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# **Long-Term Care Reform Options in Hawaii**

## **Final Report**

Prepared for

**Hawaii Long-Term Care Commission**

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## **Introduction**

This report analyzes a range of long-term care reform options for Hawaii, providing background and advantages and disadvantages for each option. It is meant to be reference document for the discussion of reform strategies by the Hawaii Long-Term Care Commission. It is not meant to be a definitive listing of options and their pros and cons. The Commission may have other options that it wishes to consider or it may not wish to consider all of the options presented here.

The paper has four sections. The first is a brief discussion of some of the problems of the existing long-term care system and the goals of reform. The goals are meant to help frame some criteria for the evaluation of various options. The second section examines reform options that depend on promoting and strengthening private long-term care insurance. The third section examines a range of options to expand and strengthen public sector financing, including Kupuna Care, Medicaid, and the Community Living Assistance and Supports (CLASS) Act insurance product. The fourth section examines options to reform the long-term care delivery system.

## **Problems of the Current Long-Term Care System and the Goals of Reform**

The current system of financing, organizing and delivering long-term care satisfies almost no one. Many analyses identify at least five goals that should be addressed by long-term care reform (*Exhibit 1*). Agreement on the goals of reform should help the Hawaii Long-Term Care Commission to evaluate various options. The Commission should decide whether the goals listed below are the ones it wishes to adopt or whether it wishes to delete, modify, or add goals.

### **Exhibit 1. Goals of Reform**

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- Treat the risk of needing long-term care as a normal life risk.
  - Protect against catastrophic out-of-pocket costs.
  - Prevent dependence on welfare in the form of Medicaid.
  - Improve access to long-term care services.
  - Make the long-term care system more responsive to consumers.
  - Change the balance of institutional and home and community-based services.
  - Design an affordable system, both for individuals and the government.
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### **Treat the Risk of Needing Long-Term Care as a Normal Life Risk**

Although not often explicitly discussed, perhaps the most important goal of reform is for society 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). 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 chronic illness and disability 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. People should know how their long-term care expenses will be paid. Mechanisms need to be established so that people will know how to pay for services should they need them.

### **Protect 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 Hawaii was \$132,860 in 2010 (MetLife Mature Market Institute, 2010). In the Hawaii Long-Term Care Survey conducted for the Commission, about three-fifths of respondents said that they could not afford to pay any of the cost of a year in a nursing home or 24-hour home care (Khatutsky et al., 2010). The costs of long-term care can easily impoverish people with long-term care needs.

## **Prevent Dependence on Welfare in the Form of Medicaid**

A separate but related goal is to prevent people who have been financially independent all their lives from depending on welfare—Medicaid—at the end of their lives. Most people believe that only a small proportion of the population should receive welfare. Yet, in 2010, 70 percent of nursing home residents in Hawaii had their care paid by Medicaid (American Health Care Association, 2010). A substantial portion of Medicaid nursing home residents were not eligible for the program when they were living in the community and turned to Medicaid because they had impoverished themselves paying for long-term care. Medicaid financial eligibility rules are very strict. For example, individuals in Hawaii with more than \$2,000 in financial assets are ineligible for Medicaid (Walker and Accius, 2010).

## **Improve Access to Long-Term Care Services**

Access to long-term care services in Hawaii is to be limited. On a population basis, the supply of nursing home care is half the supply in the country as a whole (O’Keeffe and Wiener, 2010). Partly as a consequence, according to some observers, some people needing high levels of care have difficulty gaining access to services, forcing them to remain in acute care hospitals. Similarly, although the Medicaid QUEST Expanded Access demonstration appears to be expanding access to home and community-based services, Hawaii’s Medicaid spending on home and community-based services per 1,000 people aged 75 and older has historically been much less than the national average (O’Keeffe and Wiener, 2010). Hawaii’s many islands impede access to long-term care services; people are not able to travel from island to island to receive long-term care. To the extent that they must do so, then they are separated from their family and friends.

## **Make the Long-Term Care System More Responsive to Consumers**

The financing and delivery of long-term care services in Hawaii and most other places in the United States are fragmented, with a confusing array of programs, funders, eligibility rules, and provider types. For example, Medicaid is the dominant funder, but a very limited amount of long-term care is also funded by Medicare, Kupuna Care, the Department of Veterans Affairs, the U.S. Office on Aging, and other state programs. One of the goals of Medicaid’s QUEST Expanded Access is to create a more seamless system by making one organization responsible for all Medicaid medical and long-term care services for an individual. Similarly, Hawaii’s Aging and Disability Resource Center seeks to provide consumers with a “one-stop shop” for information about long-term care resources, but its services are still fairly underdeveloped, although initiatives are underway to improve them. Closely related to these activities is the movement to consumer-directed home care, which gives consumers rather than agencies the right to hire, train, schedule, supervise, and fire their workers (Foster et al., 2003; Schore, Foster, and Phillips, 2007; Wiener, Anderson, and Khatutsky, 2007).

## **Change the Balance of Institutional and Home and Community-Based Services**

The overwhelming majority of people who need long-term care live in their homes and want to stay there. In the Hawaii Long-Term Care Survey, only 4 percent of respondents said that they want to be cared for in a nursing home and only 12 percent want to live in assisted

living or small group homes (Khatutsky et al., 2010). The overwhelming majority of people want to be cared for at home, either by friends and relatives or home care providers. Despite these preferences, public expenditures for long-term care for older people are overwhelmingly for nursing home rather than home care. Few data are available to evaluate how the demonstration program is performing, but nursing home use appears to have dropped somewhat and home and community-based services use has increased significantly.

### **Design an Affordable System, Both to the Individual and Government**

Political reality dictates that any reforms be “affordable” to both users and tax payers. Although there is little consensus about how much society is willing 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.

With the aging of the population in Hawaii and nationally, demand for long-term care will increase, as will public and private expenditures. Reforming the system will require additional resources and a key issue is how to obtain them. Additional funding for long-term care can be obtained through general revenue taxes, private insurance, or public insurance. Another key issue is how to convince people to either prepare financially so they can afford to pay privately to meet long-term care needs or to be willing to pay more taxes to support public programs that provide long-term care services.



## Options for Long-Term Care Financing Reform

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 persons 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 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 to ensure that all people who need long-term care, regardless of ability to pay, receive the services they need. In this view, long-term care for older people should be treated more like health care for older people and should not require people to be poor or become poor to receive government aid. The long-term care financing systems of Germany, Japan, the Netherlands, and Sweden reflect 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.

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 total (public and private) long-term care for older people in 2000; Sweden, where 17 percent of the population was elderly in 2000, 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).

Public long-term care expenditures are a small proportion of the national economy, accounting for about 0.9 percent of the U.S. gross domestic product in 2005 (Organization for Economic Co-operation and Development, 2006). Long-term care is also a small proportion of total health care expenditures. In 2005, health care was 16.0 percent of the overall U.S. economy and long-term care was approximately 5.6 percent of total health expenditures (author's calculations using data from the Organization for Economic Co-operation and Development, 2006 and the Centers for Medicare & Medicaid Services, 2011).

With the aging of the population, the percentage of GDP for public long-term care expenditures is projected to double or triple by 2050 (Organization for Economic Co-operation and Development, 2006). Although this change is a big increase in percentage terms, it is a relatively modest change in absolute terms, given the aging of the population. Indeed, between 1999 and 2009, total health care expenditures as a percentage of the U.S. economy increased by 3.8 percentage points, more than is expected for long-term care between 2005 and 2050 (Centers for Medicare & Medicaid Services, 2011).

On the other hand, these projections would mean a very large percentage increase in what state governments pay for long-term care as a proportion of their budgets, which would be a strain. In addition, long-term care will be needed primarily by older people, who will also require

Medicare and Social Security spending. Thus, substantial additional funds will be needed to pay for long-term care services, and many states, including Hawaii, are worried about the long-range impact of an aging population on their budgets.

Medicaid, the major source of funding for long-term care, is a major expenditure for state governments. Although Medicaid expenditures (federal and state shares for all services and populations) accounted for 21.8 percent of total expenditures by states nationally in fiscal year 2010, they accounted for only 13.3 percent of expenditures in Hawaii during that same year (National Association of State Budget Officers, 2010). Long-term care for older people and younger persons with physical disabilities accounted for about 22 percent of Hawaii's Medicaid spending in 2008, the most recent year for which data are available (Eiken, Sredl, and Burwell, 2009). Medicaid long-term care services accounted for about 2.9 percent of total state expenditures, including the federal match.

How policymakers view these projections partly 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. They are unwilling to consider raising taxes to pay for the increased costs and argue that it is imperative to shift as much long-term care costs as is possible to the private sector.

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 or tripled, it would remain a small portion of the health care system. 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). Advocates of mandatory public long-term care insurance argue that offering additional benefits to the population as a whole is a way of building support for the additional revenues that will be needed to cover existing as well as additional services.

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 present barriers—such as medical underwriting—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 themselves and their families. The classic virtue of the competitive market is its flexibility to adapt to individual needs and wants and to local conditions, a virtue that is mitigated for long-term care insurance by the long lead time between purchase and use of insurance. In addition, some private long-term care insurance advocates hope that private sector initiatives can prevent middle class people from having to turn to Medicaid when they have spent all of their assets on long-term care services. In addition, if private sector initiatives could prevent middle-class people from having to depend on Medicaid, they might reduce Medicaid long-term care spending.

Over the last decade, the national policy debate on financing reform has primarily focused on private sector initiatives. The marked improvement in the financial position of the elderly over the last 30 years has made it plausible to argue that private sector financing other than out-of-pocket payments might play a significant role in the future financing of long-term care.

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 have some form of private long-term care insurance (Feder, Komisar, and Friedland, 2007), compared to 0.2 percent of people aged 20–49. Most policies have limitations. For example, many policies do not cover lifetime need for services, provide only fixed indemnity benefits rather than payment for all incurred costs, provide benefits that are not inflation-adjusted over time, and do not include a nonforfeiture benefit in case of policy lapse.<sup>1</sup> In recent years, sales have been increasingly to people under the age of 65; in 2009, 81 percent of long-term care insurance purchasers were under age 65 (American Association for Long-Term Care Insurance, 2010).

