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# CRS Report for Congress

## Medicare and Medicaid Nursing Home Reform Provisions in the Omnibus Budget Reconciliation Act of 1987, P.L. 100-203

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**MEDICARE AND MEDICAID NURSING HOME REFORM  
PROVISIONS IN THE OMNIBUS BUDGET RECONCILIATION  
ACT OF 1987, P.L. 100-203, AS AMENDED**

**SUMMARY**

Over the past two decades Congress has been concerned with a variety of issues related to the quality of nursing home care paid for by the Medicare and Medicaid programs. More recently congressional attention has focused on comprehensive reform of nursing home regulation. This interest was generated largely as the result of regulations published by the Health Care Financing Administration (HCFA) in 1982 that had the effect of easing the regulatory requirements nursing homes had to meet in order to participate in Medicare and Medicaid. The controversy of these regulations resulted in an agreement by HCFA to commission the Institute of Medicine (IOM) of the National Academy of Sciences to undertake a comprehensive study of Federal nursing home regulations and to make recommendations on changes needed to assure quality of care. IOM completed its report in 1986. Among other things, IOM found the quality of care provided by many nursing homes to be unsatisfactory and argued that a strong Federal role is essential in order to improve quality. IOM's report, *Improving the Quality of Care in Nursing Homes*, contained detailed recommendations for reforming the Federal Government's role in regulating nursing homes.

IOM's recommendations, together with consensus positions developed by national organizations representing nursing home residents, the nursing home industry, and professionals working in nursing homes, served as the basis for provisions in the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) that reform the statutory authority applying to nursing homes participating in Medicare and Medicaid. The nursing home reform provisions of OBRA 87, as they are often called, are divided into three major parts: (1) requirements that nursing homes must meet in order to participate; (2) provisions revising the survey and certification process for determining whether nursing homes comply with these requirements; and (3) provisions expanding the range of sanctions and penalties that HCFA and the States may impose against noncompliant nursing homes. Implementation of these provisions is to be phased in from 1988 through 1991, with major sections of the new law becoming effective October 1, 1990. The provisions as they are contained in the Medicare and Medicaid statutes are summarized in this report.

Since the enactment of the nursing home reform provisions of OBRA, a variety of issues have arisen concerning the legislation. These have focused principally on HCFA's implementation of the law. Nursing home associations, advocate groups for residents of nursing homes, as well as the States have expressed concern with HCFA's failure to meet deadlines for providing guidance on certain provisions that have become effective in 1988 and 1989. They are also concerned with the content of regulations that HCFA has recently published. This report discusses various implementation issues in the new law. The recently enacted Omnibus Budget Reconciliation Act of 1989 addressed some of these issues by, among other things, requiring HCFA to publish regulations by specified dates and by delaying certain effective dates.

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**MEDICARE AND MEDICAID NURSING HOME REFORM  
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ACT OF 1987, P.L.100-203, AS AMENDED**

**INTRODUCTION**

Over the past two decades Congress has been concerned with the quality of nursing home care paid for by the Medicare and Medicaid programs, to which significant Federal resources are devoted. Medicare's coverage of nursing home care is focused on short stays for those persons who are acutely ill and need skilled medical care. In FY 1987, Medicare's payments for nursing home care amounted to about \$600 million, or less than 1 percent of total benefit payments made under the program. The Medicaid program's payments are considerably larger, in part because the program pays not only for short stays related to medical problems, but also longer stays needed by chronically ill and chronically impaired individuals. In FY 1987, Medicaid payments for nursing home care amounted to \$13.2 billion, or nearly 30 percent of total program spending.

Recently, congressional attention has focused on reform of Federal nursing home regulation that is intended to assure that Medicare and Medicaid beneficiaries receive quality care. This interest was generated largely as the result of regulations proposed by the Health Care Financing Administration (HCFA)<sup>1</sup> in 1982 that had the effect of easing the regulatory requirements nursing homes had to meet in order to participate in Medicare and/or Medicaid. Among other things, the proposed changes would have eased the annual inspection and certification requirements for facilities with a good record of compliance. These regulations would have also authorized States to accept accreditation of nursing homes by the Joint Commission on Accreditation of Hospitals (JCAH) in lieu of State inspections as a basis for certifying nursing homes as meeting Federal requirements for participation in Medicare and Medicaid. Following their publication, Congress twice enacted legislation prohibiting the Secretary of Health and Human Services (HHS) and HCFA from implementing these regulations.

