2005/2006). Mechanisms should be established so that people will know how they will pay for services should they need them. The large expenses of long-term care should not come as an unpleasant surprise that causes severe financial distress to individuals and their families. Currently, the problem of coping with disabilities is compounded by worries about paying for care. Older people and others fear that if they need long-term care, they will become a burden on their family.

Protecting Against Catastrophic Out-of-Pocket Costs

With very little public or private insurance coverage against the high costs of long-term care, it is not surprising that users of long-term care services often incur very high out-of-pocket costs. The average private pay cost for a year in a nursing home in the top 31 metropolitan markets was $78,475 as of the second quarter of 2007 (National Investment Center, 2007), but the median income of older people with disabilities was $18,480 in 2001 (Johnson and Wiener, 2006). Among current retirees who will have long-term care out-of-pocket costs during their lifetime, 36 percent will have expenditures that exceed $25,000 and 10 percent will have expenditures that exceed $100,000 (Kemper, Komisar, and Alecxih, 2005/2006).

Preventing Dependence on Welfare

A separate but related concern is to prevent people who have been financially independent all their lives from depending on welfare—Medicaid—at the end of their lives. Two thirds of all nursing home residents depend on Medicaid to pay for their nursing home care (American Health Care Association, 2008), and a substantial portion of residents were not eligible spent down to Medicaid because of the high cost of services (Wiener, Sullivan, and Skaggs, 1996).

Changing the Balance of Institutional and Home and Community-Based Services by Maximizing Consumer Choice

Reform of the financing system should also aim to create a more balanced delivery system by expanding paid home and community-based services. The overwhelming majority of people with disabilities are at home and want to stay there (AARP, 2003). Despite these preferences, public expenditures for long-term care for older people are overwhelmingly for nursing home rather than home care. In 2004, only about 32 percent of total long-term care expenditures for older people were for home and community-based services (U.S. Congressional Budget Office, 2004). Of total home care expenditures, 25 percent was financed by Medicaid, 42 percent by Medicare, and the remaining 33 percent by out-of-pocket payments, private insurance, and other government programs.

Designing an Affordable System

Political reality dictates that any reform system be "affordable" to both users and governments. Although there is little consensus as to what constitutes society's willingness to pay for long-term care services, there is little doubt that raising taxes to pay for a public program is always difficult, even for popular programs like Social Security and Medicare. Total (public and private) long-term care expenditures for older people are projected to be 2.1 percent of the gross domestic product (GDP) in 2048, compared with 1.21 percent in 1993 (Wiener, Illston, and Hanley, 1994). While this change is a big increase in percentage terms, it is a relatively modest change in absolute terms, given the aging of the population. On the other hand, long-term care will be needed primarily by older people, who will also require much larger Medicare and Social Security spending.

SETTING THE STAGE ON FINANCING

The debate over long-term care financing is primarily an argument over the relative merits of private versus public sector approaches. Some people believe that the primary responsibility for care of older people and younger adults with disabilities belongs with individuals and families and that government should act only as a payer of last resort for those unable to provide for themselves. Policymakers who hold this view generally advocate private sector initiatives, such as private long-term care insurance and using reverse mortgages to pay for long-term care services and insurance, and may advocate tightening eligibility for public programs to prod people to plan for their own long-term care needs. The long-term care financing systems of the United Kingdom, New Zealand, and the United States largely reflect this view (Organization for Economic Co-operation and Development, 2006).

The opposite view is that the government should take the lead in ensuring that all people with disabilities, regardless of financial status, are eligible for the long-term care services they need. The long-term care financing systems of Germany, Japan, the Netherlands, and Sweden reflects this view. U.S. policymakers who hold this view generally favor expansions of Medicaid, Medicare, the Older Americans Act, and other public programs and advocate a social insurance program for long-term care. Between these polar positions, many variations are possible.

Cutting across political ideology is the question of whether the current system of long-term care financing will be affordable in the future because of increased demand associated with the aging of the baby boom generation. Surprisingly, recent projections to assess this issue are

lacking, but Wiener, Illston, and Hanley (1994) projected that total long-term care for older people would increase from about 1.4 percent of GDP in 2008 to about 2.1 percent of GDP in 2048; public spending would account for about half those amounts. In the view of the author, new projections might put the total spending percentage at about 3.0 percent for 2048, roughly doubling the percent of GDP for long-term care. Projections of this type depend on a number of factors, including assumptions about the growth of the economy. Under a "slow" growth scenario, total long-term care expenditures for older people were projected to be 3.7 percent of GDP in the earlier projections (Wiener, Illston, and Hanley, 1994).