In some respects, the slow growth of private long-term care insurance is surprising because of the widespread use of automobile insurance, homeowner's insurance and private health insurance. A major reason that relatively few people have private long-term care insurance is that long-term care insurance is expensive, especially for older people with fixed retirement incomes. In 2008, the average premium for private long-term care insurance policies providing a \$150 daily benefit amount, 3 years of coverage, a 90-day elimination period, and 5 percent compound inflation protection, but no nonforfeiture benefit was \$2,329 per year if purchased at age 60 (Tumlinson and Aguiar, 2009). In 2009, among people who purchased their policy in the individual market, the average long-term care insurance premium among people age 55-64 and 65 and over, respectively, was \$2,200 and \$3,250 (American Association for Long-Term Care Insurance, 2010). Using the National Association of Insurance Commissioners' suitability criteria for purchase of private long-term care insurance (premium not exceeding 7 percent of

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<sup>1</sup> For example, 57 percent of policies purchased in 2009 covered 4 years or fewer years of care (American Association for Long-Term Care Insurance, 2010). Similarly, while 91 percent of policies purchased during that same year had some inflation protection, only 53 percent of policies purchased provided inflation protection either through 5 percent compound inflation adjustment or a consumer price index inflation adjustment.

income and financial assets of at least \$35,000), only 21 percent of people between age 60 and 79 could afford to buy a “mid-range” policy (Merlis, 2003). Thus, even with generous assumptions about the willingness of people to pay, private long-term care insurance is very expensive for most older people (Wiener, Illston, and Hanley, 1994).

Even if long-term care insurance was more affordable, for many people, there is no point in buying private long-term care insurance because they think they already have coverage through Medicare. This is incorrect. While Medicare covers short-term post acute care, it does not cover long-term care in nursing homes or at home. In a national survey by AARP, almost 60 percent of respondents said that Medicare covered long-term care (GfK NOP, 2006). Medicare coverage rules for skilled nursing facilities and home health care are complex, making benefits difficult to explain to people. One of the goals of the *Own Your Own Future* awareness campaign sponsored by the U.S. Department of Health and Human Services is to educate people about the lack of Medicare coverage and Medicaid’s financial eligibility requirements.

Although everyone recognizes the risk for use of physician and hospital services, the risk of needing long-term care is much less well known among the general population, and people are unlikely to buy long-term care insurance if they believe it is a low or no risk event. In fact, the lifetime risk of needing long-term care is quite high—69 percent of people aged 65 and older will have some long-term care need before they die and 20 percent of people aged 65 and older will have long-term care needs for more than 5 years (Kemper, Komisar, and Alecxih, 2005/2006).

Because of the risk of adverse selection, individual long-term care insurance policies are medically underwritten—that is, insurance companies will not sell policies to people they deem having a high risk of using long-term care services in the relatively near term because of existing health and other problems. Although underwriting practices differ among companies, one study estimated that 28 percent of people aged 65 to 69 could not pass medical underwriting standards (Merlis, 2003). Among applicants for insurance, 9 percent of persons age 50-59 and 15 percent of persons age 60-69 were declined coverage as a result of medical underwriting (American Association for Long-Term Care Insurance, 2010).

The limitations of the unsubsidized, individual private long-term care insurance market has led to a number of proposals and initiatives to “jump start” it. These include educating the public about their risks of long-term care, encouraging policy makers to enact tax incentives for the purchase of private long-term care insurance and public-private partnerships that combine private insurance with Medicaid coverage.

*Exhibit 2* summarizes private sector options and their advantages and disadvantages.

## Exhibit 2. Private Sector Financing Options

Option	Advantages	Disadvantages
Establish educational campaign for private long-term care insurance	<ul style="list-style-type: none"> <li>▪ Motivates some people to plan for their own long-term care needs</li> <li>▪ Can be relatively low cost compared to providing benefits</li> <li>▪ This approach could be combined with several other options</li> </ul>	<ul style="list-style-type: none"> <li>▪ Does not address affordability of long-term care insurance</li> <li>▪ Encourages people to purchase products with limitations</li> </ul>
Strengthen regulation of private long-term care insurance to better protect consumers	<ul style="list-style-type: none"> <li>▪ Helps to protect consumers</li> <li>▪ Low-cost option</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reduces consumer choices</li> <li>▪ Raises price of policies by imposing additional requirements, such as inflation protection</li> </ul>
Establish a “public-private” partnership	<ul style="list-style-type: none"> <li>▪ Brings private insurance and Medicaid together into integrated program</li> <li>▪ May increase number of people with private insurance</li> <li>▪ Allows people to receive lifetime asset protection (while receiving Medicaid) without buying a long-term care insurance policy that provides lifetime coverage.</li> <li>▪ Reduces price of long-term care insurance by reducing amount of coverage needed</li> <li>▪ If it successfully encourages additional people to purchase insurance, it may reduce Medicaid costs</li> <li>▪ Forty-three states are operating or planning to operate “public-private partnerships”</li> </ul>	<ul style="list-style-type: none"> <li>▪ Experience in other states suggests that it will motivate few additional people to buy insurance</li> <li>▪ Asset protection and easier access to Medicaid may not be what people want from long-term care insurance, making it an ineffective incentive</li> <li>▪ If it does not successfully encourage additional people to purchase insurance, it may result in additional Medicaid costs</li> </ul>
Provide tax incentives for purchase of private long-term care insurance	<ul style="list-style-type: none"> <li>▪ Helps to lower the price of insurance a little, making it more affordable for some</li> <li>▪ Encourages individuals to take responsibility for their own long-term care needs</li> <li>▪ Has substantial support among Hawaii state residents</li> <li>▪ Could reduce Medicaid expenditures</li> </ul>	<ul style="list-style-type: none"> <li>▪ Empirical evidence suggests that typical state tax incentives do not substantially increase number of people with insurance</li> <li>▪ Potential reductions in Medicaid costs likely to be smaller than the cost to the State of the tax incentives</li> <li>▪ Empirical evidence suggests that tax incentives will not produce net Medicaid savings</li> <li>▪ Tax incentives are typically regressive</li> <li>▪ Tax loss must be made up with tax increases or expenditure cuts elsewhere</li> </ul>

### ***Private Sector Option #1: Establish an Education and Marketing Campaign to Promote the Purchase of Private Long-Term Care Insurance***

In this option, the State of Hawaii would develop and finance an education campaign that explains the risk and costs of needing long-term care and the available financing options. The emphasis would be on encouraging people to take active steps to plan for their own long-term care needs, including the purchase of private long-term care insurance.

#### *Background*

Americans know little about long-term care services, costs, or financing of long-term care and deny their potential risk of needing services. The MetLife Mature Market Institute survey conducted in 2005 and in 2009 demonstrated that most people underestimate the need for long-term care as they age and the majority do not know who pays for it, with few taking action to protect themselves from these expenses (MetLife Mature Market Institute, 2009). Lack of knowledge and low preparedness is widespread: In a survey of California voters, 69 percent of respondents inaccurately believed that Medicare covers long-term nursing home care and 78 percent thought it covers long-term in-home care (Lake Research Partners and American Viewpoint, 2010).

Although recent polls demonstrate low levels of preparedness and knowledge of long-term care costs among the American public, the polls also show that there is a lack of confidence in being able to pay for long-term care. For example, a survey conducted for the SCAN Foundation showed that 66 percent of Californians aged 40 and older worry about being able to pay for long-term care that they or a family member may need in the future (Lake Research Partners and American Viewpoint, 2010). Similarly, in an AARP survey, 59 percent of registered voters in Hawaii expressed lack of confidence in their ability to afford long-term care services (Binette & Dinger, 2008). In the Hawaii Long-Term Care Survey, half of respondents did not know how they would pay for an extended nursing home stay or 24-hour home care (Khatutsky et al., 2010). These findings suggest that the public may be receptive to an educational campaign that provides current and relevant information about long-term care planning options (Life Plans Inc., 2007).

#### *Advantages*

- An advertising campaign that educates the people of Hawaii about long-term care risks could motivate them to plan for their own long-term care needs.
- An advertising campaign is relatively low cost, because it does not directly provide services, insurance, or other financing.

#### *Disadvantages*

- Education, by itself, does not address the most important barrier to purchasing long-term care insurance: lack of affordability. Education without a viable “action plan” will likely be ineffective in motivating behavioral change.
- Unless private long-term care insurance is better regulated, people may be encouraged to purchase policies that do not meet their needs.

## ***Private Sector Option #2: Strengthen Regulation of Private Long-Term Care Insurance***

Under this option, Hawaii long-term care insurance regulations would be reviewed for possible revision and strengthening. Major focuses of the review would be inflation protection, nonforfeiture benefits, and premium increases by insurance companies.

### ***Background***

All states, including Hawaii, regulate private long-term care insurance, usually based, to a greater or lesser extent, on the model statute and regulation of the National Association of Insurance Commissioners. At least three areas are of concern to consumer advocates nationally.

- The first area relates to inflation adjustment (Wiener, Illston, and Hanley, 1994). Unlike health insurance where benefits are typically a fixed percentage of the allowable costs, private long-term care insurance typically pays up to a fixed amount per home care visit or per day in a nursing home or assisted living facility regardless of the cost of care. Unless there is an annual inflation adjustment, the maximum amount stays the same over time. Like virtually all other states, the Hawaii insurance regulations require insurers to offer compound inflation adjustment over time but they allow insurers to sell policies without inflation adjustments. The problem is that long-term care insurance is typically purchased far in advance of using benefits; thus, inflation over time can severely undermine the purchasing power of the policies. For example, assuming a 5 percent annual increase in price, a policy bought at age 60 that pays \$4,000 per month for nursing home care needs to pay more than \$10,600 per month at age 80 to retain equivalent purchasing power.

Without inflation protection, the value of the benefit would drop by 60 percent. Compound insurance protection greatly increases the premium compared to policies without inflation protection. For example, at age 65, policies with 5 percent annual compound inflation protection cost approximately 75 percent more than policies without inflation protection (Coronel, 2004), while the proportion of policies with inflation protection has increased substantially over time. Fully 91 percent of policies purchased nationally in 2009 had some inflation protection, but only 53 percent of policies purchased that year had compound inflation protection or linked increases in benefits to the Consumer Price Index (American Association for Long-Term Care Insurance, 2010).

- The second area relates to lapse rates and nonforfeiture benefits. Long-term care insurance policies are designed to have level premiums; that is, the premiums are supposed to stay the same year after year. Thus, relative to their risk of using long-term care, insureds overpay during the early years of their policy and underpay during the later years of their policy. During the early years of having insurance, individuals contribute to the buildup of reserves which will be used when the individual is older and has a higher risk of needing care. If policyholders terminate or “lapse” their policies, they typically receive no residual benefits even though the insurance company has built up financial reserves during the period of premium payment.