The controversy of these regulations resulted in an agreement by HCFA to commission the Institute of Medicine (IOM) of the National Academy of Sciences to undertake a comprehensive study of Federal nursing home regulations and to make recommendations on changes needed to assure quality care. IOM published its findings in 1986 in a report entitled *Improving the Quality of Care in Nursing Homes*. This report contains recommendations for the comprehensive revision and expansion of statutory and regulatory requirements for nursing homes wishing to participate in Medicare and Medicaid. The IOM found that the quality of care and quality of life in many nursing homes are not satisfactory and that more effective government regulation, including a stronger Federal role, could substantially

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<sup>1</sup>HCFA is the agency within the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

improve quality in nursing homes. To accomplish this, the IOM report recommended:

- (1) specific changes in the standards of care which nursing homes must meet in order to participate in Medicare and Medicaid;
- (2) measures to strengthen the process of determining the extent to which nursing homes are complying with standards for providing quality care; and
- (3) improvements in enforcing compliance with Federal standards.

The IOM report received broad support from both nursing home associations and patient advocates' groups. Many of these groups met regularly after the publication of the IOM report and developed detailed consensus positions outlining how nursing home laws and regulations should be changed and strengthened. Consensus positions on a variety of issues were published by these groups in April 1987, in *Campaign for Quality Care in Nursing Homes*.

Following the publication of the IOM report, several bills whose provisions embodied many of the IOM's recommendations were introduced into the 99th Congress. At that time, final action was not taken by the Congress on any one of these. Bills were again introduced in the 100th Congress, including those by Chairmen of Subcommittees and Committees with jurisdiction over the Medicare and/or Medicaid programs. In the 100th Congress, Congressmen Dingell, Waxman, and others introduced H.R. 2270, which would amend requirements for nursing homes participating in the Medicaid program. Congressman Stark and others introduced H.R. 2770, which would amend the requirements for nursing homes participating in Medicare. Senator Mitchell and others introduced S. 1108, which would amend requirements for nursing homes participating in Medicare and/or Medicaid. Versions of these bills were included in House and Senate reconciliation bills considered in 1987.

The Omnibus Budget Reconciliation Act of 1987, P.L. 100-203 (OBRA 87), as finally enacted at the end of 1987, included provisions that comprehensively reform the statutory authority applying to nursing homes participating in Medicare and/or Medicaid. A number of technical and correcting amendments to the original enactment were included both in the Medicare Catastrophic Coverage Act of 1988, P.L. 100-360, and the Family Support Act of 1988, P.L. 100-485. Implementation of these provisions is to be phased in from 1988 through 1991, with major sections of the new law becoming effective October 1, 1990. The amended new Medicare and Medicaid law pertaining to nursing homes, commonly referred to as the nursing home reform legislation, is summarized below.

While Congress was considering this legislation, HCFA proceeded on another track of implementing IOM recommendations. HCFA argued that

many of the report's recommendations could be included in revised regulations under then existing statutory authority. During 1987, HCFA issued two sets of proposed regulations: A proposed rule of October 16, 1987, would have revised requirements that nursing homes would have to meet in order to participate in Medicare and/or Medicaid. A second proposed rule, published November 18, 1987, would have revised the procedures for determining whether a nursing home actually met the requirements for participation and would have established sanctions for chronic or repeat violators of these requirements. Before the comment period for these regulations had ended, Congress had enacted a new statutory authority for nursing homes participating in Medicare and Medicaid.

In February 1989, HCFA decided to move forward with one set of these proposed rules. On February 2, HCFA published as a final regulation its original October 1987 regulation to revise and consolidate requirements that nursing homes must meet in order to participate in the Medicare and/or Medicaid programs. (Earlier it had withdrawn its November 1987 regulation.) This final regulation was revised to take into account comments from the public on its original provisions. HCFA also incorporated in this final regulation provisions that would implement certain new requirements contained in OBRA 87 that are to become effective October 1, 1990. HCFA indicated in its February 2 notice that the provisions of the regulation would become effective August 1, 1989.