Moreover, long-term care for persons of all ages accounted for about a third of total Medicaid expenditures. As a result, Medicaid long-term care for persons of all ages accounted for 4.6 percent of state-revenue expenditures in 2004, and might, therefore, account for roughly 10 percent of state revenue expenditures in 2048 (author's calculation based on Scott, 2005). States, in particular, are worried about the long-range impact of an aging population on their budgets.

Countries such as Germany, the Netherlands, and the United Kingdom that have populations older than the United States spent between 1.35 and 1.44 percent of GDP for long-term care for older people in 2000; Sweden, where 17 percent of the population was elderly, was the outlier, spending a little under 3.0 percent of GDP for long-term care for older people (Organization for Economic Co-operation and Development, 2006).

How policymakers view these projections heavily determines what type of financing reform they propose. Advocates for private sector initiatives view these increases and their implications for public spending to be unacceptably high and worry that they will crowd out other worthwhile public spending, especially for younger people. In addition, they note that long-term care expenditure increases would be on top of huge projected increase spending for Social Security and Medicare, programs that serve the same population. Because of these fiscal burdens, they argue that it is imperative to shift as much long-term care cost to the private sector as possible.

On the other hand, the implicit assumption of advocates for a greater role for the public sector is that these costs are affordable. From their perspective, long-term care is a small portion of the total health care system and even if its proportion doubled, it would remain a small portion of the health care system. Indeed, overall national health expenditures increased by more than 2 full percentage points of GDP between 2000 and 2006 (Catlin et al., 2008) with relatively little notice and modest economic consequences. Moreover, from a macroeconomic perspective, it may matter little in terms of the burden to the economy whether services are financed by the public or private sector (Wiener, Illston, and Hanley, 1994).

In addition to these ideological and value choices, the choice of emphasis between public and private programs also depends on who would benefit and whether they meet specified policy goals. For example, if a large majority of citizens were to purchase private long-term care insurance, then many people would see less need for expanding government programs. Conversely, if private insurance were to prove widely unaffordable or otherwise encounter barriers that prevent people from voluntarily purchasing policies, then the case for an expanded public role would be stronger.

PRIVATE SECTOR INITIATIVES

Private sector approaches are appealing because they reflect the American tradition of individuals taking responsibility for their own lives and those of their families. Moreover, problems of the economy, the huge budget deficit, resistance to new taxes, and the aging of the baby boom generation make large-scale expansions of public programs difficult. In the case of long-term care, advocates contend that private sector initiatives might hold down public spending by preventing the middle class from spending down to Medicaid, although most previous research suggests that this is unlikely (Rivlin and Wiener, 1988; Wiener, Illston, and Hanley, 1994). Over the last decade, most national policy debate on financing reform has focused on private initiatives. Private sector initiatives fall into two broad categories—individual asset accumulation and use and various forms of private risk pooling, principally long-term care insurance. These options are summarized in ***Exhibit 1,*** along with their strengths and weaknesses.

Individual Asset Use: Reverse Mortgages

Motivated by the historically large amount of home equity among older people and, up to recently, the substantial increases in housing prices, there has been interest in finding ways to use reverse mortgages to finance long-term care (Merlis, 2005). Typically, reverse mortgages are home equity loans that do not have to be paid off until the borrower dies or moves from the house. These loans can be used for long-term care or anything else. They can either provide a regular stream of income or a line of credit. In 2007, there were approximately 100,000 older people with reverse mortgages (National Council on the Aging, 2009).

Reverse mortgages raise a number of issues: First, home prices are falling rapidly. Thus, like everyone else, older people are likely to have much less home equity than just a few years ago and mortgage lenders may be more reluctant to offer reverse mortgages, which are riskier than conventional mortgages. Second, even before the housing crash, home equity by older people with disabilities was not as high as it is for people without disabilities. In 2002, median home equity among older persons with disabilities (including those with no home equity) was only $56,956, and $35,640 for persons with severe disabilities (Johnson and Wiener, 2006). Third, restrictions on the amount of home equity that can be obtained, closing costs, and interest costs substantially erode the amount of money available to pay for long-term care directly (Merlis, 2005). Finally, the home has a near mythic quality in the United States, and it is uncertain how many older people would be willing to deplete their major asset, especially if home values are not rising.[2]

