

Comment on Donald L. Redfoot's “Long-Term Care Reform and the Role of Housing Finance”

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The conundrum of how to address the pressing needs of disabled Americans at a time when the nation is focusing on health care costs and their impact on the federal budget deficit has led supporters of long-term care programs to lower their sights. In the early and mid-1980s, there were strong calls for a comprehensive, universal approach to long-term care. That now seems unrealistic and beyond our grasp. Rather, much of the debate now centers on ways to devise a sensible first step that relies on a combination of government and private resources. Donald Redfoot's article is in that tradition, offering a particular approach to long-term care and integrating it into the resources and opportunities he observes in the housing sector.

Public programs generally treat housing and health as separate and distinct issues. For long-term care, this division is particularly troublesome because it creates gaps and coordination problems. Different agencies manage programs that are authorized and overseen by competing congressional committees. But nursing homes formally combine health and housing, and any responsible home care program for the disabled needs to take both aspects into account.

By calling attention to this issue, Redfoot makes a valuable contribution to the policy debate, and there is much to be lauded in the specifics of his arguments. Many of my concerns with the article stem from its emphasis, tone, and packaging. But in some areas, I am skeptical of his sanguine belief that we can patch together a system that meets the needs of disabled Americans.

Before examining Redfoot's arguments, I seek in the first section of this comment to carefully define the issues under discussion. The second section describes where I differ with Redfoot on the causes of the problems facing long-term care. I conclude with a strategy for policy that differs in several important ways from the approach Redfoot advocates. While I recognize the importance of housing, my comments are, by design, largely restricted to long-term care services. Sandra Newman's (1993) comment in this issue emphasizes housing.

The context

What is long-term care?

One of the challenges in discussing possible policy changes in long-term care is to agree on a definition of what it is and who needs such care. Problems of poor health, disability, or frailty give rise to the need for long-term care. But while people recognize long-term care when they see it, specifying exactly what qualifies as long-term care proves a difficult task. Implicit is the need for extended care, but there is no agreement on the point at which acute services become long-term care. Moreover, the types of services that fall under this rubric vary widely. Some services are more medical, including rehabilitation and monitoring of medications, but others are supportive services, helping disabled persons meet daily personal needs that range from housework to such basics as eating or bathing.

Nor is there agreement on who should receive these services. Some recipients can trace their disabilities to specific illnesses or medical problems, such as broken hips or strokes. But in other cases, frailty results from the slow deterioration in function resulting from the aging process. The only consistent theme is that long-term care is commonly of concern for older women, in part because women are much more likely than men to live into their eighties and nineties and hence require some assistance.

Perhaps the most challenging issue of all is how to determine when the need for services begins. Although it may be easy to justify need for care among the severely disabled, at what point on the continuum of disability should we expect formal services to become available? And from a public policy standpoint, when should we expect persons to qualify for help in meeting those burdens? The fear of unlimited obligations in this area has led to restrictive definitions that confine publicly subsidized services to only the severely disabled. The desire to limit the costs of care, perhaps more than any other reason, is why we continue to focus policy attention on nursing homes. In an era of scarce resources, policy makers fear most of all establishing open-ended benefits for public programs. The difficulty of placing bounds on long-term care is thus an important element for understanding the debate.

How is long-term care delivered?

While the options for disabled persons are changing rapidly in the United States, care for the most disabled persons in our

society has traditionally been in institutions. The 1990 census found that 1.77 million persons were in nursing homes in 1989 (U.S. Bureau of the Census, data supplied by telephone, 1993). Two older surveys of nursing home residents indicate that the proportion of the population in nursing homes has been declining (National Center for Health Statistics 1987).

In contrast, use of formal home and community-based services has grown dramatically over this same period. Data from 1984 indicated that just 30 percent of all persons with at least one limitation in activities of daily living used home and community-based services (Keenan 1988). By 1987, that figure rose to 41 percent (Agency for Health Care Policy and Research 1992), and the growth in the use of those services continued into the 1990s.