A coalition of consumer nursing home groups, led by the National Citizens Coalition for Nursing Home Reform, asked HCFA to delay implementation of the February 1989 regulations for a year. Other groups filed suit asking a Federal court to declare the regulations illegal. All these groups argued that HCFA was implementing portions of OBRA 87 without providing them opportunity for public comment. These provisions, they noted, were not to become effective until October 1990. They also pointed to provisions of the regulations which they found inconsistent with the new law. In addition, these groups expressed concern with HCFA's failure to meet deadlines for publishing regulations for certain other provisions of nursing home reform law that had become effective in 1988 and 1989.

At a hearing held by the Senate Aging Committee in May 1989, HCFA indicated that it would very likely delay the effective date of the February regulation. On July 14, 1989, HCFA published a notice delaying implementation of the regulation until January 1, 1990.

In budget reconciliation legislation considered in 1989, both the House and Senate included in their respective bills, H.R. 3299 and S. 1750, provisions that would amend certain provisions of the new nursing home reform law. The enacted legislation, the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), P.L. 101-239, includes provisions that prohibit the Secretary of HHS from implementing HCFA's February 2 regulation before October 1, 1990; that require the Secretary to publish regulations on nurse aide training programs and preadmission screening programs for the mentally

ill and mentally retarded; and that modify the training and competency evaluation requirements of OBRA 87 for certain nurse aides.

This report provides (1) background information on how nursing homes are regulated under Medicare and Medicaid; (2) a short summary of the nursing home reform provisions of OBRA 87, as amended; (3) a discussion of current issues in the implementation of the new law and amendments contained in OBRA 89 that address these issues; and finally (4) a more detailed summary of the law's provisions. This report will be revised from time to time to reflect additional congressional actions to amend the nursing home reform provisions of Medicare and Medicaid law.

For additional information on nursing home care in the context of issues related to the financing and delivery of long-term care, see: U.S. Library of Congress. Congressional Research Service. Long-Term Care for the Elderly. Issue Brief No. IB88098; Financing and Delivery of Long-Term Care Services for the Elderly. CRS Report for Congress No. 88-379 EPW; and Long-Term Care Legislation: Summary of Selected Bills. CRS Report for Congress No. 89-238.

## **GENERAL BACKGROUND INFORMATION ON LAW AND REGULATIONS APPLYING TO NURSING HOMES PARTICIPATING IN MEDICARE AND/OR MEDICAID**

Medicare and Medicaid have different nursing home benefits. However, the requirements that nursing homes must meet for participation, the procedures for surveying a nursing home's compliance with these requirements, and sanctions for noncompliance are similar.

### **Medicare Requirements for Nursing Homes**

Medicare is the Nation's Federal health insurance program for the elderly and disabled and has a uniform eligibility and benefit structure throughout the country. It includes among its benefits extended care services for persons who need skilled nursing care on a daily basis or other skilled rehabilitation services, which as a practical matter, can only be provided in a facility known as a skilled nursing facility (SNF).

For those who qualify for the benefit, extended care must be provided by a SNF which is certified to participate in Medicare. In order to participate in the program and to receive Medicare reimbursement for services provided to qualifying beneficiaries, SNFs must comply with certain requirements contained in Medicare law and regulations. These requirements are often referred to as "conditions of participation." They specify standards of staffing, organization, and health and safety that the facility must meet. The nursing home reform provisions contained in OBRA 87 revise these requirements for SNFs, with an effective date of October 1, 1990.

Medicare law and regulations also specify general procedures for determining whether a SNF complies with the requirements for participation. The law requires the Secretary of HHS to enter into agreements with States to survey SNFs to certify their compliance with these participation requirements. With the survey agency's recommendations, HCFA, the HHS agency responsible for administering Medicare, then makes a determination as to whether it should enter into an agreement with the SNF to allow it to participate. Agreements with SNFs in compliance with the requirements last for 12 calendar months. This has the effect of requiring the survey agency to review the SNF at least annually for compliance/noncompliance. OBRA 87 also contains provisions revising the survey and certification process for determining whether SNFs should be permitted to participate in the Medicare program. These provisions become effective October 1, 1990.