[2] Some analysts have suggested using home equity conversions to purchase private long-term care insurance, which provides more coverage than may be available through direct use of home equity to purchase long-term care services. While the use of home equity would marginally increase the proportion of older people who can afford private long-term care insurance, it seems unreasonable to expect that people will partly deplete their major asset to purchase a product, one of whose major purposes is to protect their major asset. Moreover, individually sold private long-term care insurance has high overhead, because of substantial marketing, commission, and profit costs. Most private long-term care insurance policies have long-term loss ratios of 60 percent, which roughly means that 60 percent of the premiums are used for benefits (U.S. Government Accountability Office, 2006). Thus, the use of home equity (with a "loss ratio" of 66 percent) to purchase a private long-term care insurance policy (with a "loss ratio" of 60 percent) would result in only about one in three home equity dollars providing long-term care benefits (Merlis, 2005).

Exhibit 1: Principal Private Long-Term Care Financing Options

Option	Pros	Cons
Reverse mortgages	• Older people have substantial home equity, although older people with disabilities have much less	• Various restrictions, fees, and interest payments reduce the amount of money available for long-term care • Older people may resist using home equity for long-term care costs • Recent drop in home prices may reduce demand by older people and lenders
Employer-sponsored long-term care insurance policies	• Reduces premium costs and medical underwriting • Encourages private responsibility	• Employer and employee market take-up has been low • Policies still relatively expensive • Selling to younger people means predicting what will happen far into the future • More employers may offer policies, but few help pay for them
Tax incentives for private long-term care insurance	• Reduces net cost of policies, making them more affordable • Encourages individual responsibility	• Results in loss of federal revenue • May be inefficient, providing benefits mostly to people who would have purchased policies without the incentive • Tax deductions are regressive, providing greater benefits to upper-income persons • Most people would receive relatively small tax benefits, not solving affordability problem
Public-private partnership, whereby people who purchase state-approved long-term care policies can become eligible for Medicaid while retaining much higher level of financial assets	• Brings together public and private sectors • Makes policies more affordable to middle class	• Previous partnerships have had limited market penetration • Asset protection and easier access to Medicaid may not motivate many purchasers • Inflation protection provided in the Deficit Reduction Act is weak
Hybrids of long-term care insurance with other types of insurance (e.g., disability insurance)	• Allow people to buy one policy to protect against two or more risks	• Products are complicated and difficult to understand • Offer only small premium savings by combining products

Risk Pooling: Private Long-Term Care Insurance

A viable private long-term care insurance market, primarily sold on an individual basis, has existed since the mid-1980s. In 2005, approximately 7 million policies were in force, covering about 3 percent of the total American population aged 20 and older; about 10 percent of older people, but only 0.2 percent of people aged 20–49, have private long-term care insurance (Feder, Komisar, and Friedland, 2007). Most policies have substantial limitations in terms of length of covered benefits, inflation adjustments, and benefits in case of lapse.

Among the reasons that relatively few people have private long-term care insurance are that people think that Medicare covers long-term care services, failure to recognize the potential risk, medical underwriting of policies which excludes many applicants, and the existence of a public safety net in Medicaid. Especially in the current economic environment, questions about the financial stability of insurance companies may deter people from buying policies.

Perhaps the greatest obstacle to purchase is that private long-term care insurance is expensive, especially for older people on relatively fixed incomes (Feder, Komisar, and Friedland, 2007; Wiener, Illston, and Hanley, 1994). The average premium in 2002 for private long-term care insurance policies providing $150 daily benefit amount, 4 years of coverage, a 90-day elimination period, 5 percent compound inflation protection, and a nonforfeiture benefit was $2,862 per year if purchased at age 65, meaning that married couples would face premiums exceeding $5,000 a year (Coronel, 2004). However, the median income for households headed by persons aged 65–74 was $34,243 in 2004, and declines sharply with increasing age (U.S. Census Bureau, 2006). Thus, even with generous assumptions about the willingness of people to pay, private long-term care insurance is expensive for most older people. It is also expensive for many working-age adults, who may lack health, life, and disability insurance. In addition, insurers are generally unwilling to sell insurance to people with health problems, eliminating them from the market.