Since services often follow reimbursement in our society and since government programs to fund and facilitate long-term care services are not well coordinated and are often restricted, this sector of the economy has been slow to develop. Creative work in fashioning new living environments such as life care communities has led to some expansions in services and exciting programs, but these tend to be limited to the small proportion of the elderly population who can afford to pay for them fully out of pocket. For example, continuing care retirement communities and other assisted living facilities combine living situations with desirable amenities and access to supportive services. Residents may receive varying levels of care as need increases. But while such facilities are growing rapidly, they are still targeted to the upper end of the income distribution.

Given the variability in needs, an ideal long-term care system should offer flexibility. Both institutional services for those who cannot be served at home and community-based services that offer a variety of options for persons who remain in their homes are crucial components of a long-term care system. Community-based services include skilled and unskilled services in the home and programs such as adult day care in a group setting. Such personal services offer flexibility and choice for the recipients and in many cases may be delivered informally. Another important part of any ideal long-term care setting is informal care provided by relatives and friends. Indeed, such care is often crucial to help recipients remain in the community. Institutional care may be needed not just for the level of skill required, but also for the constancy of care needed. In such cases, the intensity of services needed makes it more efficient to offer care in a formal setting. Thus nursing homes will continue to play a crucial role even as other options evolve.

How is long-term care paid for?

The coverage offered by current public programs is generally agreed to be inadequate. Individuals pay for home care or nursing home care out of their own resources, and when those resources are exhausted—or if they were nonexistent to begin with—people generally turn to the welfare-based Medicaid system for support. Unlike insurance, which protects people against financial catastrophe, the current system provides protection only *after* catastrophe occurs. Medicaid is not an insurance program; it is a welfare program for those who have impoverished themselves. And even after individuals become eligible, they must devote most of their income toward the cost of care.

The joint federal-state Medicaid program is inadequate in another way. Much of its spending goes for nursing home care. Program rules encouraged this emphasis in the beginning, and although greater flexibility is now allowed in determining which services to offer, states have been reluctant to expand substantially into home and community-based services. Such expansions would likely impose additional costs on Medicaid at a time when states are feeling fiscal pressure. Thus, at present, the barriers are largely financial. But even in the best of times, some states offer only the basic Medicaid services.

Other public programs offer much more modest coverage. Medicare, the acute care program for the aged and disabled, covers less than 5 percent of long-term care expenses (Letsch et al. 1992). Indeed, many elderly persons are surprised to discover how little Medicare covers when they seek help for long-term care. Medicare offers skilled nursing facility benefits and home health care services, but they are limited to only those with medical problems. At best, Medicare provides transition care for persons after acute episodes. Social Services Block Grants and elderly nutrition programs of the Administration on Aging also offer limited benefits, but these are appropriated programs and not very generously funded.

Over the past decade, private insurance has emerged as another means for spreading the cost of long-term care. Today, about 2 million Americans have private insurance policies. However, policies that promise adequate protection against likely costs (a standard many do not meet) are unlikely to be affordable to the majority of senior citizens most in need of protection. The Health Insurance Association of America (1991) estimated the cost of such a policy in 1990 at \$1,400 for a 65-year-old and more than

\$4,000 for a 79-year-old. Further, these premiums are made more "affordable" by preventing persons with any of a long list of health problems from purchasing policies.

Private insurance, with the addition of consumer protection standards, can provide some Americans with some security against the financial risks of long-term care. But for the vast majority of the elderly, for anyone who already has a disabling condition, and for the younger population with a small but real risk of long-term care needs, the emerging market provides little prospect of protection.

Sources of funding for long-term care are thus fragmented and limited for most Americans. This fragmentation often leads to perverse incentives and blocks some desirable options and choices. Medicaid, while recognized as inadequate, is still the major source of funding for most of those in need.

Why is the current system in trouble?