The recent dramatic increase in long-term care insurance premiums among many

insurers is expected to result in a large increase the number of lapses. The insurance companies will be able to retain the excess funds for their own use rather than returning the reserves to the policyholders. Observers also note that policies with high lapse rates will have lower premiums, all other things being equal, than policies with low lapse rates, creating an incentive for insurers to assume high lapse rates. If the high lapse rates do not occur, the policy will lose money, causing the insurer to raise premiums, which will increase the lapse rates. Thus, some experts have advocated mandatory residual or nonforfeiture benefits be provided to policyholders when they lapse. Some policies offer “contingent nonforfeiture benefits” which provide a residual benefit if premiums are increased greatly, but the level of required premium increases needed to trigger benefits can be quite large.

- The third area of concern relates to premium increases for existing policyholders. As noted above, premiums are designed to be the same after initial purchase. Although insurance companies may not raise the premiums of individual policyholders, they reserve the right to raise premiums for an entire class of policyholders (e.g., people who bought a certain policy during a particular year) if the policy encounters substantial financial difficulty. Although large, unexpected premium increases have been an ongoing problem in the industry; in the last few months, several well-known insurers, including MetLife, Genworth Financial, and John Hancock, have substantially raised premiums for existing policyholders.<sup>2</sup>

Insurers have raised premiums partly because they are receiving a lower rate of return on investments than they expected and because fewer people than they anticipated allowed their policies to lapse. A large increase in premiums can cause financial hardship for policyholders and may lead some to lapse their policies, leaving them with no financial protection or may cause them to substantially reduce their coverage. Insurance regulators generally review the insurance premium rates for private long-term care insurance, both initially and for proposed increases to determine appropriateness. Thus, the large premium increases, in some way, reflect a failure both by state regulators and by the insurance companies to accurately price long-term care insurance policies.

#### *Advantages*

- Strengthening private long-term care regulations will help to protect consumers by ensuring that the policies that they purchase actually provide the financial protection that they promise, that they will receive some benefits from the financial reserves of the companies if they have to lapse their policies, and that the cost of the policies will be known in advance.

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<sup>2</sup> Genworth Financial is seeking an 18 percent increase on older policies held by about 25 percent of its customers. John Hancock has filed for permission to raise premiums for about 80 percent of its customers by an average of 40 percent and has also temporarily stopped offering new long-term care insurance plans through employers while it recalculates premiums (Lieber, 2010). John Hancock Financial said it would ask state regulators for an average 40 percent increase for about 850,000 of its 1.1 million policyholders (Tergsen and Scism, 2010).



- Regulatory reform is a low-cost option to implement because it does not directly finance services or provide tax benefits.
- Because long-term care insurance is a particularly complex product that few consumers understand, strict regulation is warranted.

*Disadvantages*

- Consumers are already offered compound inflation benefits and some are offered nonforfeiture benefits. If they do not want to purchase policies with this protection, they should not have to incur the extra costs.
- Stricter regulation will raise costs, causing fewer people to purchase policies.

## ***Private Sector Option #2: Establish a “Public-Private” Partnership for Long-Term Care***

In this option, private long-term care insurance would be promoted by providing purchasers of state-approved private long-term care insurance policies with easier access to Medicaid. In these public-private partnerships, policyholders are allowed to keep much more of their financial assets than is typically allowed by Medicaid financial eligibility rules.

### *Background*

A number of policy analysts have suggested a public-private partnership for long-term care to promote private long-term care insurance and to align it with Medicaid. These public-private partnerships have been in effect for more than 15 years in California, Connecticut, Indiana, and New York. In determining Medicaid eligibility, these partnership programs generally allow policyholders to keep an extra dollar in financial assets for each dollar that their insurance policies pay in benefits. For example, in Connecticut, persons with state-approved private long-term care insurance policies that pay \$150,000 in benefits can keep \$152,000 in financial assets and still qualify for Medicaid once the insurance policy has paid all of its benefits. At its core, this approach offers asset protection as its inducement to purchase insurance. Medicaid beneficiaries still must contribute all of their income except for a small personal needs allowance towards the cost of care. However, individuals would still have to use their assets or income to pay for care not covered by insurance, and—once insurance benefits run out—must contribute all of their income to their care before Medicaid will pay.

Although the Omnibus Budget Reconciliation Act of 1993 limited this strategy to the four states mentioned above, the Deficit Reduction Act of 2005 removed those restrictions, opening the approach to all states. The Deficit Reduction Act also lowered the consumer protection standards of the policies that had been set by the original four states. For example, all of the original four states required policies to have automatic compound inflation adjustment to the benefit; the Deficit Reduction Act eliminated that requirement and replaced it with less strict inflation adjustment requirements. As of June 30, 2010, 43 states have adopted the partnership approach, with 228,293 policies in force (Thomson Reuters, 2010).

### *Advantages*

- The partnership brings together the public and private sectors into an integrated system, with the private sector accepting the front-end risk for long-term care and the public sector accepting the back-end risk.
- This approach may increase the number of people who have private long-term care insurance above what might otherwise be the case.
- This strategy allows the insured to obtain lifetime asset protection without having to buy an insurance policy that provides lifetime coverage, thus reducing the price of the private insurance policy needed and increasing affordability for more middle-class people.
- Compared to providing tax incentives, this approach is a relatively low-cost option to promoting private long-term care insurance. If the partnership can induce people who would not have otherwise purchased long-term care insurance to do so, then some Medicaid savings may result in the future.

### *Disadvantages*

- Although this approach is favored by some policy analysts because it melds the public and private sectors, partnerships have not significantly increased the number of people with private long-term care insurance. Only modest numbers of partnership policies have been sold in the four states in which the initiative has been offered, despite more than a decade of active promotion and marketing by the respective states. In 2005, there were approximately 172,000 partnership policies in force in the four states with the longest experience, about 2.2 percent of the older population in the four states (U.S. Census Bureau, 2006; U.S. Government Accountability Office, 2005a). This strategy uses Medicaid to protect the assets of middle- and upper-middle-class insurance purchasers. The majority of purchasers of partnership policies in California, Connecticut, and Indiana had more than \$350,000 in assets (U.S. Government Accountability Office, 2005a).
- Asset protection may not be a decisive motivator for the purchase of private long-term care insurance. Most surveys of private long-term care insurance purchasers point to less concrete reasons for buying policies, such as retaining autonomy and independence, not being a burden to one's children, and having more choice of providers.
- A core component of this approach is to offer easier access to Medicaid, but older people may not want to be on Medicaid. Indeed, most private long-term care insurance is marketed as a way of avoiding Medicaid.
- Depending on who purchases these policies, who eventually needs long-term care, and what services they use, partnership policies may not reduce Medicaid costs, and conceivably could even increase them.

### ***Private Sector Option #3: Provide Tax Incentives for the Purchase of Private Long-Term Care Insurance***

This option would provide a Hawaii tax deduction or credit for the purchase of private long-term care insurance. The deduction or credit could be capped and could vary by income.

#### *Background*

One strategy to improve the affordability of private long-term care insurance is to provide tax incentives for their purchase, which would reduce the net cost of the insurance. Current federal law allows qualifying long-term care insurance premiums to be deducted from income as part of medical expenses, but only if total out-of-pocket expenses exceed 7.5 percent of adjusted gross income and only for the expenses that exceed the threshold. As a result, fewer than 5 percent of all tax returns report medical expenses as itemized deductions (Ignani, 2006). Even for those able to meet the federal threshold, some policyholders are unable to claim the federal deduction because of other requirements that they do not meet. The recently enacted health reform legislation will increase the threshold for tax deductibility of medical expenses from 7.5 percent to 10.0 percent. Because this provision is a deduction rather than a credit, a deduction is worth more to them than it is for moderate income people who are in lower tax brackets.

Under federal law, employers may deduct their contributions toward the cost of private long-term care insurance as they do health insurance. Despite this incentive, few employers contribute to the cost of private long-term care insurance. The vast majority of employers that offer long-term care insurance to their employees do so on an employee-pay-all basis.

Many states offer some type of tax incentive for private long-term care insurance. In 2006, 23 states and the District of Columbia offered some type of tax incentive: 15 states allowed taxpayers to deduct premiums from income; six states offered tax credits; and two states offered both (Goda, 2010).<sup>3</sup> The credits are not refundable so do not benefit individuals with low incomes who do not pay taxes. Tax incentives in the form of deductions are generally allowable in addition to the standard deduction, not requiring taxpayers to itemize. Because state tax rates are low in absolute terms, the value of the tax incentives is small, generally in the range of \$30 to \$100 per year on a \$1,000 policy (Nixon, 2006). Only three states provide more than a 10 percent subsidy (Goda, 2010).

#### *Advantages*

- Tax incentives help some people to buy private long-term care insurance.
- Tax incentives lower the net price of private long-term care insurance. Although responsiveness of consumers to variations in price is not known, standard economics predicts that people will buy more of a good or service when prices are lower.
- Tax incentives are easy to administer through the tax system.

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<sup>3</sup> These states were Alabama, Colorado, the District of Columbia, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Minnesota, Missouri, Montana, Nebraska, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Utah, Virginia, West Virginia, and Wisconsin.

- Private long-term care insurance encourages individuals to take responsibility for financing their own care.
- Private long-term care insurance increases the amount of funds available for the long-term care system.
- Some advocates of tax incentives argue that, if properly targeted, they can reduce Medicaid expenditures and save state government money.
- Tax incentives for private long-term care insurance have substantial support among people in Hawaii. In the Hawaii Long-Term Care Survey, 80 percent of respondents favored tax incentives for purchasing long-term care insurance (Khatutsky et al., 2010). This was the highest level of support of any option assessed. When asked to choose the single option they most favored, 33 percent of respondents chose tax incentives for private long-term care insurance, which made it the most popular option by a small margin.

### *Disadvantages*

- The limited empirical evidence suggests that tax incentives will increase the number of people with private long-term care insurance only slightly, although the tax loss will be significant. In one of the first analyses of the impact of tax incentives, using a microsimulation model, Wiener, Illston, and Hanley (1994) found that a 20 percent nonrefundable federal tax credit would only increase the relatively small number of people with private long-term care insurance by about a third compared to the number of people with private long-term care insurance without a tax subsidy 25 years into the future. In a cross-sectional multivariate analysis, Nixon (2006) did not find that offering a state tax incentive was a significant predictor of private long-term care insurance market penetration.

Using a price elasticity of private long-term care insurance of  $-0.75$  to  $-1.25$ , Feder, Komisar, and Friedland (2007) calculated that a tax deduction for private long-term care insurance might increase the number of people with private long-term care insurance by 11 to 19 percent. In an unpublished paper, Kim (2010) found that the estimated price elasticity of long-term care insurance demand is  $-0.08$ , implying that tax subsidies will have a very small impact on the number of people with insurance.