Survey agencies have been able to certify SNFs for participation if they are found to be deficient in one or more standards and if the deficiencies, individually or in combination, do not jeopardize the health and safety of patients, and if the facility submits an acceptable plan of correction for achieving compliance within a reasonable period of time. In August 1986, HCFA implemented "intermediate sanction" requirements of law to provide HCFA with an alternative penalty for SNFs with deficiencies that do not

immediately jeopardize the health and safety of the facility's patients but are serious enough to require more emphasis than simply a plan of correction. Prior to this time, the only sanction available to HCFA for such facilities was termination of the facility's participation agreement. The intermediate sanction authority implemented in 1986 has allowed HCFA to deny payments for new admissions of Medicare patients to SNFs that are not in substantial compliance with the law's requirements and standards of care, so long as the deficiencies do not immediately jeopardize the health and safety of the facility's patients. However, if it is determined that the deficiencies immediately jeopardize the health and safety of the facility's patients, then HCFA must terminate the facility's participation in Medicare. If the decision is made to deny program payment instead of terminating a facility's participation, the facility must achieve substantial compliance with program requirements or be found to have made a good faith effort to correct its deficiencies by the end of the 11th month following the month when a decision was made to deny payment. Effective January 1, 1988, OBRA 87 revises and expands the intermediate sanctions that may be imposed against facilities found to be out of compliance with the law's requirements. HCFA has not yet issued regulations to implement the new sanction authority, and existing policy remains in effect until their publication.

### **Medicaid Requirements for Nursing Homes**

The Medicaid program is a Federal-State matching program providing medical assistance for low-income persons who are aged, blind, disabled, or members of families with dependent children. All States (except Arizona which is operating an alternative demonstration program), the District of Columbia, and the Territories currently participate in the program. Within Federal guidelines, each State designs and administers its own Medicaid program.

Under current law, the Medicaid program pays for services in three different categories of nursing homes: skilled nursing facilities (SNFs), intermediate care facilities (ICFs), and intermediate care facilities for the mentally retarded (ICFs/MR). Neither the IOM report nor the nursing home reform legislation enacted in 1987 dealt with ICFs/MR.

Medicaid law defines SNF services as services which are required to be given to an individual who needs on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services which as a practical matter can only be provided in a SNF on an inpatient basis. Medicaid law requires SNFs participating in Medicaid to meet the requirements specified in Medicare law for SNFs participating in that program. Medicaid SNFs must therefore meet the standards of staffing, organization, and health and safety that are specified in Medicare law and regulations for SNFs.

Medicaid also pays for ICF services. Medicaid law defines an ICF as an institution that is licensed under State law to provide on a regular basis

health-related care and services to individuals who do not require the degree of care and treatment which a hospital or SNF is designed to provide but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities. ICFs are also required to meet: (1) standards prescribed by the Secretary as he finds appropriate for the proper provision of care, (2) such standards of safety and sanitation as are established under regulation of the Secretary in addition to those applicable to nursing homes under State law, and (3) requirements for protecting patients' personal funds. As is the case for SNFs, ICFs must meet various requirements for staffing, organization, and health and safety that have been specified by the Secretary of HHS in regulations. These various requirements for ICFs are often referred to as "standards" (in contrast to the "conditions of participation" that apply to SNFs).

Effective October 1, 1990, OBRA 87 will eliminate the Medicaid program's distinction between SNFs and ICFs, and, in so doing, will create a "nursing facility" benefit under that program. At that time, nursing facilities (NFs) will have to meet a single set of requirements in order to participate in Medicaid.

Medicaid law and regulations, like those for Medicare, specify general procedures for determining whether nursing homes participating in Medicaid actually comply with the requirements for participation. Medicaid law requires State Medicaid agencies to contract with the State survey agency used by Medicare (if that agency is the agency responsible for licensing health facilities) to survey facilities to determine whether they meet the requirements for participation. The State Medicaid agency then decides whether it should enter into an agreement with the nursing home in order to allow the facility to participate in and receive reimbursement from the State's Medicaid program. Survey agencies may certify a facility that is in compliance with the requirements for participation for up to 12 months. OBRA 87 revises the survey and certification process for nursing homes participating in Medicaid in ways similar to the provisions governing SNFs participating in Medicare.

