“Medicare and Medicaid policy resembles a fiscal tug-of-war, rather than a concerted effort to address people’s needs.”

dwelling elderly with long-term care needs, persons reporting unmet need are disproportionately severely impaired, living alone, and poor or near-poor.

A second concern is the way in which current Medicare and Medicaid long-term care policy is being made. The Medicare home health expansion largely reflected the withdrawal rather than the introduction of policy guidance. No decision was made to rely upon Medicare to finance an expansion of long-term care, and many question the targeting of its benefits (based on a need for skilled care without regard for personal care needs) as well as the efficiency of its delivery system (reliance on agencies).\(^1\)

Similarly, the retractions in service stimulated by the BBA’s changes in home health payment policy may be poorly targeted. Although the policy change was intended to promote efficiency, it may replace incentives to provide what may have been too much care with what may be too little.\(^2\) In reviewing recent evidence, the Medicare Payment Advisory Commission (MedPAC) concluded that some beneficiaries who require costly home care are facing difficulties obtaining services.\(^3\) There is little professional consensus on norms of care under Medicare’s home health benefit—an issue that reflects both the design of the benefit (skilled over personal care) and the complexity of evaluating the “appropriate” amount of personal care. In the absence of such norms, a shift to incentives for agencies to spend as little as possible would seem to put the patients who need the most care at greatest risk.

Medicare and Medicaid policy resembles a fiscal tug-of-war, rather than a concerted effort to address people’s needs. Medicare’s expansion of home health benefits offered states an opportunity to “shift” responsibility to Medicare—that is, allow the program to finance care that states might otherwise provide. Analysis suggests that some states (with relatively high Medicaid home-care spending) adopt policies to assure that Medicare revenues are “maximized”—explicitly shifting financing for some services from the Medicaid program, for which states share financial responsibility, to the fully federal Medicare program.\(^4\)

What will happen to these and other home care services as Medicare shrinks? Medicare’s expansion may have filled needs for home care in states with more limited Medicaid coverage. It is not clear that Medicare’s retraction will be offset by Medicaid growth.
Medicaid is targeted to the poorest population; many persons who are not very poor nevertheless cannot afford paid help. Further, states have always varied in the generosity of their Medicaid home-care benefits and will undoubtedly vary in their willingness to fill the possible service gaps. Hence, Medicare changes will likely reduce access to care for some persons with long-term care needs.

**Current And Future Policy Choices**

Both the outcomes and the process of U.S. long-term care policy have serious shortcomings, and the consequences of these shortcomings will increase as the population ages. Policymakers continue to face an array of complex policy problems regarding the balance between nursing home and home care, assurance of quality, integrating acute and long-term care, and affordable access.

- **Improving the nursing home/home care balance.** Despite Medicare's home health expansion, Medicaid continues to dominate long-term care spending, and institutional care continues to dominate Medicaid services, accounting for three-quarters of Medicaid long-term care spending in FY 1998. States have struggled for years to reduce nursing home use, by limiting nursing home care (through preadmission screening, limits on the supply of nursing home beds, and constraints on growth in Medicaid payments) on the one hand, and expanding home care (primarily through "waivers" of Medicaid requirements, allowing states to target benefits to limited geographic areas and to specific groups and numbers of beneficiaries) on the other. However, in most states policy initiatives have had a modest impact on the allocation of resources between nursing homes and home and community-based care. The continued emphasis on nursing homes over home care reflects in part a reluctance to expand support for home care as an add-on to, rather than a replacement for, current institutional care. Although home care can (and does) substitute for nursing home care, enhanced public support for home care will likely expand the total number of persons receiving care. Many who would resist going to nursing homes may welcome care at home. Indeed, improving quality of life for individuals and families struggling to maintain care at home is as much a goal of home care as is reducing nursing home use. Nevertheless, the result is that broader support for home and community-based care will raise, not lower, costs.