Similarly, Goda (2010) found that the average state tax subsidy increased private long-term care insurance coverage rates by only 2.7 percentage points, mostly among higher income and asset-rich individuals. Because tax subsidies are unlikely to substantially increase the proportion of people with private long-term care insurance, most of the tax subsidy will go to people who would have bought insurance without the incentive. As a result, the cost per additional person with insurance is likely to be high. Feder, Komisar, and Friedland (2007) calculated that each additional policy purchased would cost \$1,308 to \$2,125 in lost revenue, a high proportion of the cost of the policies.

- The tax loss is not likely to be offset by Medicaid savings. Wiener, Illston, and Hanley (1994) found that the 20 percent tax subsidy in their simulation would not be

offset by Medicaid savings within their 30-year simulation period. Goda's simulations of state tax subsidies found that a dollar of state tax expenditure produces approximately \$0.84 in Medicaid savings, about half of which in Hawaii would result in savings to the federal government. As a result, tax incentives are expenditures as surely as direct spending. The tax loss would need to be offset either with other tax increases or expenditure cuts.

- Tax deductions are regressive, providing more benefits to higher income than lower and moderate income people. Unless refundable, many older people do not qualify for deductions because they pay no federal income taxes because of the exclusion of some or all of their Social Security benefits from taxation.

## 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 public subsidies for its purchase. An alternative approach is to rely more heavily on the public sector. For advocates of a greater role for public sector programs, four factors are important:

- Long-term care services are already extensively financed by the public sector. Public sector spending for persons of all ages and types of disabilities (including intellectual and other developmental disabilities) accounted for about two-thirds of all national long-term care spending in 2008 (O'Shaughnessy, 2010). 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 heavy role by the public sector in financing long-term care is typical of all developed countries (Organization for Economic Co-operation and Development, 2006).
- The public sector originated or played an important role in many innovations in long-term care, including consumer-directed home care, cash and counseling programs and policies, money follows the person policies, case management, capitated approaches to integrating acute and long-term care, and third-party funding for residential care facilities such as assisted living. Thus, it is well positioned to lead future innovations.
- 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 (Komisar and Rogers, 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.
- Tax incentives are expensive and are likely to be regressive or at least not targeted to working- and lower-middle class families who most need the help in purchasing insurance. 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 most social insurance programs, would be spent primarily on lower- and moderate-income people with disabilities (Wiener, Illston, and Hanley, 1994).

Opponents of expansion of the public sector in long-term care argue the following:

The financial burden of existing public long-term care programs, let alone additional ones, will be significantly greater in the future (U.S. Government Accountability Office, 2005b). Although spending for Medicare post-acute and short-term skilled long-term care and Medicaid long-term care is small in comparison to Social Security and overall Medicare expenditures, all of these programs primarily benefit the older

population and are mainly financed by people in the working population. Additional public spending for long-term care may crowd out expenditures for children, higher education, and health care for the uninsured, among other worthy programs.

- Medicaid already provides a safety net for people who cannot pay the costs of long-term care. People who can pay for their own long-term care should do so.
- Americans have a low tolerance for additional taxation, and will not support higher taxes for long-term care. Higher taxes are already likely to support the existing Social Security and Medicare programs.

*Exhibit 3* summarizes public sector options and their advantages and disadvantages.



### Exhibit 3. Public Sector Financing Options

Option	Advantages	Disadvantages
Increase funding for Kupuna Care and similar programs	<ul style="list-style-type: none"> <li>▪ Provides funding for people not eligible for Medicaid, but not high income</li> <li>▪ Focuses on home and community-based services</li> <li>▪ Has broad support among people in Hawaii</li> </ul>	<ul style="list-style-type: none"> <li>▪ Might increase fragmentation of financing system</li> <li>▪ Funding for appropriated programs less likely to increase over time than entitlement programs</li> <li>▪ Program not eligible for a federal match, as with Medicaid</li> <li>▪ Would require additional government spending; additional spending would require additional taxes or expenditure cuts elsewhere</li> </ul>
Liberalize Medicaid financial eligibility	<ul style="list-style-type: none"> <li>▪ Reduces level of catastrophic out-of-pocket costs that people must incur before receiving government help</li> <li>▪ Easy to implement because it builds on existing system, which dominates long-term care financing</li> <li>▪ Targets people in great financial need</li> </ul>	<ul style="list-style-type: none"> <li>▪ Does not prevent people from incurring catastrophic out-of-pocket costs</li> <li>▪ Increases number of people dependent on public means-tested system</li> <li>▪ Would require additional government spending; additional spending would require additional taxes or expenditure cuts elsewhere</li> <li>▪ Hawaii already makes use of many standard options for liberalizing Medicaid eligibility</li> </ul>
Help federal government to market the CLASS Act	<ul style="list-style-type: none"> <li>▪ Provides additional resources for CLASS Act to help make it a success</li> <li>▪ Relatively low-cost option compared to actually providing services</li> <li>▪ CLASS Act likely to be main focus of expanding long-term care insurance over next several years</li> </ul>	<ul style="list-style-type: none"> <li>▪ Hawaii has too few people to make much impact on overall success or failure of CLASS Act</li> <li>▪ Private insurers will object to favoring public sector option</li> <li>▪ Marketing not likely to overcome affordability problems of CLASS Act insurance product</li> </ul>
Provide tax incentives for enrolling in CLASS Act	<ul style="list-style-type: none"> <li>▪ Reduces the net cost of enrolling in CLASS Act, increasing the number of people with insurance</li> <li>▪ Easy to administer</li> <li>▪ CLASS Act likely to be main focus of expanding long-term care insurance over next several years</li> </ul>	<ul style="list-style-type: none"> <li>▪ Unless tax incentive is quite large, unlikely to significantly increase number of people with insurance</li> <li>▪ Lost revenue per additional person with insurance could be large</li> <li>▪ Would require additional government spending; additional spending would require additional taxes or expenditure cuts elsewhere</li> <li>▪ Private insurers object to favoring public plan</li> </ul>

(continued)

### Exhibit 3. Public Sector Financing Options (continued)

Option	Advantages	Disadvantages
Establish a Hawaii-specific wraparound policy for CLASS Act	<ul style="list-style-type: none"> <li>▪ Addresses perceived limitations in CLASS Act benefits</li> <li>▪ Would have lower overhead costs than private sector policies</li> <li>▪ Private insurers unlikely to offer competing policies</li> <li>▪ Has substantial support among people in Hawaii</li> </ul>	<ul style="list-style-type: none"> <li>▪ Limitations of CLASS Act benefits overstated; CLASS benefits adequate for most people</li> <li>▪ CLASS Act premiums likely to be too high to enable the creation of supplemental insurance market</li> <li>▪ Premature in that key elements of CLASS Act insurance product unknown at this time</li> <li>▪ State of Hawaii would have to bear financial risk</li> </ul>
Mandatory public long-term care insurance, similar to CarePlus	<ul style="list-style-type: none"> <li>▪ Would provide additional revenue for long-term care</li> <li>▪ Premiums would be low and more affordable than pure private insurance or CLASS because all working people would contribute</li> <li>▪ With no medical underwriting, this option would provide coverage for people who are already disabled</li> <li>▪ Would provide near universal coverage</li> <li>▪ Would reduce the number of people who depend on Medicaid to pay for their long-term care</li> <li>▪ Because benefit is limited, leaves substantial role for private insurance</li> <li>▪ Flexible benefit would expand home and community-based services, reducing institutional bias</li> <li>▪ Because the insurance is mandatory, administrative costs would be lower than private insurance (fewer marketing costs or profit)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Because of the difficulty in establishing premiums for long-term care insurance, the state of Hawaii would be exposed to substantial financial risk</li> <li>▪ Mandatory premiums are taxes, which are opposed by most people in Hawaii</li> <li>▪ Largely duplicates the existing private long-term care insurance market</li> <li>▪ Benefit is too low to pay for nursing home care</li> <li>▪ Benefit is too short (1-year lifetime maximum) to cover risks of long-term care for substantial number of people</li> <li>▪ Unrestricted cash benefit might be abused</li> </ul>

***Public Sector Option #1: Increase Funding for State-financed Long-Term Care Programs, Such as Kupuna Care***

In this option, spending levels would be increased for Kupuna Care and other state-financed long-term care programs.

*Background*

Apart from 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. The Older Americans Act programs are generally offered without a means test, while services funded through the Social Services Block Grant and the Department of Veterans Affairs are typically subject to limitations on income and assets.

Similarly, Hawaii funds operates some state-only funded long-term care programs, of which Kupuna Care is the most important. Kupuna Care is an entirely state-financed program designed to meet the needs of frail older adults who cannot live at home without adequate help from family or formal services. The program was developed by the Executive Office on Aging in partnership with the Area Agencies on Aging to address the growing number of older persons with long-term care needs who are not eligible for Medicaid. The Area Agencies on Aging administer the program.

Kupuna Care provides the following:

- personal care
- adult day care
- assisted transportation
- attendant care (volunteer companion)
- case management
- chore services
- home delivered meals
- homemaker-housekeeper

The four services that account for the bulk of Kupuna Care spending are personal care (28%), home-delivered meals (22%), case management (20%), and transportation (15%) (Executive Office on Aging, 2008).

The program has no financial eligibility criteria and services are free to clients, although consumers are asked to make voluntary donations to the service provider. Nonetheless, the program is focused on lower-income individuals. Donations are used to provide services to additional clients.

To be eligible for Kupuna Care, individuals must be

- 60 years or older;
- not eligible for services from another public program, such as Medicaid, or already receiving private pay services;
- living in an apartment or house (not an institution, residential care facility, or foster home); and
- impaired in two or more activities of daily living (ADLs) or instrumental activities of daily living (IADLs) or have significantly reduced mental capacity, and have one or more unmet ADL or IADL need.

Clients receiving a single service are assessed by the service provider. Clients receiving more than one service are assessed by case managers. In State Fiscal Year 2009, Kupuna Care expenditures were \$4.7 million (Hawaii Executive Office on Aging, 2008).

#### *Advantages*

- Because programs are funded through direct appropriations, they would be subject to direct fiscal control, unlike Medicaid, which is an entitlement program.
- The program provides funding for services to populations who are not eligible for Medicaid, but cannot afford services or insurance on their own. If targeted to people at high risk of institutionalization, the marginal public cost might be reduced because nursing home use may be lessened.
- The focus on home and community-based services would help to address the institutional bias of the current financing system.
- Because the programs are entirely state funded, they are free of federal rules and regulations. Thus, they can be designed to more fully meet the needs of individual consumers and the traditions of Hawaii.
- In the Hawaii Long-Term Care Survey, 61.4 percent of respondents favored increasing funding for state programs, such as Kupuna Care (Khatutsky et al., 2010).