The limitations of the unsubsidized, individual private long-term care insurance market has led to a number of proposals and initiatives to “jump start” the private long-term care insurance market, primarily by finding ways to make policies more affordable. These initiatives or proposals include encouraging employer-sponsored policies so that people will buy policies when they are younger when policies are less expensive, federal and state tax deductions or credits for the purchase of private long-term care insurance so that the net cost to the purchaser would be lower, public-private partnerships that apply less stringent Medicaid financial eligibility requirements to persons who purchase a state-approved private long-term care policy, and combining long-term care insurance with other types of insurance (such as life insurance) to provide value to people with other types of financial products.

PUBLIC SECTOR INITIATIVES

Private sector initiatives can play a bigger role than they do today, but none of the options described above is likely to result in private long-term care insurance or similar initiatives replacing public financing of long-term care without very substantial federal subsidies. An alternative approach would rely more heavily on the public sector. For advocates of a greater role for public sector programs, five factors are important:

First, long-term care services are already heavily financed by the public sector. In 2004, 56 percent of long-term care spending for older people was by Medicare, Medicaid, the Older Americans Act, state home care programs, and the Department of Veterans Affairs (U.S. Congressional Budget Office, 2004). In addition, a large portion of out-of-pocket payments are, in fact, contributions toward the cost of care required of Medicaid beneficiaries in nursing homes and not purchases of services by private payers. A substantial but unknown proportion of the out-of-pocket payments for long-term care is paid for with Social Security payments to individuals. A heavy role by the public sector in financing long-term care is typical of virtually all developed countries (Organization for Economic Co-operation and Development, 2006).

Second, the public sector originated or played an important role in many innovations in long-term care, including consumer-directed home care, cash and counseling, money follows the person, case management, capitated approaches to integrating acute and long-term care, and third-party funding for residential care facilities such as assisted living.

Third, the public sector is more likely to be able to address the needs of younger people with disabilities, who accounted for 36 percent of people with long-term care needs in 2000 (Rogers and Komisar, 2003). Medical underwriting for private long-term care insurance products excludes people with existing disabilities and working-age adults are less likely to purchase private long-term care insurance because the risk seems small and far away.

Fourth, because they require substantial discretionary income to be affordable, private sector initiatives are likely to be regressive or at least not to target working class and lower-middle class families. On the other hand, Medicaid targets a relatively low-income population and Medicare covers virtually all older people regardless of financial status. The relatively low incomes and assets of people with substantial disabilities (Johnson and Wiener, 2006) means that most additional spending, even under social insurance programs, would be spent primarily on lower- and moderate-income people with disabilities (Wiener, Illston, and Hanley, 1994).

Fifth, public programs have much lower administrative overhead and other nonbenefit costs than does private insurance. Most private long-term care insurance policies budget 40 percent of the revenue for administrative overhead, profits, marketing, and so on.

At least three broad strategies exist for expanding the role of the public sector—increasing funding for the Older Americans Act or similar appropriated programs, expanding Medicaid eligibility and covered services, and establishing a social insurance program. These options are summarized in ***Exhibit 2***. While increasing funding for the Older Americans Act or similar programs and expanding Medicaid are incremental approaches that could have relatively modest costs, establishing a new social insurance program would be a major departure for the existing financing system and would require large additional investment of federal funds, now and in the future.

Increase Funding for the Older Americans Act or Similar Programs

Apart from Medicare and Medicaid, the federal government funds long-term care through a number of appropriated programs, including the Older Americans Act, the Social Services Block Grant, and the Department of Veterans Affairs. Compared with Medicare and Medicaid, these programs are very small and have been relatively flatly funded in recent years. As a result, their role in the direct funding of long-term care services has declined over time (Rabiner et al., 2007).

Exhibit 2: Principal Public Sector Long-Term Care Financing Options

Option	Pros	Cons
Increase funding for Older Americans Act and similar programs	• Provides funding for people not eligible for Medicaid, but not high income • Focuses on home and community-based services • Could provide funding to build infrastructure through Aging Network	• Might increase fragmentation of financing system • Funding for appropriated programs less likely to increase over time than entitlement programs • Would require additional government spending
Expand the Medicaid program	• Easy to implement because it builds on existing system, which dominates long-term care financing • Targets people in greatest financial need	• Does not prevent people from incurring catastrophic out-of-pocket costs • Higher Medicaid spending may squeeze other priorities at state level • States will resist additional mandates • Increases number of people dependent on public means-tested system • Would require additional government funding
Expand Medicare nursing home and home health benefits	• Builds on already existing program • Administrative structures already in place • Provides near universal coverage for older people and some younger persons with disabilities	• Would require substantially greater government funding • Medical model would likely dominate • Program could be rigid and bureaucratic • Limited range of services • Does not make use of state expertise
Social insurance for long-term care	• Treats needs of people with disabilities the same as acute care • Provides universal coverage • Recognizes that vast majority of people cannot afford long-term care • Spreads risk over largest possible group	• Would require substantially greater government funding • Some funding would support services to upper-income and wealthy individuals • Program could be rigid and bureaucratic