Under Medicaid, survey agencies have been able to certify nursing facilities for participation even if they are found to be deficient in certain standards for providing care, just so long as the deficiencies do not jeopardize the health and safety of patients and if the facility submits an acceptable plan of correction for achieving compliance within a reasonable period of time. For deficiencies that require more than a plan of correction, the State, like HCFA, has authority to deny payments for new admissions of Medicaid patients to nursing facilities. OBRA 87 revises and expands the sanctions that States and the Secretary may impose against noncompliant facilities participating in Medicaid.

## **SHORT SUMMARY OF NURSING HOME REFORM PROVISIONS**

OBRA 87, as amended, includes provisions that comprehensively reform the statutory authority applying to nursing homes participating in Medicare and/or Medicaid. The enactment contains two sets of provisions: those that apply to SNFs participating in Medicare and other provisions that apply to nursing facilities (NFs) in Medicaid. Often the provisions in the two sections are identical. Each of the two sections is divided into three major parts: (1) requirements which nursing homes must meet in order to participate in the programs, (2) provisions revising the survey and certification process for determining whether nursing homes comply with the requirements for participation, and (3) provisions expanding the range of sanctions and penalties the Secretary and States may impose against noncompliant nursing homes. Both the Medicare and Medicaid provisions on nursing home reform are summarized briefly below. Where significant differences in Medicare and Medicaid law exist, the individual provisions are noted. A more detailed summary of the provisions as they exist separately in Medicare and Medicaid statutes is contained in the appendix of this report.

### **Skilled Nursing Facility and Nursing Facility Requirements for Participation**

In order to participate in Medicare and/or Medicaid, SNFs and NFs must care for residents in a manner and in an environment that promotes the quality of life of each resident. They must conduct and periodically update a comprehensive assessment of each resident's functional capacity. SNFs and NFs must provide certain specified services, directly or under arrangements with others: nursing and specialized rehabilitative services; medically-related social services; pharmaceutical services; dietary services; an on-going activities program; and routine and emergency dental services. They must provide 24-hour licensed nursing care sufficient to meet the nursing needs of residents and must use a registered professional nurse at least 8 consecutive hours a day 7 days a week. (HCFA may waive the registered nurse requirement for certain rural SNFs, and States may waive both the registered nurse requirement and the licensed nurse requirement under certain circumstances.) Both SNFs and NFs must use as nurse aides only those persons who have completed an approved training and/or competency evaluation program, or who have had certain other training or work experience.

SNFs and NFs must protect and promote a resident's rights relating to (1) choice of physician, (2) freedom from abuse, punishments and restraints, (3) privacy (4) confidentiality of records, (5) accommodation of individual needs and preferences, (6) voicing grievances, (7) organizing and participating in resident groups, (8) participating in social, religious, and community activities; (9) examination of survey results, and (10) any other right established by the Secretary. SNFs and NFs must allow immediate access to any resident by Federal and State officials, by the State ombudsman, and by the resident's physician and immediate family members. They may transfer or discharge a resident only under specified circumstances.

Facilities must establish and maintain identical policies and practices with regard to transfer, discharge and Medicare/Medicaid covered services for all individuals, regardless of source of payment. They must not require individuals to waive their rights to benefits under Medicare or Medicaid. Nor can they require a third party guarantee (or gift, money, donation, or other consideration, in the case of Medicaid), as a condition of admission, or continued stay in, the facility.

### **Survey and Certification Process**

OBRA 87 establishes a new process for surveying SNFs and NFs to determine their compliance with the requirements for participation. These provisions are intended to assure that the survey process is resident-centered and outcome-oriented, and not limited to observations of the facility, its policies, and procedures. They are also designed to permit survey agencies to concentrate their efforts on facilities providing substandard care. The new law provides for two different surveys for certification: a standard survey and an extended survey.