Donald Redfoot presents a similar picture of the fragmented long-term care system in the United States, but we part ways on the sources of the problem. Redfoot criticizes government regulation, which impedes competition, for raising costs and lowering quality. This regulation, he argues, stems from two sources: the use of a welfare model for financing long-term care and the use of a medical model for establishing standards and requirements. Consequently, we rely too much on nursing homes when lower cost options could be used. Redfoot proposes to lean more in the direction of housing policy, thus emphasizing competition within the private sector and moving away from the regulatory medical model.

Before examining his solution, it is important to look more closely at the causes of high costs and lack of choice in our long-term care system. Redfoot is certainly correct that the particular welfare-based system we have creates problems and that the medical model influences how care is organized, but I do not see these two constraints as the major source of other aspects of the problems that Redfoot cites.

First, financing constraints and regulation do not arise just because of our reliance on a welfare-based system. Rather, it is the rapid growth in the costs of long-term care that has led states to focus on holding down the number of nursing home beds, to limit reimbursement for nursing homes, and to restrict

programs to institutional settings.¹ These concerns are not unique to a welfare-based approach. Certainly, if we had universal coverage of long-term care, the government responsible for financing that system would also be anxious to hold down costs. All the efforts surrounding cost control and Medicare underscore that a program offering universal social insurance would not be immune.

Moreover, since one tool for limiting costs—means-testing the benefit—would no longer be available under a social insurance model, other regulations and restrictions might be even greater. That is, if everyone were eligible, we would have to rely even more on controls, such as limiting the benefits or raising the disability standards, to hold down costs.

The slow growth in Medicaid home care programs reflects the states' recognition that once offered, these services might be difficult to control. Limiting services is more difficult in a setting where recipients remain comfortably at home. Policy makers fear an explosion of use, since disabled persons would see government-provided home care services as a benefit with few disadvantages and hence would seek more services whenever possible. In contrast, having to make a major decision to move to an institutional environment is itself an impediment to demanding such care. Nursing home care is, to some extent, self-limiting.

Redfoot is correct in arguing that settings that are less institutional often may serve people better than nursing homes would. Inappropriate institutionalization stems from the perverse incentives created by offering better coverage for nursing home care than for other services. When there are few alternatives, especially for those with limited means, too many people are inappropriately placed in facilities that offer services and protections beyond their needs. If other facilities were equivalently subsidized, the problem would undoubtedly lessen. But the issue is not so much competition but people who cannot afford private care and instead must adapt to what public services are offered.

Redfoot is also critical of the medical model for long-term care. He is quite right to point out that the quality of life is an essential aspect of the quality of care. Whatever the type, long-term care settings are likely to be relatively permanent arrangements,

¹ This area has been changing very rapidly, however, as states have sought new approaches and the federal government has loosened its standards. More rapid shifts toward home and community-based care are now likely blocked by states' poor fiscal condition and their alarm over the rising costs of long-term care.

stretching over months if not years. Consequently, as Redfoot argues, housing and services need to reflect quality-of-life concerns and the overall living environment of the disabled. In this way, long-term care differs substantially from the acute care setting, which is designed for the convenience of the providers and to which patients are only briefly exposed. Too often, long-term care institutional settings take on an air of sterility and discomfort rather than incorporating the housing, services, and other needs of residents into facility design and operation.

But some aspects of the medical model are important for the severely disabled. Many of those with disabilities do not simply need pleasant surroundings and supportive services. They need the care available in nursing homes. For example, residents who are very frail may be more susceptible to illness and require more sterile surroundings. Supervising patients with dementia necessarily results in some lack of privacy. Thus, we must take care not to forget that nursing homes are where our most vulnerable disabled citizens reside. These severely disabled persons are likely to have substantial acute care needs, and many have cognitive impairments as well. And many reside in fine nursing homes that meet both medical and humane needs.

Consequently, I am reluctant to push as far as Donald Redfoot proposes to change this end of the continuum. I believe we need to enhance options for the less disabled, while recognizing that licensed nursing homes will always have a place in long-term care. Strict regulations to protect residents will still mean that we must balance desires for quality-of-life enhancements with medical necessities. Reducing the medical model too far could lead to situations that require frequent hospitalizations—an unwanted disruption for recipients.²

If Redfoot's point is that the nursing home is not always the appropriate setting and that people need more options, then I fully agree. But it is too harsh a criticism to suggest that we could largely eliminate nursing homes or the need for them in the continuum of care. Moreover, as care becomes available in alternative settings, nursing homes are even more likely to become the site of treatment for the severely disabled for whom a medical model may not be far wrong. Better alternatives should reduce the number of nursing home residents who could be served in less institutional surroundings.