Through programs funded by the Older Americans Act, the U.S. Administration on Aging funds three types of activities. First, the Older Americans Act funds a nationwide system of 655 Area Agencies on Aging and 56 State Units on Aging, which provide information and referral, advocacy, and services to the older population. Many State Units on Aging and Area Agencies on Aging are involved in administering Medicaid home and community-based services waivers. Second, the Administration on Aging funds a variety of home and community-based services to people aged 60 and over, including supportive services, senior centers, congregate- and home-delivered meals, disease prevention and health promotion services, and caregiver support services. Third, the Administration on Aging funds long-term care infrastructure development grants to states and Area Agencies on Aging on improving Alzheimer's disease services, establishing health promotion and disease prevention services, implementing nursing home diversion programs, and creating Aging and Disability Resource Centers, which are "one-stop shops" for information and referral on long-term care.

Expand the Medicaid Program

Medicaid, a means-tested welfare program, has strict requirements on income and assets and home care coverage that vary greatly by state. For example, the $2,000 limit on financial assets that single Medicaid beneficiaries may retain has not increased since 1984. The Deficit Reduction Act of 2005 restricted Medicaid eligibility for long-term care by reducing the amount of home equity that beneficiaries may retain and by tightening the rules against transfer of assets. Most states allow nursing home residents to retain only $40 per month or less in income as a personal needs allowance, only about $1 a day (Bruen, Wiener, and Thomas, 2003). In 2007, while almost all states provided home and community-based services through Medicaid waiver programs, only 34 states and the District of Columbia covered personal care services as part of their regular Medicaid program (Burwell, Sredl, and Eiken, 2008).

An incremental approach to long-term care reform would be to expand the Medicaid program. This approach targets public expenditures to people in greatest financial need. Possible changes could be establishing more lenient financial eligibility standards—raising the level of protected assets and increasing the amount of income that nursing home and community-based beneficiaries can retain for personal needs—and expanding home care coverage either by providing financial incentives to states or by mandating coverage. The Community Choice Act is an example of a proposal that would expand home and community-based services by mandating more home and community-based services and by liberalizing financial eligibility standards. Another example would be to repeal the requirement that states recover the cost of home and community-based services from the estates of Medicaid beneficiaries, a requirement widely believed to deter some people from receiving needed services. Without the federal government providing all or almost all of the funds for any expansion, states are likely to resist any new requirements as unfunded mandates.

It should be noted that some observers contend that the existence of Medicaid as a safety net for long-term care and the possibility of transfer of assets to qualify for Medicaid lead middle class people to forego private insurance (Moses, 2005). The provisions in the Deficit Reduction Act of 2005 that tightened transfer of assets restrictions and lowered the level of protected home equity were heavily influenced by the argument that it is too easy for middle-class persons to obtain Medicaid long-term care services. However, given the widespread misunderstanding of Medicare coverage, the denial of the risk of needing long-term care, and the lack of knowledge about Medicaid eligibility rules, it is unlikely that Medicaid eligibility rules are a major reason that people in their 50s and early 60s do not buy long-term care insurance. Moreover, despite the conventional wisdom that transfer of assets to obtain Medicaid eligibility is widespread, there is a large, rigorous research literature that finds that transfer of assets is relatively infrequent and usually involves quite small amounts of funds when it occurs (Bassett, 2004; Lee, Kim, and Tanenbaum, 2006; O'Brien, 2005; Waidmann and Liu, 2006). The maximum amount of asset transfer is probably no more than about 1 percent of Medicaid nursing home expenditures (Bassett, 2004; Waidmann and Liu, 2006).