#### *Disadvantages*

- Because the program is not an entitlement, expenditures do not automatically increase as the population in need increases. Funding for appropriated programs tend not to increase with need and inflation over time. Thus, initial gains could be eroded over time.
- Because no federal matching is available, the state would incur 100 percent of the cost.
- Because these programs only fund home and community-based services, they do not help people finance nursing home services.
- Expanding the role of these programs could increase the fragmentation of the financing and delivery system because they are separate from other, larger sources of financing.

- In the Hawaii Long-Term Care Survey, when asked to choose their single preferred option, only 11.7 percent of respondents chose expanding state programs, such as Kupuna Care.
- Without new sources of revenue, expansion of state long-term care programs may squeeze funding for other state priorities. In the Hawaii Long-Term Care Survey, 57.8 percent of respondents said they opposed raising taxes to pay for expanding access to long-term care services.

***Public Sector Option #2. Liberalize the Financial Eligibility Criteria for the Medicaid Program to Allow More Working- and Lower Middle Class People to Participate***

In this option, Medicaid financial eligibility standards would be raised to allow people with higher income and assets to become eligible for Medicaid.

*Background*

An incremental approach to long-term care reform would be to liberalize financial eligibility for the Medicaid program by raising the level of protected assets and increasing the amount of income that nursing home and community-based beneficiaries can retain. For example, currently, \$2,000 is the maximum amount of financial assets that single Medicaid beneficiaries may retain in Hawaii (Walker and Accius, 2010).<sup>4</sup> An expansion of Medicaid eligibility could be implemented through Section 1902(r)(2) of the Social Security Act, which allows states to “disregard” certain income and assets in determining Medicaid eligibility. *Exhibit 4* presents some examples of provisions that can reduce countable income or resources for determining Medicaid eligibility, thus increasing the maximum level of income and assets that beneficiaries could retain. In addition, Hawaii’s “personal needs allowance” for nursing home residents is \$50 per month, which is below the level in 12 other states and the District of Columbia.<sup>5</sup>

**Exhibit 4. Examples of Provisions That Can Reduce Countable Income or Resources for Determining Medicaid Eligibility**

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- 
- Allow more than the standard SSI income disregard of \$20.
  - Disregard higher amounts of work earnings.
  - Disregard all or part of certain types of resources that are limited under SSI; for example, income-producing property essential to self-support, burial funds, and the cash value of life insurance.
- 
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*Advantages*

- Raising Medicaid financial eligibility standards reduces the level of catastrophic out-of-pocket costs that people incur paying for long-term care services.
- Raising Medicaid financial eligibility standards is easy to implement and builds on the existing system. Implementation of this provision merely requires establishing new levels of protected assets.
- Raising Medicaid financial eligibility standards targets people in great financial need. The main beneficiaries would be people with somewhat more income and assets than current Medicaid beneficiaries, but not people who are wealthy.

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<sup>4</sup> Minnesota and North Dakota have a resource limit of \$3,000 (Walker and Accius, 2010).

<sup>5</sup> Alaska, Arizona, Connecticut, the District of Columbia, Indiana, Kansas, Maryland, Massachusetts, Minnesota, New Hampshire, New Mexico, South Dakota, and Texas have higher personal needs allowances, ranging from \$52 to \$101 per month (Walker and Accius, 2010).

- In the Hawaii Long-Term Care Survey, 71.5 percent of respondents supported changing Medicaid so that more middle class people would be eligible for government help in paying for long-term care services. When respondents were asked to choose the option that they most supported, 31.4 percent of respondents chose this option, virtually tying with providing incentives for private long-term care insurance.

#### *Disadvantages*

- Although this strategy would allow those with modestly higher income and assets to become eligible for Medicaid, it would not prevent people from incurring catastrophic out-of-pocket costs for long-term care.
- Liberalizing Medicaid financial eligibility rules would require additional state funding. Higher Medicaid spending may squeeze other state priorities. In the Hawaii Long-Term Care Survey, 57.8 percent of respondents said they opposed raising taxes to pay for expanding access to long-term care services.
- Liberalizing Medicaid financial eligibility rules would increase rather than decrease the number of people dependent on a welfare program, Medicaid.

### ***Public Sector Option #3: Help the Federal Government Market the CLASS Act Insurance Program***

This option would support the marketing of the federal CLASS Act insurance product by funding advertising and education that would educate the public about long-term care and encourage enrollment in the CLASS Act insurance program. This option could be broadened to include promoting private long-term care insurance as well.

#### *Background*

The Affordable Care Act of 2010 establishes a new voluntary public, long-term care insurance program. Although the legislation gives the Secretary of the U.S. Department of Health and Human Services considerable discretion in designing and implementing the program, **Exhibit 5** summarizes the main elements of the CLASS Act insurance program outlined in the legislation. Only working people are eligible to enroll. Unlike most individually purchased private long-term care insurance policies, the CLASS insurance program does not require medical underwriting. Thus, people with disabilities who work will be able to enroll. In addition, benefits are provided on a lifetime basis rather than for a fixed number of years or expenditure level. This feature of the CLASS insurance program will be especially attractive to younger persons with disabilities, who could receive benefits for decades. After paying premiums for at least 5 years, enrollees who meet the disability benefit criteria will receive regular cash payments to help meet their long-term care needs. Average benefit payments must be at least \$50 per day. Insurance benefits are entirely financed by premiums paid by the insured; there is no general revenue contribution to benefits.

#### **Exhibit 5. Main Characteristics of the CLASS Act Insurance Program, Section VIII of the Patient Protection and Affordable Care Act (P.L. 111-148)**

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The CLASS insurance program is designed to provide insurance benefits for people with disabilities who need long-term care.

- The CLASS insurance program is a government plan. It is a “public option” for long-term care.
  - Enrollment is voluntary. However, for people who work for participating employers, everyone is automatically enrolled unless they choose not to participate.
  - There is no medical underwriting, but there is a 5-year waiting period before individuals can receive benefits.
  - Enrollment is limited to people who are employed. Children, retirees, and people who are not working are not eligible (including spouses).
  - To receive benefits, individuals must have fairly severe disabilities.
  - Benefits will vary by level of disability as determined by the Secretary of the Department of Health and Human Services, but average benefit payments will be at least \$50 per day.
  - Insurance premiums are the sole source of financing. Deep premium subsidies for full-time students and people with incomes below the federal poverty level will be financed by premium payments by other policyholders.
  - No more than 3 percent of premiums may be used for administrative costs. Additional administrative expenditures may be financed from other appropriated government funds.
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Unlike public long-term care insurance programs in Japan, Germany, and the Netherlands and Medicare Part A, the CLASS insurance program does not require that everyone enroll. Thus, the program is potentially subject to adverse selection that could drive up the cost of premiums and potentially create an insurance death spiral. In other words, without medical underwriting to exclude them, people with disabilities who need long-term care may disproportionately enroll in the program. To the extent that people with disabilities disproportionately enroll, the program's ability to spread the costs of people using benefits across a broad population will be limited and premiums will be high. High premiums may reduce the number of nondisabled people who enroll or cause them to disenroll. Thus, a high level of enrollment by people without long-term care needs is critical to establishing premiums affordable to a large percentage of the working population. A vigorous marketing campaign is likely to be necessary to achieve a high level of enrollment.

This marketing initiative could build on the Long-Term Care Campaign, a federally funded project started in January 2005, to increase consumer long-term care awareness and planning. The Campaign's core activities are state-based direct mail campaigns supported by each participating state's governor and public service announcements targeted to households with members between the ages of 45 and 70. Campaign materials include a Long-Term Care Planning Kit. As of January 2010, 25 states have participated in the Long-Term Care Campaign. (Further information is available at [http://www.longtermcare.gov/LTC/Main\\_Site/Planning\\_LTC/Campaign/index.aspx/.](http://www.longtermcare.gov/LTC/Main_Site/Planning_LTC/Campaign/index.aspx/))

#### *Advantages*

- Low enrollment is one of the biggest risks to the success of the CLASS Act insurance program. By providing additional marketing, Hawaii would help ensure the success of the overall program. Federal funds for marketing may be limited as a result of resistance by opponents of health reform in the new Congress. Thus, outside funds will probably be necessary to ensure the success of the program.
- Funding advertising is relatively low cost compared to increasing funding for existing long-term care programs or starting a new program. After the initial rollout, funding levels could be reduced.

#### *Disadvantages*

- Hawaii has too few people to make a major contribution to either the success or the failure of the overall CLASS Act enrollment campaign. Although it has not been decided, it is likely that premiums will be set nationally and will not vary by state. Thus, a high enrollment in Hawaii will not materially affect future premiums.
- Unless they are included, private insurers will object to the promotion of the CLASS Act insurance product, which competes with their products.
- Marketing is unlikely to be able to overcome the high cost of the CLASS Act insurance product or private long-term care insurance. As a result, enrollment is likely to remain low.

#### ***Public Sector Option #4: Provide Hawaii Income Tax Incentives for Purchase of CLASS Act Insurance Product***

Under this option, people who enroll in the CLASS program would be entitled to a Hawaii income tax deduction or credit, which would increase affordability. The amount of the deduction or credit could be tailored to the amount of funds available.

#### ***Background***

A key barrier to expanding private long-care insurance and to a high rate of enrollment in the CLASS program are the high premium costs, which limit the number of people who can afford to enroll (Wiener, Illston, and Hanley, 1994). Although they have not yet been set, premiums for the CLASS Act insurance product are expected to be expensive. Premium estimates developed during the health reform debate assumed low levels of enrollment, resulting in average premiums ranging from \$123 to \$240 per month (American Academy of Actuaries, 2009; Foster, 2009; U.S. Congressional Budget Office, 2010). Premiums will vary by age and these premiums assume a fairly high average age of enrollment. In calculating these premiums, actuaries and other cost estimators note that voluntary enrollment in private long-term care insurance policies in employment settings is usually low, with generally only about 5 to 7 percent of workers enrolling.

Aside from the general substantial cost of long-term care, these premiums are expected to be high for several reasons. First, unlike public long-term care insurance programs in other countries where premiums rise with income, financing is expected to be regressive with everyone except for low-income working people and students paying the same premiums. Moreover, there is no tax subsidy for low- and moderate-income people to moderate the cost. Instead, all financing for the program must come from the premium.