A few states—most notably, Oregon, Washington, and Wisconsin—stand out for efforts to avoid this outcome by explicitly limiting the use of nursing homes—that is, moving people and dollars out of nursing homes and into home and community-based care. However, control over spending levels not only required limits on nurs-
Long-Term Care Systems

ing home use; it also required limits on the availability of home care that in some cases created waiting lists for care. Also, despite fairly dramatic reductions in nursing home use (especially in Oregon), total long-term care spending continued to rise.37 All told, it may be difficult to achieve a better balance across services without expanding overall investment in long-term care. Willingness to make that investment, however, is at best uncertain.

■ Quality assurance. Despite reform of nursing home regulation more than a decade ago, recent reports to Congress indicate that about a quarter of the more than 17,000 nursing homes nationwide still have serious deficiencies.38 About 40 percent of those homes have had repeated deficiencies.39 Such poor performance is attributed to insufficient attention to and support for federal and state enforcement activities.40 Both levels of government have stepped up activities as a response to public criticism, but concerns remain.

Nursing home payment policy also can influence quality of care. Although higher payment does not ensure higher quality, payment rates can be too low to support adequate quality. The BBA repealed requirements limiting states' flexibility in setting nursing home rates. To date, states have not responded with major changes in nursing home payment, but inaction may be a reflection more of economic prosperity than of comfort with payment methods and rates. In the coming years decisions on how much and how nursing homes are paid (by Medicare as well as Medicaid) will be critical in establishing incentives or disincentives to provide high-quality care.41 Although nursing home quality assurance is problematic, assurance of quality outside the nursing home has barely begun. Assuring the quality of care at home has historically been regarded as challenging because of the numerous sites of care, potential isolation and vulnerability of persons receiving care, and the lack of information on the relationship between services and outcomes. Supportive housing arrangements raise another set of quality assurance issues. Board-and-care homes for low-income persons receive barely more than subsistence payments and fall outside both federal and many states’ regulatory scope. Assisted-living facilities, although better paid, fall outside about half the states’ regulatory frameworks and offer providers a potential escape from nursing home regulation.42 Enhancing the effectiveness of quality tools and extending their reach will remain a considerable challenge for policymakers.

■ Integrating acute and long-term care. People in need of care are clearly frustrated by the challenge of coordinating different types of services across different programs—specifically, Medicare, which finances acute medical care, and Medicaid, which finances long-term care. Better integration across services and programs...
could reduce this burden and improve both the quality and the efficiency of care. However, there is much more rhetoric than reality to “service integration.” Its promotion, especially through reliance on capitation (a single payment per user to cover all services) rather than fee-for-service, reflects a continued quest for cost containment, at least as much as it does a pursuit of high-quality care.

To date, experience with capitation, even for acute care for the elderly, is limited. Medicare managed care now covers about 17 percent of beneficiaries. Limited evidence on its performance, relative to fee-for-service, has raised quality concerns—generally, regarding outcomes for persons with chronic conditions, specifically, regarding reduced use and worse outcomes related to home health care and rehabilitation facilities. Medicare also has promoted the development of new managed care arrangements that include long-term care, which have recently been adopted as provider options. Although demonstration projects provide some evidence of more efficient service delivery, there is concern about the ability to replicate these models and attract enrollees.

Medicaid managed care focuses on acute care for the low-income population under age sixty-five. A capitation payment including acute and long-term care for the elderly requires the “integration” of Medicaid and Medicare and a negotiated arrangement between the state and federal governments. Both the states and the federal government have been cautious in pursuing these arrangements—states, uncertain about the capacity of organizations, including commercial managed care plans, to take on responsibility for long-term care; the federal government, generally unwilling to allow states to require beneficiaries to participate in managed care and concerned about giving states control over the use of Medicare dollars.