Augment the Post-Acute Care Benefits under Medicare

The Medicare program already provides some coverage for skilled nursing facility care and home health on a non-means-tested basis. However, this coverage is oriented toward short-term, medically oriented services; Medicare does not cover nursing home or home health care

over an extended period and does not cover services such as assisted living. For beneficiaries with at least a 3-day hospital stay, Medicare covers up to 100 days of care in a skilled nursing facility for beneficiaries requiring skilled nursing or rehabilitation services on a daily basis. The average length of a Medicare covered stay is only about 26 days (U.S. Centers for Medicare & Medicaid Services [CMS], 2008). In addition, Medicare covers home health care, but it is limited to people who need part-time or intermittent skilled nursing care or physical, speech-language, or occupational therapy. Although no hospital stay is required, beneficiaries must be homebound. During the 1990s, the Medicare home health benefit was used by many beneficiaries with largely long-term care needs, but this practice ended abruptly with passage of the Balanced Budget Act of 1997. Thus, one option would be to expand Medicare coverage, perhaps by eliminating the 3-day hospitalization requirement for skilled nursing facility care or by removing the homebound requirement for home health.

New Social Insurance Program for Long-Term Care

A much more ambitious approach to reform would be to establish a new social insurance program for long-term care. This strategy offers coverage to all persons who need it, regardless of their financial need. While not much discussed in the United States in recent years, a number of other countries, including Japan, Germany, the Netherlands, and some parts of Canada and Scandinavia, have financing systems that are based on a universal coverage approach (Organization for Economic Co-operation and Development, 2006). One example of a social insurance proposal is the Community Living Assistance Services and Supports (CLASS) Act, introduced by Senator Edward Kennedy. The CLASS Act would create a nationwide voluntary long-term care insurance program financed through voluntary payroll deductions of $30 per month, with an option to opt out for those who choose not to participate. This legislation would provide a $50–$100 per day cash benefit to those individuals who need long-term care for a limited period of time.

MOVING FORWARD: FIRST STEPS

The long-term care financing and delivery systems in the United States need a dramatic overhaul. Although long-term care affects people of all ages, the increase in the elderly population over the next 40 years, and with it the growth in the number of older people with long-term care needs, inevitably will force long-term care onto the policy agenda. Some observers worry about whether the current Medicaid-dominated system can be sustained, although it seems likely that America can muddle through, albeit in a less than optimal fashion. While the costs and other demands of long-term care are almost certain to be greater in the future than they are today, long-term care in the future does not have to look like the long-term care of today. We have the opportunity and the responsibility to build a better system than the one we have today.

Common Understanding of the Problems

While there are strong disagreements among long-term care stakeholders on many issues, most observers would agree with the following observations on financing:

- Because each state has its own coverage and eligibility rules, the heavy emphasis on Medicaid financing results in great variation across the country in what services older and younger persons needing long-term care have available to them.
- States are not fiscally structured to address the large long-run increase in demand for long-term care.
- Addressing the problem of long-term care financing is likely to require a combination of public and private initiatives and will need to address both older people and younger persons with disabilities.
- While private sector financing is likely to increase, it will not become a major source of financing without much greater financial incentives, which would be costly to federal and state governments.
- Although substantial progress has been made over the last 10 years, the long-term care financing and delivery system continues to be tilted toward institutional care rather than to home and community-based services.
- The split between acute and long-term care financing and delivery results in suboptimal care for older and younger people with long-term care needs.

Agreements and Disagreements on Policy Directions

Long-term care stakeholders agree on some policy directions and disagree about others. In terms of financing, policymakers face a fundamental choice on whether they wish to devote the resources necessary to substantially change the existing system. Significant changes from the status quo—be it a large expansion of private long-term care insurance, modifying Medicaid, expanding Older Americans Act programs, or enacting a new public insurance program or expanding Medicare—will require substantial additional government spending either as direct government expenditures or as tax losses through deductions or credits for private long-term care insurance or other private financing mechanisms. As with the stimulus package and health care for the uninsured, sharp disagreements exist among policymakers over whether expansion of public or private programs is desirable or possible.

In contrast to the disagreements about long-term care financing, there is broad policy consensus to expand and reform home and community-based services. Most, but not all, stakeholders would strongly prefer that this expansion be accompanied by a decline in the use of nursing homes. The Medicaid funds to attain this goal are lacking in most states, but the direction is clear. Moreover, a number of initiatives are underway to expand participant-directed care, the use of residential care facilities, nursing facility transition programs and money-follows-the-person initiatives, and single points of entry to the long-term care system. This policy direction enjoys remarkable consensus across the political spectrum—liberals view these initiatives as a way of empowering a disadvantaged underclass and conservatives view these initiatives as a way of promoting market solutions.