Second, to encourage enrollment of full-time students and people with incomes below the federal poverty level who work, premiums for these groups will initially be only \$5 per month, far below the expected premiums for unsubsidized groups. These premium subsidies, however, are financed by other insurance enrollees, not by federal general tax revenues, which may substantially raise the premium for people who are not low income or students. The SCAN Foundation/Avalere Health premium simulator estimates that average premiums for a voluntary long-term care insurance program with a low-income subsidy to be about 50 percent higher than the premiums would be without a low-income subsidy (SCAN Foundation/Avalere Health, 2010).

Third, because the program is voluntary, the CLASS Act is subject to adverse selection, which raises premiums. The SCAN Foundation/Avalere Health premium simulator estimates average premiums for a voluntary long-term care insurance program with some features similar to the CLASS Act to be three times what they would be for a mandatory program.

### *Advantages*

- Providing a tax incentive could decrease the net cost of enrolling in the CLASS insurance product and increase the number of people who could afford coverage. However, to substantially increase affordability, the tax benefit would need to be large.
- A tax incentive would be relatively easy to administer because it could be added to the existing Hawaii income tax system.
- This option could be combined with the initiative to help the federal government market the CLASS Act.

### *Disadvantages*

- Depending on how the tax incentive is structured, the tax loss could be large, which would require new taxes to compensate for the lost revenue. In the Hawaii Long-Term Care Survey, 57.8 percent of respondents said they opposed raising taxes to pay for increased access to long-term care services.
- Most tax incentives are regressive (Wiener, 2000); that is, they provide more tax benefits to upper-income people than to lower-income people. Deductions usually are more regressive than tax credits, but even these can be regressive unless they are refundable because many lower-income people do not pay any income taxes.
- Unless the tax incentive is quite large, it is unlikely to substantially change the affordability of the CLASS Act insurance premium.
- Many tax incentives subsidize people to do what they would have done without the tax incentive. As a result, the incremental cost per additional person with the CLASS Act insurance may be high.
- Proponents of private long-term care insurance oppose the creation of a new public long-term care insurance program and do not favor anything that would increase its market share. Furthermore, they argue that private long-term care insurance should receive a similar tax incentive subsidy, which would increase the cost.

### ***Public Sector Option #5: Develop, Market, and Manage a Hawaii-specific Wraparound Product to the CLASS Act Insurance Plan***

In this option, the state of Hawaii would develop, market, and manage a Hawaii-specific public long-term care insurance product that would supplement the CLASS Act insurance plan. The plan could have many different designs, including higher benefit levels or specific coverage for higher cost nursing home care. The insurance policy could provide lifetime coverage or coverage for a shorter period of time. The policy could also be limited to a less expansive set of beneficiaries.

#### *Background*

The legislation enacting the CLASS Act outlines some broad insurance coverage parameters, but it leaves a great deal to the discretion of the Secretary of the Department of Health and Human Services. Persons eligible to receive benefits are persons needing help with two or more ADLs, substantial cognitive impairment, or an equivalent level of disability (which is meant to include some persons with intellectual disabilities/developmental disabilities and severe mental illness). The legislation specifies that the benefits will (1) be a cash payment, with the average value of not less than \$50 per day; (2) consist of between two and six benefit levels, which will vary by disability level; (3) be provided on a lifetime basis; and (4) increase with inflation over time. Thus, hypothetically, people with deficits in two ADLs could receive a benefit of \$30 a day, while people with deficits in four ADLs could receive an average benefit of \$70 a day, so long as the average of all payments was estimated to be \$50 a day.

Some observers have criticized the benefit and eligibility structure. First, the benefit amount will not be enough to cover the costs of nursing home care, especially in a state like Hawaii, which has higher costs than the national average. The law does not preclude that the benefit levels vary by geographic area, but it does not require that they do so. Second, some critics argue that the benefit level is not adequate for home and community-based services, covering only about 2 hours a day of home health aide service on average. Third, some observers note that private long-term care insurance policies do not generally provide benefits to people with intellectual disabilities or severe mental illness and that doing so will greatly increase premiums if individuals with these disabilities enroll in large numbers.

#### *Advantages*

- A public supplemental policy that fills in the gaps on the CLASS Act insurance product might be attractive to people who enroll in the CLASS program.
- A public long-term care insurance policy might have lower overhead costs than private long-term care insurance. However, if the policy is not mandatory, substantial marketing costs will have to be incurred to sell the wraparound policy.
- Although it is not known for sure at this time, it seems unlikely that private long-term care insurance companies will offer supplemental policies. The current conventional wisdom is that private insurers will market against the CLASS program and not work with the government to create wraparound policies.

- Insurance policies that take a similar approach, such as Medicare supplemental insurance policies, have been very successful. The vast majority of Medicare beneficiaries have some type of supplemental insurance.
- A supplemental public insurance policy would build on the public insurance approach passed by the Hawaii legislature a decade ago.
- A supplemental public insurance policy would bring additional revenue into the long-term care financing system on a voluntary basis.
- A supplemental policy has substantial support among residents of Hawaii. In the Hawaii Long-Term Care Survey, 56.6 percent of respondents supported a public long-term care insurance program sponsored by the state of Hawaii that would offer benefits additional to the CLASS Act federal insurance program.

#### *Disadvantages*

- The limitations of the CLASS benefit structure may be overstated. Although the average \$50 per day benefit payment level has been criticized as inadequate, it is paid every day that the individual qualifies for benefits, regardless of whether the individual uses services on that day. Many people receiving paid home care do not receive it every day. Moreover, \$50 a day (\$18,250 a year) is about twice what Medicaid spends per year on participants in home and community-based services waiver programs for people aged 65 and older and nonelderly persons with physical disabilities (Ng, Harrington, and O'Malley, 2009).
- The premiums for the CLASS Act have not yet been determined, but the premiums estimated during the debate over health reform were quite high. As a result, enrollment may be low. In the Hawaii Long-Term Care Survey, while about a fifth of working respondents said that they wanted to enroll in the CLASS insurance plan, only about 3 percent of working respondents said that they were willing to pay the level of premiums previously estimated for the CLASS Act. Thus, the market for long-term care insurance policies *in addition to* the CLASS Act insurance product may be extremely small.
- Although certain aspects of the CLASS Act insurance plan are set by the legislation, many features are not. Preliminary and unverified information on the CLASS Act development process suggests that the U.S. Department of Health and Human Services is considering several innovative approaches to structuring the insurance product. No information is available about what those approaches are. Thus, designing a wraparound product may be premature for the next few years.
- Depending on how it is designed, a public long-term care insurance plan could require the state of Hawaii to bear substantial financial risk if premiums are too low to pay benefits.

***Public Sector Option #6: Establish a Mandatory Public Long-Term Care Insurance Program in Hawaii, Such As That Envisioned in CarePlus***

This option would establish a mandatory public long-term care insurance program in Hawaii financed by premiums. The program would provide a basic level of coverage to which private insurers could offer supplemental coverage. It would be modeled on the insurance plan passed by the legislature in 2003 but vetoed by Governor Linda Lingle.

*Background*

The 2003 CarePlus Financing Program (HB 1616 and SB 1088) had the following features:

- Everyone age 25 or over with income above a minimum threshold would have to pay a \$10 monthly premium for the CarePlus public long-term care insurance program. This requirement would include retirees and homemakers. Payment of the premium through payroll deduction would be available; self-employed persons would contribute on their own. The premium would increase with the Consumer Price Index. Administrative costs would be kept low by having the tax department collect the premium and having the same premium for everyone.
- Individuals would have to pay premiums for 10 years before they could receive full benefits, although a partial benefit would be available earlier. The benefit would be portable if the insured moves away from Hawaii.
- Eligibility to receive benefits would be limited to people who need assistance with two or more ADLs or who have substantial cognitive impairment.
- The benefit would be \$70 per day which could be used for any purpose. Benefits would be available for a total of 365 days, which need not be consecutive. The benefit amount would increase annually with the Consumer Price Index.
- An independent Board of Trustees would be appointed by the governor, which would be responsible for the administration of the program and the management of the trust fund.

*Advantages*

- This approach would raise additional revenue for long-term care in a way that spreads the risk over the entire population. Because the vast majority of workers will participate and benefit, the premium will be low enough to be affordable to the vast majority of workers in Hawaii.
- Because this option does not require medical underwriting, it would allow people with disabilities to obtain insurance coverage.
- This option would provide basic long-term care insurance to the vast majority of people in Hawaii. It would provide benefits to people with a wide range of income and assets.
- By providing an additional source of financing for long-term care, the program would reduce the number of people dependent on Medicaid.

- The broad flexibility in the use of benefits would encourage the expansion of home and community-based services.
- Because the program provides only a limited benefit, it leaves a significant role for private insurance.
- Because the program is mandatory and public, administrative costs will be lower and no profit is needed. Thus, a higher percentage of the premium would be spent on benefits than is spent under private long-term care insurance.

#### *Disadvantages*

- Given the difficulty in predicting future long-term care use and expenditures, this public insurance option would represent a substantial financial risk for the state of Hawaii. If premiums are set too low, there will be substantial pressure on state government to pay benefits through increased taxes.
- The premium may be viewed as an additional tax by many people. In the Hawaii Long-Term Care Survey, 57.8 percent of respondents said they opposed raising taxes to pay for improved long-term care services (Khatutsky et al., 2010).
- This new program duplicates the existing long-term care insurance market.
- The limited benefit leaves substantial numbers of people who need long-term care for more than 1 year with no coverage. This will be a particular problem for younger people with disabilities who will live for a long time.
- The \$70 benefit is too low to pay for nursing home care in Hawaii. The cost of private pay nursing home care in Hawaii is more than \$200 per day (MetLife Mature Market Institute, 2010).
- The unrestricted granting of \$70 per day might be abused in some instances by people who do not use the money for long-term care services.

## **Options for Long-Term Care Delivery System Reform**

Long-term care is supplied by many different providers, including nursing homes, home health agencies, home care agencies, homemaker agencies, personal assistants, adult day health programs, assisted living facilities, and many more. Three of the main critiques of the long-term care delivery system are that (1) the system is biased toward institutional care, (2) home and community-based service providers sometimes ignore consumer preferences, and (3) the needs of informal caregivers are not met.

### **Balance the Long-Term Care System**

Probably the most common critique of the long-term care delivery system is its institutional bias. Despite the fact that the overwhelming majority of people with disabilities are at home and want to stay there (AARP, 2003), spending for long-term care for older people is overwhelmingly for nursing home rather than home care. Over the last 10 years, states, in part encouraged by the federal government, have expanded home and community-based services.