Although states have been cautious in assuming that managed care can be applied to long-term care, interest in the concept reflects factors other than efficient delivery of high-quality care. Capitation, especially combining Medicare with Medicaid dollars, offers states financial advantages: the opportunity to control dollars that the federal government now manages and, through fixed capitated payment, to limit liabilities for service. Pursuit of those advantages without evidence that care is truly managed would place the most vulnerable beneficiaries at considerable risk.

- Expanding Insurance for Long-Term Care. Theoretically, there is little rationale for failing to finance long-term care as we finance acute care—that is, relying on insurance to spread its risk. We typically rely on insurance to deal with costs that are potentially catastrophic and unpredictable. Long-term care satisfies both criteria. Purchasing extensive personal care, at home as well as in nursing
homes, is a catastrophic expense. Further, the probability that a given person will need long-term care is uncertain. For example, although 39 percent of persons at age sixty-five are likely to use some nursing home care before they die, almost half will require less than a year of care, while about a fifth will require five years or more.47 Public discussion all too often assumes that a need for long-term care is an inevitable part of aging and that saving is therefore the right strategy to address it. With costs so varied and unpredictable, savings will be inadequate and inefficient. Insurance makes more sense.

The U.S. long-term care system, however, does not provide insurance against the risk of long-term care costs. As described above, the private insurance market is small, and (public) Medicare explicitly limits coverage for long-term care. Medicaid provides support that is critical to persons who need long-term care, but that support is available only after all other resources have been exhausted. Thus, even with Medicaid, risks are concentrated, not spread.

Some argue that with supportive public policies—notably, subsidies through the tax system—the private insurance market could spread the risk of long-term care costs, thereby reaching a much larger portion of the population and greatly reducing burdens on the public sector.48 Recent estimates by the American Council of Life Insurance are that private insurance could grow to finance 29 percent of nursing home costs in 2030, ten times their estimate of 3 percent today.49 However, reliance on private insurance to address future long-term care needs raises critical policy questions.

The first question is the adequacy of protection. Observed inadequacies are numerous: market practices that make policies unavailable to those most likely to need long-term care; benefits that cover only a portion of the costs of care and are not guaranteed to keep pace with rising costs or changing practices of care; and the possibility of unanticipated premium increases (even with policies that promise the same premium for the life of the policy). These features of private insurance, which reflect insurers’ incentives to limit risk, create a barrier to risk spreading that is also apparent in the private individual health insurance market. The nation’s continued dissatisfaction with this market should generate skepticism about the wisdom of following a similar path for long-term care.

A second question is whether tax support for private insurance represents an equitable use of public resources. Tax subsidies are far more likely to reach persons already able to purchase long-term care insurance, rather than those who cannot afford it. Analysis by the Congressional Budget Office (CBO) suggests that the latter group will grow in the coming decades. Further, it suggests that even with
an expansion of long-term care insurance, Medicaid spending must increase—from $43 billion estimated for 2000 to $75 billion for 2020—to ensure even current levels of service to low- and medium-income people (Exhibit 4). Proponents of tax subsidies for private insurance argue that the need for public investment would be even greater in the absence of support for private insurance—the CBO estimates that without any private long-term care insurance, Medicaid long-term care spending would rise to $87.8 billion in 2020. However, to accept that argument is to assume that investment in public and private support will go hand in hand. In practice, advocacy of subsidies for private insurance is more likely to obscure the need to strengthen direct public support. The result would be to target resources to the economically advantaged while leaving the disadvantaged at risk.

Expanded social insurance is an alternative to public support for private insurance. For example, Medicare could be expanded to include long-term care, entitling all Americans, regardless of income, to some insurance protection should they become greatly impaired. However, investment of resources to sustain the social insurance we have (Medicare and Social Security), let alone the social insurance we might have, is subject to considerable debate. Despite the nation’s current prosperity and underlying wealth, our willingness to redistribute resources to reflect the aging of the population seems to be in question.30

In these circumstances, better support for the economically disadvantaged—a more adequate means-tested safety net—should be our priority. We now expect people to impoverish themselves com-