Starting the Conversation

While major reform would be costly, there are many initiatives that are fairly widely agreed upon that could be implemented at relatively low cost, especially in the context of

significant health care reform. Presented below is a list of initiatives that in the opinion of the author represent the "low-hanging fruit" of long-term care reform. As such, they represent a fairly minimalist set of recommendations, but they represent a starting point, and are not inconsistent with other likely initiatives. Under the proper circumstances, much more ambitious initiatives could be adopted. These initiatives, which are summarized in ***Exhibit 3,*** include the following:

Educating the American People

Although an increasing number of people have experience with long-term care either directly or through relatives, most Americans know little about long-term care. For example, despite the fact that Medicare covers only short-term skilled nursing facility and home health care, most Americans continue to believe that Medicare covers long-term care (GfK NOP Roper Public Affairs & Media, 2006). Building on the existing *Own Your Future Campaign*, the federal government could mount a major campaign to educate Americans on the long-term care financing and delivery system, with a major focus on eligibility and coverage of government programs and options within the public sector.[3] The campaign should also educate the public about the range of long-term care services.

A National Commission on Long-Term Care

A national commission on long-term care, modeled on the Pepper Commission of the late 1980s, could be a useful way to create a consensus on long-term care reform. Mandated by the Medicare Catastrophic Coverage Act of 1987, the Pepper Commission was a bipartisan group composed primarily of members of Congress, charged with addressing health care for the uninsured and long-term care. Despite lopsided majorities on the Commission for major long-term care initiatives, they were not enacted. However, the Commission did educate Congress and the public on the problems of long-term care and its potential solutions, and was a touchstone for the long-term care debate over the next several years. While establishing a commission is likely to have significant support, some observers might object to this proposal because they see it as a way for politicians to avoid dealing with the issue, or as the British say, "kicking the ball into the long grass."

Federal Funding for State Long-Term Care Infrastructure Initiatives

The federal government currently operates a number of small programs that provide grants to the states to improve the long-term care infrastructure. For example, these grants have funded state initiatives to develop single points of entry to the long-term care system, improve quality management systems, develop nursing home transition and participant-direction programs, establish workforce initiatives, and improve services for people with Alzheimer's

[3] The Own Your Future Campaign is a project, started in January 2005, to increase consumer awareness about, and planning ahead for, long-term care. The project's core activities are state-based direct mail campaigns supported by each participating state's Governor, and targeted to households with members between the ages of 45 and 70. Campaign materials include a Long-Term Care Planning Kit and state-specific information and resources. The Own Your Future Campaign is a collaboration of CMS, the Office of the Assistant Secretary for Planning & Evaluation, and the U.S. Administration on Aging, and has support from the National Governors Association.

Exhibit 3: The Beginning Elements of a Reform Agenda

Proposal	Description
Educate the American people on long-term care	• Public education campaign to increase public understanding of the long-term care financing and delivery system
National Commission on Long-Term Care	• High-level, bipartisan commission, including appointees by the President, the House and Senate, to recommend a comprehensive strategy for long-term care reform
Increase federal funding for state long-term care infrastructure initiatives	• Substantially increase funding for existing or new grants to states to help states establish infrastructure, such as Aging and Disability Resource Centers, Alzheimer's disease programs, participant-directed home care programs, quality assurance systems for home and community-based services, and nursing facility transition programs
Ease Medicaid spend-down requirements for beneficiaries receiving home and community-based services	• Allow states to establish higher Medicaid income and asset spend down limits for people receiving home and community-based services
Increase funding for Administration on Aging and other appropriated long-term care programs	• Increase funding for infrastructure development and for home and community-based services for people of all ages
Increase support for a variety of relatively low-cost initiatives related to quality of care	• Increase funding for the Administration on Aging Ombudsman program • Increase research funding on quality of care of home and community-based services • Amend Medicaid to more clearly require states to establish standards for and monitor the quality of Medicaid home and community-based services • Establish Medicaid pay-for-performance demonstrations for nursing homes • Continue financial support for integrated data systems that cut across provider settings, such as the CARE tool
Establish grant program to states, providers, and consumers to improve direct care workforce	• Establish grant program to promote training programs, organizational change, worker registries, and other workforce initiatives
Research and development	• Increase funding for long-term care research and policy analysis. • Conduct demonstrations of innovative approaches to long-term care, including ways to coordinate and integrate with acute care.

disease. However, the size of many of these grants has been only a few hundred thousand dollars, limiting their impact; many projects have had difficulty going statewide or becoming permanently integrated into ongoing programs. In this proposal, funding for existing infrastructure programs would be increased or a new program that would consolidate and increase funding for these grants would be established. These infrastructure grants would address entry to the long-term care system, expansion and reform of home and community-based services, and workforce and quality of care initiatives.