Despite improvement in the balance of expenditures, long-term care financing in the majority of states remains heavily tilted toward institutional services, especially nursing home care, although it is becoming less so (Wiener and Anderson, 2009). Although Medicaid home and community-based services for older people and younger persons with physical disabilities have been increasing, only 34 percent of national Medicaid long-term care expenditures for this population were for noninstitutional services in 2009 (Eiken et al., 2010). To achieve their goal of increasing home and community-based services, states have relied largely on Medicaid home and community-based services waivers, which give states much greater fiscal control and allow coverage of a much broader range of services than is possible under the standard Medicaid program. However, waivers require states to limit services to a relatively severely disabled population, i.e., those who meet Medicaid requirements for an institutional level of care.

### **Consumer Empowerment**

Over the last 10 years, states have used the flexibility of Medicaid home and community-based services waivers to experiment with a variety of new service delivery models. A new paradigm of home and community-based services has taken hold drawing heavily on the long-term care systems in Oregon, Washington, and Wisconsin, among others (Wiener et al., 2009). This new paradigm emphasizes consumer choice and empowerment and is embodied in federal and state initiatives to give program participants greater choice of and control over their services, including participant-directed programs, some with individual budgets; nursing facility transition/money-follows-the-person initiatives; and providing services in residential care facilities, including assisted living facilities.

Traditional public home care programs rely on public or private agencies to hire and manage home care workers, schedule and direct services, monitor quality of care, discipline and dismiss workers if necessary, and pay workers and applicable payroll taxes. In the agency-directed model, clients can express preferences for services or workers, but have no formal control over them. This approach to care is based on the assumption that professional expertise



and accountability are critical to the provision of good quality care at reasonable cost. At its extreme, a “medical model” is imposed and individuals with disabilities are considered to be “sick,” as opposed to needing compensatory services, such as help with bathing.

Programs that allow participants to direct their services represent the opposite end of the management continuum from agency-directed services. These programs give participants control over who provides services, when they are provided, and how these services are delivered. Typically, participant-directed programs allow the consumer to hire, train, supervise, and dismiss the home care worker. In some programs, participants have flexible individual budgets with which they purchase the goods and services they need.

Residential care facilities, such as assisted living facilities and smaller board and care or personal care homes, are an important and growing component of the long-term care service system. State interest in funding services in residential care settings through Medicaid, through both home and community-based services waivers and the Medicaid personal care benefit, is fueled by a desire to offer a full array of home and community services, reduce nursing home utilization, and achieve the economies of scale of nursing home care without the undesirable institutional characteristics. A recent study estimated that in 2009 there were 39,635 residential care facilities (with at least four beds) nationally serving older people and younger persons with disabilities; these facilities had an estimated 1,073,043 beds (Wiener et al., 2010). In contrast, during that same year, there were 15,691 nursing facilities certified for participation in Medicare or Medicaid with 1,708,784 beds (American Health Care Association, 2009).

### **Informal Caregivers**

Family caregivers are the main source of long-term care in the United States and virtually all other countries (Nixon, 2008; Wiener, 2003). It is commonly estimated that family caregivers provide 80 percent of the care of disabled older persons in the United States (Curry, Walker, and Hogstel, 2006). Nationally, in 2004, about 90 percent of older people with disabilities received care from family members (Houser, Gibson, and Redfoot, 2010). Nationally, the economic value of this caregiving was valued at \$350 billion in 2006 (Gibson and Houser, 2007), which dwarfs spending for nursing homes and home care. In the Hawaii Long-Term Care Survey, about 5 percent of respondents reported that they provided care for a younger family member with disabilities and about 8 percent of respondents reported that they provided care to an older family member (Khatutsky et al., 2010).

Caregiving can impose substantial burdens on family members, including financial expenses for medical and long-term care services not covered by insurance, reduced hours of work and opportunities for advancement, reduced retirement savings and Social Security income, limitations on the ability to pursue one’s own goals, depression, and health and psychological strain (Nixon, 2008). On average, Hawaii caregivers report spending 22.0 hours per week caring for their parents—more than a half-time job—and spending \$11,656 per year on various expenses. Several trends in society, including high levels of labor force participation by women (who have been the traditional caregivers), high divorce and lower marriage rates, reduced number of children per family, and family mobility are all potential threats to the provision of informal care.

Although informal caregivers provide the overwhelming majority of long-term care to people with disabilities, they receive little financial or government program support. Public programs focus on services to the eligible participant, and generally do not address the needs of family caregivers. The U.S. Administration on Aging's National Family Caregiver Support Program is a relatively rare exception, but was funded at only \$154 million in Fiscal Year 2010 (U.S. Administration on Aging, 2010). In addition, the U.S. Administration on Aging's Alzheimer's Disease Supportive Services Program (previously known as the Alzheimer's Disease Demonstration Grants to States program) focuses on demonstrating innovative programs for caregivers of people with dementia; it is funded at \$11 million per year. Limited federal and state tax deductions are available for informal caregivers, but they are very restricted in terms of who can qualify and how large a benefit is provided.

## Delivery System Reform Options

*Exhibit 6* summarizes the delivery system reform options and their advantages and disadvantages.

### Exhibit 6. Delivery System Options

Option	Advantages	Disadvantages
Cover the optional personal care benefit under Medicaid	<ul style="list-style-type: none"> <li>▪ Would help to reduce institutional bias</li> <li>▪ Builds on current system of home and community-based services waivers</li> <li>▪ Expands the range of people eligible for Medicaid personal care by including people who do not need nursing home level-care</li> </ul>	<ul style="list-style-type: none"> <li>▪ Would increase Medicaid spending and thus require a tax increase or reductions in other areas of the State budget</li> <li>▪ Because the personal care option is an entitlement in Medicaid, expenditures might be hard to control</li> <li>▪ Provides only one of many benefits needed by people with disabilities</li> <li>▪ Under QUEST Expanded Access, many people who receive chore services receive personal care from family providers (although they are not paid to do so)</li> </ul>
Increase the supply of nursing home beds	<ul style="list-style-type: none"> <li>▪ Would increase supply of long-term care services in Hawaii</li> <li>▪ Could reduce number of Medicaid and uninsured people in hospitals waiting for placement</li> <li>▪ Would increase Medicaid expenditures for nursing home care</li> </ul>	<ul style="list-style-type: none"> <li>▪ Would increase institutional bias</li> <li>▪ Would increase Medicaid expenditures</li> <li>▪ May not reduce hospital backlog, which may be better addressed through changing Medicaid reimbursement</li> </ul>
Provide tax incentives for informal caregivers	<ul style="list-style-type: none"> <li>▪ Would provide social recognition for efforts by caregivers</li> <li>▪ Would reduce economic strain on caregivers</li> <li>▪ Hawaii Long-Term Care Survey suggests strong support among the population</li> </ul>	<ul style="list-style-type: none"> <li>▪ Unlikely to change behavior of caregivers to provide more informal care or to provide care for longer periods of time</li> <li>▪ Unless tax incentive is very large, not likely to make major difference to caregiver finances</li> <li>▪ Tax loss could be substantial, requiring offsetting tax increases or cuts in other government programs</li> </ul>
Reform regulation of domiciliary care facilities	<ul style="list-style-type: none"> <li>▪ Would rationalize fragmented regulation of diverse facilities, improve quality, and make regulation more effective</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reorganization and more regulation could be time consuming and does not guarantee improved quality</li> </ul>

### ***Delivery System Option #1: Cover the Optional Personal Care Benefit Under Medicaid***

In this option, the Hawaii Medicaid program would cover personal care services as an optional benefit part of the regular Medicaid program, not just through Medicaid home and community-based services waivers. As a result, disabled Medicaid beneficiaries needing personal care services who do not need a nursing home level of care would be eligible for those services.

#### ***Background***

Personal care services include help with the activities of daily living, such as eating, bathing, dressing, transferring, and going to the toilet. Medicaid programs can cover personal care through three different mechanisms. Most states use at least two of these mechanisms. First, states can cover personal care as one of many optional benefits allowed by the federal statute. Indeed, in 2009, 34 states and the District of Columbia covered personal care services as an optional benefit as part of their regular Medicaid program (Eiken et al., 2010). As a regular optional benefit, services must be available to all Medicaid beneficiaries who qualify for the benefit; it is an open-ended entitlement. Using this option, states cover personal care services for people who are disabled, but who do not necessarily need a nursing home level of care. Beneficiaries qualifying for services using this approach must qualify for Medicaid using standard financial eligibility requirements. Prior to QUEST Expanded Access, Hawaii's Medicaid program did not cover personal care as an optional benefit.

Second, all states cover personal care through their Medicaid home and community-based services waivers. Beneficiaries qualifying for participation in Medicaid home and community-based services waivers must need institutional-level care (i.e., hospital, nursing home, or intermediate care facilities for the intellectually disabled). For the older population, people who do not need nursing home level of care are not eligible for waiver services. Under home and community-based services waivers, states may provide services to people with more income and assets than is typically allowed; people may qualify for Medicaid if they need nursing home-level care if they have up to 300 percent of the federal Supplemental Security Income level. Under the Medicaid home and community-based services waivers, states may also cover a wide range of social and support services not typically allowed to be covered in the Medicaid program, such as homemaker and chore services. Prior to QUEST Expanded Access, Hawaii's Medicaid program covered personal care services through its Medicaid home and community-based services waivers.

Third, the federal Medicaid statute allows states to apply for research and demonstration waivers (known Section 1115 waivers after the section of the Social Security Act that authorizes the demonstrations) to test new approaches to financing and delivery. QUEST Expanded Access is operating under a Section 1115 waiver. Under this research and demonstration waiver, Medicaid is covering personal care services for people who need an institutional level of care. The Centers for Medicare & Medicaid Services also allowed Medicaid to cover chore services for up to 1,600 persons. Hawaii recently reached the cap on the allowable number of people receiving chore services and created a waiting list. Thus, the state was allowed to fold state-funded chore services for Medicaid beneficiaries into the Medicaid program, receive a federal match, and increase the number of Medicaid beneficiaries receiving chore services at no

additional cost to the state. People who are not Medicaid eligible continue to receive chore services through the state-funded program. Chore workers are not allowed to provide personal care as part of their official duties, but it is believed that many family members who are paid to provide chore services provide personal care as part of their unofficial functions.

#### *Advantages*

- This option would help to meet the unmet need for personal care services among people who are disabled but do not need a nursing home level of care. Most states use this approach to covering personal care.
- Covering personal care through the regular Medicaid program would help to reduce the institutional bias of the long-term care delivery system.
- Because personal care is already being provided as part of the Medicaid home and community-based services waivers, implementation of this provision would be fairly easy. It would merely require offering the benefits to a larger number of individuals with a broader range of need.
- Although optional services under Medicaid are open-ended entitlements, the experience of other states suggests that expenditures need not increase dramatically.