² Moreover, it is from the medical model that analogies to the need for social insurance have traditionally arisen.

A final point on which I take issue with Redfoot is his assertion that lack of competition is the major reason for the high rate of cost increases. Long-term care, by its nature, is extremely labor intensive. Most of the costs of this care reflect the need to attract and retain a work force to perform what are often onerous and unpleasant duties. It is not clear how competition would substantially hold down costs for a given standard of care. Regulation, on the other hand, may lead to higher costs—for example, by requiring that all workers have certain credentials. Licensed nursing homes and home health agencies are more expensive than informal arrangements in which individuals contract for their own care or live in unlicensed facilities. But one system is not necessarily better than the other; they are simply different. A person who is able to oversee the quality of his or her own care may be in a good position to deal with unlicensed providers. On the other hand, a person with dementia or other physical problems is at risk of abuse and mistreatment. We may wish to establish substantial restrictions on long-term care service providers for such persons. What is crucial is the need for flexibility in benefits rather than competition per se.

Solutions

As recently as the mid-1980s, serious discussions of a comprehensive program of social insurance for long-term care took place. Such a program would guarantee all disabled persons access to nursing homes and home and community-based services as needed. But the high and escalating costs for long-term care, coupled with the enormous growth in the acute portions of the Medicare and Medicaid programs, have moved the discussion away from such solutions to proposals involving more modest initial steps.

Options that now get the most attention offer limits of various sorts. The first way to limit expenditures is to rely on the welfare-based approach of Medicaid and means-test access to any program. This approach limits those eligible on the basis of resources as well as needs. Other approaches restrict the type of benefits offered—through expanding only home and community-based services, for example. Further expansion of nursing home coverage would be quite expensive (although moving into a nursing home is often what people fear most). A third type of limitation is to require substantial out-of-pocket contributions by those receiving the care. This approach cuts costs directly through the sharing of expenses and may limit demand for services.

Costs may also be limited by restricting eligibility to those with severe disabilities. Finally, another approach is to change the open-ended nature of entitlement programs that expand automatically with eligibility and other factors. This limitation is usually accomplished by appropriating a set amount of money for a program for the year and then requiring the program to live within that budget.

Redfoot proposes a social insurance approach that would include all services but would not cover the costs of room and board. He argues that this reform would open the market to many innovative ways of packaging and delivering services. While he does not specifically address the issue of how severely disabled a person would need to be to receive care, implicit in his approach, with its emphasis on flexibility, is a less restrictive standard. Thus, Redfoot's view for long-term care is to accept only two of the limitations outlined above—cost sharing and limits on services (e.g., housing). He does not offer a means of financing those services; rather, he implicitly assumes that the Clinton administration's newly announced health care reform plan will provide at least part of the needed support. But he is not explicit about how much more would be necessary to meet the level of service commitment contained in his approach.

The long-term care portion of the Clinton plan is potentially quite limited. While the plan enhances the Medicaid nursing home benefit somewhat, most of the proposal centers on a new home and community-based program for the severely disabled run by the states and subject to income-related cost sharing. Further, it is strictly an appropriated block grant program that entitles those with disabilities to only an assessment of need and a care plan. Other services would depend on efforts by the states. If resources are insufficient to cover all those who are technically eligible, some people would not receive the benefits.³

Because the program establishes upper bounds on the federal contributions and restricts eligibility to the severely disabled, it would not be able to meet the range of needs that Redfoot assumes will be met by social insurance for services. The Clinton administration recognized the limitations of its approach but wanted to hold down costs. Donald Redfoot's proposed approach would rely on this new program for needed services and then try to cobble together many disparate sources on the housing side to

³ On the other hand, critics of going even this far suggest that this may be thought of more as a "capped entitlement" program like food stamps, which is often adjusted upward each year when funds run out before the fiscal year is over.

achieve reasonable options for long-term care. Such an effort would likely fall far short, however, unless further resources were brought to bear.