Ease Medicaid Spend-Down Requirements and Other Improvements

Medicaid beneficiaries eligible for home and community-based services waivers may have incomes up to 300 percent of the federal Supplemental Security level (over 200 percent of the federal poverty level), but beneficiaries receiving other home and community-based services (such as personal care under the regular Medicaid state plan) must meet normal Medicaid eligibility rules. Many states use the "medically needy" option to provide Medicaid eligibility to people who incur substantial medical expenses. However, people who "spend down" to the medically needy income level must incur expenses, which, when subtracted from their income, leave them little income on which to live. Under federal law, the maximum level of protected income is only 133 percent of each state's old Aid to Families with Dependent Children level (the Aid to Families with Dependent Children program was replaced a decade ago by the Temporary Assistance to Needy Families program). These income levels are extremely low, well below the federal poverty level and the Supplemental Security Income payment level. In this proposal, states would have the option to set higher levels of protected income and assets for persons receiving Medicaid home and community-based services outside of waivers.

Funding for Administration on Aging and Other Appropriated Programs

Federal funding for Administration on Aging and other appropriated programs providing home and community-based services could be increased without committing the federal government to large and possibly unknown increases in Medicaid and Medicare. For example, the entire budget for the Administration on Aging was only $1.4 billion in FY2008 (U.S. Administration on Aging, 2008), so significant percentage increases could be obtained at relatively low cost. Funding could be increased for Administration on Aging service programs, such as the supportive services program, the National Family Caregiver Support Program, and the Ombudsman program and for the administrative costs of State Units on Aging and the Area Agencies on Aging.

Workforce Grant Program

Options to improve the direct care workforce that involve increasing wages and fringe benefits will require significant investment of funds, which may or may not be available. Health insurance coverage for these workers is likely to be addressed as part of other health care reform initiatives. Progress on a number of other initiatives could be promoted by establishing a grant program to states, providers, and consumers to implement training programs, promote organizational change, develop worker registries, and a variety of other workforce initiatives.

Quality of Care Initiatives

While many proposals to improve quality of care, such as raising staffing levels in nursing homes, carry high price tags, other initiatives are less expensive. These initiatives include (1) increasing funding for the Administration on Aging Ombudsman program; (2) funding research on quality of care of home and community-based services; (3) amending Medicaid to more clearly require states to establish standards for and monitor the quality of Medicaid home and community-based services (Institute of Medicine, 2008); (4) establishing Medicaid pay-for-performance demonstrations for nursing homes; and (5) increasing support for integrated data systems that cut across provider settings, such as the CARE tool.

Research and Development

Despite the aging of the population, federal funding for research and development in long-term care has been modest at best. Moreover, in recent years, several private foundations have reduced or narrowed their funding of long-term care research and policy analysis. Ironically, as the need for long-term care has increased, research funding has declined. Broad health services research funding earmarked for long-term care could be increased in the Office of the Secretary, CMS, the National Institute on Aging, the Administration on Aging, and the Agency for Healthcare Research & Quality. Beyond health services research, increased biomedical research on Alzheimer's disease would target one of the main causes of disability and use of long-term care services and increase the likelihood that interventions that prevent or treat this disease would be discovered, thus potentially reducing the need for long-term care services.

Closely allied to increasing the research base would be sponsoring new demonstrations of innovative long-term care programs, including those that better coordinate acute and long-term care services, including those that integrate these two systems. In addition, recognizing the high health care costs of people with long-term care needs, including long-term care and older and younger persons with disabilities in future Medicare chronic disease demonstrations is critical to meeting the needs of this population and finding ways to reduce costs. These demonstrations should include rigorous evaluation of their impacts.

CONCLUSIONS

Despite the fact that long-term care is the third main pillar of retirement security along with health care and income support, it has not received the policy attention it deserves. There is no doubt that when the baby boom generation is age 80 or 85, long-term care will be at the center of public policy debates, but those days are still quite far away (although not as far as they used to be). However, we are now at a time when the parents of the baby boom generation are now elderly; some of these parents are quite old and in need of long-term care. It may be the combination of the baby boomers and their parents that put long-term care on the national political agenda sooner rather than later. The health reform debate that is about to begin is a vehicle to begin to achieve the needed reforms.

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