**EXHIBIT 4**
Projected Spending On Long-Term Care For The Elderly, By Payer, 2000 And 2020

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<thead>
<tr>
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<th>Billions of 2000 dollars</th>
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<tr>
<td></td>
<td>2000^a</td>
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<tr>
<td>Medicare</td>
<td>43</td>
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<tr>
<td>Medicaid</td>
<td>29</td>
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<tr>
<td>Out of pocket</td>
<td>0</td>
</tr>
<tr>
<td>Private insurance</td>
<td>51</td>
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**SOURCE:** Congressional Budget Office, *Projections of Expenditures for Long-Term Care Services for the Elderly* (Washington: CBO, March 1999).

**NOTE:** For each year, total spending includes less than $5 billion in spending by “other payers” (not shown).

^a Total spending: $123.1 billion.

^b Total spending: $207.3 billion.
pletely before providing them assistance with long-term care. That system seems excessively harsh. Further, it is geographically inequitable and will become more so as the population ages. Analysis of future population growth and resources reveals that growth in the demand for long-term care and the ability to finance it will vary greatly across states. To create a stronger, more fair safety net will therefore require not just more dollars, but more federal dollars.

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NOTES
2. Estimates based on national health expenditures data, adjusted to include estimated hospital-based nursing home and home health services and Medicare services provided under home and community-based waivers, which are not included in the nursing home and home health categories. Health Care Financing Administration, Office of the Actuary, available online at www.hcfa.gov/stats/nheactables/Tables.pdf (accessed 22 February 2000); B. Burwell, “Medicaid Long-Term Care Expenditures in FY 1998” (Cambridge, Mass.: MEDSTAT Group, 1 April 1999); and unpublished data from HCFA Office of the Actuary (February 2000).
8. K. Liu, K.G. Manton, and C. Aragon, Changes in Home Care Use by Older People with
13. Merlis, “Financing Long-Term Care.”
14. Burwell, “Medicaid Long-Term Care Expenditures.”
19. Liu et al., “Changes in Home Care Use.”
22. Ibid.
23. Liu et al., “Changes in Home Care Use.”
24. Burwell, “Medicaid Long-Term Care Expenditures.”
27. Bishop, “Where Are the Missing Elders?”
28. Liu et al., “Changes in Home Care Use.” These rates may underestimate the proportion who use Medicare home health at any time during the year. Other research found that 24 percent of elderly Medicare beneficiaries needing help with one or more ADLs received Medicare home health services in 1992. H.L. Komisar, J.H. McCool, and J. Feder, “Medicare Spending for Elderly Beneficiaries Who Need Long-Term Care,” Inquiry (Winter 1997/98): 302-310.
29. Liu et al., “Changes in Home Care Use.”
35. Skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) for persons with developmental disabilities accounted for 58 percent and 17 percent, respectively. Burwell, "Medicaid Long-Term Care Expenditures."
36. C.M. Murthaugh et al., "State Strategies for Allocating Resources to Home and Community-Based Care" (New York: Center for Home Care Policy and Research, Visiting Nurse Service of New York, September 1999).
39. GAO, Nursing Homes.
41. B. Manard, "The New Medicare Payment System for Skilled Nursing Facilities: A Primer Regarding Key Issues and Options" (New York: Commonwealth Fund, forthcoming).
42. Coleman, "New Directions for State Long-Term Care Systems."
43. GAO, Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues, Pub. no. GAO/HEHS-99-91 (Washington: GAO, 1999).
46. Arizona's Medicaid program has never offered anything except capitated payment for long-term care. Feder and Lambrew, "Why Medicare Matters."
48. Such policies include the recently enacted "clarification" of tax policy, under which long-term care policies are deductible from taxable income, as are health policies. A proposal to expand deductibility to anyone purchasing a long-term care policy is in the tax bill that Congress passed in summer 1999.
49. Merliss, "Financing Long-Term Care."
51. Merliss, "Financing Long-Term Care."