#### *Disadvantages*

- Covering personal care as a Medicaid-covered service would likely increase Medicaid spending. Without additional revenue, this might squeeze other state priorities.
- Changing coverage would require negotiations with the Centers for Medicare & Medicaid Services to change the research and demonstration waiver.
- Because a large proportion of people with disabilities do not receive paid home care services, expenditure levels might increase substantially and be hard to control.
- Personal care is only one of many services that people with disabilities need. The personal care option is a fairly narrow service compared to the array of services available through the Medicaid home and community-based services waiver.
- Some people receiving Medicaid chore services who do not need a nursing home level of care are receiving personal care informally from family members.
- Given limited resources, the state should focus any additional spending on a more disabled population.

## ***Delivery System Option #2: Increase the Supply of Nursing of Nursing Home Beds***

In this option, the state would work to increase the supply of nursing home beds.

### *Background*

Compared to the rest of the country, Hawaii has an exceptionally low supply of nursing home beds per 1,000 population aged 75 and over. In 2009, Hawaii had 43.4 nursing home beds per 1,000 persons aged 75 and older, compared to the national average of 88.9 nursing home beds per 1,000 persons aged 75 and older (American Health Care Association, 2010; U.S. Census Bureau, 2010). Between 1997 and 2009, the nursing bed/population ratio declined, both nationally and in Hawaii. It is not known why the nursing home bed ratio is so much lower in Hawaii than in the nation as a whole. Possible explanations include that the high level of three-generation households in the state combined with a strong tradition of informal caregiving has resulted in lower demand for nursing home care. Another explanation is that the high cost of real estate and construction constrains the number of nursing home beds.

The relatively low supply of nursing home beds in Hawaii has several consequences. First, the state's nursing facility occupancy rate is very high—92.8 percent in 2010 compared to the national average of 83.6 percent (American Health Care Association, 2010). Second, because of high occupancy rates, some stakeholders contend that some individuals with a high level of impairment and extensive nursing needs cannot be discharged from acute care hospitals because no nursing home will take them. Third, with so few beds, nursing homes tend to serve a more severely disabled population than the national average. The average nursing home ADL Index—a measure of the need for assistance with ADLs—is 4.52 for Hawaii compared to the national average of 4.02; Hawaii's index is the highest of any state.

### *Advantages*

- Increasing the nursing home bed supply could increase access to institutional care by older disabled people in Hawaii.
- Increasing the nursing home bed supply might reduce hospital backlog.

### *Disadvantages*

- Hawaii already has one of the highest percentages among states of Medicaid long-term care spending for nursing home care. Increasing the supply of nursing homes would exacerbate Hawaii's institutional bias.
- The problem of hospital backlogs by people waiting for nursing home placement can be addressed more efficiently by increasing the Medicaid reimbursement for high-need nursing home residents.
- Increasing the bed supply is likely to increase Medicaid expenditures for nursing home care, squeezing funds for other long-term care services and improvements.

### ***Delivery System Option #3: Provide Income Tax Incentives for Family Caregivers***

In this option, people who provide a substantial amount of personal care or supervision to disabled relatives would receive a tax credit or could deduct expenses related to care of the relative from their income when calculating their Hawaii income tax.

#### ***Background***

Some policymakers are concerned about the burdens on family caregivers, the economic consequences of their caregiving, and the potential impact on Medicaid and other public programs should they stop or reduce providing care. Older people with disabilities who receive informal care are less likely to use nursing homes (Lo Sasso and Johnson, 2002).

To encourage people to continue to provide informal care and to compensate them for some of their expenses and burdens, a number of states provide limited caregiver tax incentives. As of 2006, 24 states and the District of Columbia provided some type of dependent care tax credit or caregiver tax credit or deduction (Alzheimer's Association, 2006).

Nixon (2008) analyzed the Hawaii caregiver tax credit proposed in S.B. No. 1199, S.D. 2 (2007). This incentive provided a tax credit toward the caregiver's state income tax, regardless of actual expenses. Because the credit would be refundable, it would be available regardless of whether the resident owed any state income taxes. This legislation limited the credit to individuals caring for an older adult who is at least 60 years old and is targeted to lower-income caregivers (the value of the credit varies from \$100 to \$1,000, depending on the caregiver's income). Care recipients must require substantial supervision because of cognitive impairment or need help with at least two ADLs. In addition, the care recipient must have lived with the caregiver for at least 6 months of the year and received at least half of his or her financial support from the caregiver. The estimated cost of the caregiver tax credit in terms of lost revenue was approximately \$37 million a year, and the likely consumer benefit was estimated to be slightly more, approximately \$38 million. If the credit was extended to care of people of all ages, the tax loss would be considerably higher.

#### ***Advantages***

- Family caregivers will receive societal recognition of their support for their disabled relatives. In addition, they will receive some financial compensation for the costs that they incur caring for people with disabilities.
- As a cash payment, it provides maximum flexibility to caregivers on how to use the money.
- As a tax incentive rather than direct public program, it minimizes the amount of government bureaucracy needed to administer the program.
- If a refundable tax credit rather than a deduction, it can be structured to be progressive rather than regressive in its tax effects.
- Tax incentives for informal caregivers have broad support in Hawaii. In the Hawaii Long-Term Care Survey, 73.5 percent of respondents said that they favored reducing state income taxes for people who provide a lot of care to their disabled relatives (Khatutsky et al., 2010).

### *Disadvantages*

- Although the tax payment provides social recognition, it is unlikely to change behavior unless the incentive is much larger than those commonly offered by states. For example, people are unlikely to decide to leave the labor force to care for their disabled relatives or not place their relative in a nursing home based on the receipt of a \$1,000 tax credit. Given the current high level of informal caregiving, a tax incentive is likely to provide funds to people who are already providing informal care at no cost to the government. Given the costs of providing informal care in Hawaii, the tax incentive would have to be much larger to come close to compensating caregivers for their costs.
- The tax loss would be large. Direct service programs have the advantage over tax incentives in that they can target resources to people most in need rather than providing funds to all persons who qualify.
- Monitoring whether care recipients have the required level of disability could be difficult and expensive and viewed as intrusive by taxpayers. On the other hand, without it, substantial numbers of people may claim the benefit to which they are not entitled.
- Tax incentives are expenditures just as much as direct public spending. Without new sources of revenue to compensate for the tax loss, increases in tax incentives may squeeze other government priorities. In the Hawaii Long-Term Care Survey, 57.8 percent of respondents said they opposed raising taxes to pay for expanded access to long-term care services (Khatutsky et al., 2010).



***Delivery System Option #4: Reform the Regulation of Domiciliary Care Facilities, Including Adult Residential Care Homes, Extended Care Adult Residential Care Homes, Community Care Foster Homes, and Assisted Living Facilities***

Reform of the system of domiciliary care facilities would include (1) ensuring that all of the state's information outlets—particularly the Aging and Disability Resource Center (ADRC) website—provide clear and consistent information about all of the residential care options available; (2) improving the quality of care in domiciliary care facilities by assessing state allocation of responsibilities for quality assurance across departments; and (3) reviewing the standards and inspection processes for residential care facilities.

*Background*

Hawaii has a very complex system of community-based residential care settings—broadly called domiciliary care homes—which can be very confusing for service providers and consumers alike (O’Keeffe and Wiener, 2010). The state lacks a source of accurate, comprehensive, and comparative information about residential care options, making it very difficult to ensure optimal use of residential care by people with long-term care needs. A clear written description of the system is unavailable on any of the state’s websites—including the ADRC websites. The information available about various components of the system on various websites is incomplete and unclear.

Many stakeholders express concerns about the quality of care provided in residential care settings—particularly Adult Residential Care Homes and Extended Care Adult Residential Care Homes—which they believe is the result of division of responsibility for regulation and oversight by two agencies, inadequate licensing and certification requirements, and insufficient oversight (O’Keeffe and Wiener, 2010a). Responsibility for regulating Hawaii’s residential care facilities is divided between the Department of Health and the Department of Human Services, which have significantly different regulatory and service philosophies.

Community Care Foster Homes, which serve individuals with a nursing home level of care, are certified by the Department of Human Services, using a social model of care. Assisted living facilities, which may also serve individuals who need a nursing home level of care, are licensed by the Department of Health. Adult Residential Care Homes (ARCHs), which serve individuals who do not need a nursing home level of care, are licensed by the Department of Health, which uses a medical model.

Several stakeholders noted that some of the requirements for ARCHs are more stringent than for foster care homes even though the latter serve Medicaid waiver clients and the former are not permitted to. (O’Keeffe and Wiener, 2010a). The 2002 auditor’s report concluded that the additional stringency was appropriate because ARCHs are facilities that serve a larger number of people than foster homes. However, many ARCHs serve five or fewer individuals in what were private homes. Extended Care Adult Residential Care Homes (EC-ARCHs), which may also serve individuals who need a nursing home level of care, are licensed by the Department of Health but the Department of Human Services oversees placement and case management services to Medicaid-eligible clients in these settings. EC-ARCH operators must meet additional

Department of Health staffing and other requirements to be allowed to offer expanded services and accept residents who need nursing home–level care.

The Hawaii Department of Health and the Department of Human Services employ different approaches for ensuring quality of care and dealing with complaints. Some stakeholders believe that having two different state agencies regulating residential care facilities leads to inconsistencies in oversight that fail to protect residents. Nonetheless, a 2002 state auditor’s report recommended against consolidating oversight into a single agency for a variety of reasons. One reason was that the overlap in responsibilities between the agencies would continue because the single state agency responsible for administering the Medicaid program (the Department of Human Services) would inevitably continue to have some oversight responsibility for Medicaid clients in the three types of settings in which they are served as required by federal law—even if all three were licensed/certified by the Department of Health.

#### *Advantages*

- Residential care facilities are difficult to regulate because they have some characteristics of nursing homes and some characteristics of private homes. A careful review of the allocation of responsibilities and standards and procedures for quality assurance could result in better quality care.

#### *Disadvantages*

- Reorganizations are time consuming and disruptive to the organizations involved. Merely shifting responsibilities may not result in better quality assurance. Likewise, the state is unlikely to devote substantial additional resources to monitoring these facilities.

## **Conclusions**

This paper discusses the background and advantages and disadvantages of a large number of financing and delivery system options for reform of long-term care in Hawaii. None of the options are perfect and all require weighing of the costs and benefits and their distributional impact. It is hoped that this analysis will help the Hawaii Long-Term Care Commission choose the options that will be most beneficial to the people of the state.

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