Many of the innovations that excite Redfoot are occurring for the less severely disabled who are still able to retain considerable independence. Many such persons, unfortunately, will not be eligible for the new long-term care benefit as it is currently structured. And without government support for these services, middle- and lower income senior citizens will likely still find themselves at risk. Even if the Clinton proposal passed without revision, we would not have fully resolved the services side of the long-term care problem. Certainly, the Clinton program would expand the options available and reduce inappropriate institutionalization, but the limitations of the program preclude the comprehensive solution Redfoot desires. His article, however, does not specifically address how to fill in these gaps.

My own suggested approach for long-term care shares many of the goals Redfoot outlines, but I would offer some differences. If we had more resources than are being discussed in the administration's health care proposal, I would favor partial coverage of *all* types of long-term care, including nursing home care, in a single plan. One of the limitations I would stress would be income-related premiums at least as great as those in the Clinton plan (which calls for 40 percent cost sharing for persons with incomes above 400 percent of the poverty level and scaled down for those with lower incomes). The cost-sharing requirements could be even greater for nursing homes, thus implicitly separating out the costs of room and board as well as including cost sharing for the services component. In this way, I concur with Redfoot that we might distinguish between service costs and costs of housing. Further, by covering care in any setting (including nursing homes), we could eliminate the bias for one type of care over another and encourage people to receive care in appropriate settings.⁴ Financing for such a scheme would undoubtedly require a mandatory "premium"—that is, a tax-supported effort.

Since we are unlikely to begin with so ambitious a plan, I would incrementally move in that direction by eliminating the asset test for Medicaid nursing home services and dramatically expanding Medicaid's activities in providing home care. These changes would retain a welfare-based approach but eliminate

⁴ The Clinton plan explicitly excludes covering people in licensed nursing homes, perhaps unintentionally promoting unlicensed institutional care for the severely disabled.

some of the problems of the current system. The convoluted process of spending or giving away assets to gain eligibility would be greatly reduced, but people would still have to contribute a substantial share of their own incomes to the program. Putting services on a more equal footing across all locations would eliminate the incentives to misuse the system to get coverage. We could also allow persons more flexibility in the types of care they wish to receive by closely monitoring eligibility but regulating care less closely. In this regard, I would follow the approach of the Clinton proposal to allow great flexibility in putting together care packages. Such flexibility is also an area that Redfoot stresses.

Thus, to make services available to less disabled persons, I would relate eligibility to income to hold down the costs. The Clinton approach is just the opposite, placing no income limits on participation but restricting coverage to the severely disabled. Redfoot simply assumes it is possible to ignore both constraints.

I believe that most of the development on the housing side that Redfoot outlines would still leave many gaps. I am therefore reluctant to devote resources to specific subsidies and expansions in programs that can hope only to scratch the surface. If mechanisms like reverse mortgages begin to become a serious part of the landscape, we should revisit the question of subsidies to make the program more feasible to those with modest incomes. But in the meantime, I would save scarce resources for proven programs that can be more carefully targeted.

Improved coordination of housing, income support, and long-term care services could make better use of existing public services. At the federal level, such programs are administered by different bureaucracies, creating conflicting rules and unnecessary stumbling blocks. Attention should be directed to facilitating innovative activities to better combine and coordinate services. Similarly, modest expansion of Social Services Block Grants to facilitate the development of infrastructure in areas such as care coordination and availability of home modifications would be useful.

The approach I have outlined would focus attention on those with low and moderate incomes. This should be the first step. When money is added to the program, the eligibility level could simply be extended higher up the income scale. I would prefer that we develop a carefully coordinated system for part of the population, rather than encouraging a patchwork approach on many fronts and hoping that all the pieces happen to fall into place.

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