Every SNF and NF will be subject to an unannounced standard survey that must be conducted not later than 15 months after the date of the previous standard survey. The average interval between standard surveys in a State must not exceed 12 months. Standard surveys must include, for a resident sample that takes into account the differing characteristics of residents in a facility, a review of the quality of care provided, residents' plans of care and assessments, and the facility's compliance with resident's rights.

Each facility found under a standard survey to have provided substandard care will be subject to an extended survey. This survey must be conducted immediately after the standard survey and must identify the policies and procedures that resulted in substandard care. The extended survey must also determine compliance with every requirement for participation, and must include an expanded sample of residents' assessments, a review of staffing, in-service training, and, if appropriate, contracts with consultants. At the discretion of the Secretary or the State, any other facility, besides those found to be providing substandard care, can be subject to an extended survey (or a partial extended survey).

The Secretary of HHS must conduct onsite validation surveys of a representative sample of each State's nursing homes, to determine the adequacy of State survey activities. These validation surveys must amount to at least 5 percent of the number of facilities surveyed by the State in a year, but in no case less than 5 SNFs and 5 NFs.

### **Enforcement Process**

OBRA 87 revises and expands the sanctions that States and the Secretary may impose against nursing homes found to be out of compliance with the

requirements for participation. New sanctions that may be imposed include: denial of payment for current residents (Medicare only) or new admissions (Medicare and Medicaid); civil money penalties for each day of noncompliance; appointment of temporary management; and, in the case of an emergency, authority to close the facility or transfer residents, or both (Medicaid only).

### **Preadmission Screening and Annual Resident Review for the Mentally Ill and Mentally Retarded**

OBRA 87 requires in Medicaid law that States establish preadmission screening programs to determine for mentally ill or mentally retarded individuals seeking admission to a nursing home that they require the level of services provided by a nursing home and, if so, whether they require active treatment. Active treatment generally refers to an aggressive and continuous program of specialized and generic training and specific therapies or activities to improve an individual's functioning. OBRA also requires that all nursing home residents who are mentally ill or mentally retarded and who were admitted prior to January 1, 1989, be reviewed on an annual basis to determine whether their continued placement is appropriate and whether they require active treatment. The law requires that certain residents be discharged if their placement in a nursing facility is found to be inappropriate. These include persons who have not resided in the nursing home for at least 30 months and those who do not require active treatment.

### **ISSUES IN THE IMPLEMENTATION OF OBRA 87 NURSING HOME REFORM PROVISIONS**

The nursing home reform provisions of OBRA 87 represent nearly 2 years of congressional deliberation on a variety of legislative proposals dealing with the quality of nursing home care, detailed recommendations of a comprehensive Institute of Medicine report, and the consensus positions of national organizations representing the nursing home industry, nursing home residents, and nursing home professionals. Since enactment, a variety of issues have arisen concerning the legislation. These are currently centered on HCFA's implementation of the new law.

### **Health Care Financing Administration's Publication of Final Regulations February 2, 1989**

On February 2, 1989, HCFA published final regulations that revise and consolidate requirements that nursing homes must meet in order to participate in Medicare and/or Medicaid. In general, the regulations would have become effective August 1, 1989. These final regulations incorporated revisions to an October 1987 proposed regulation that represented HCFA's response to the Institute of Medicine report, *Improving the Quality of Care in Nursing Homes*. The proposed regulations were published prior to the enactment of the nursing home reform provisions of OBRA 87 in December of that year. The final regulations also included provisions that applied to certain new requirements contained in OBRA 87.

Nursing home associations and consumer organizations objected to HCFA's decision to move forward with these regulations. The Gray Panthers Advocacy Committee and nursing home residents from three States and the District of Columbia filed suit asking a Federal court to declare the final regulations illegal. The groups bringing the case to court argued that the regulations are inconsistent with the new law, fail to carry out the intent of the law, and, for those provisions that implement portions of OBRA 87, did not provide them opportunity for public comment prior to becoming effective.

Nursing home groups also objected to HCFA's decision to implement, with this final regulation, provisions of OBRA 87 that were not to become effective until October 1990. They pointed to other regulations which OBRA required the Secretary to issue in 1988 and 1989, and whose deadlines the Secretary had failed to meet. These included regulations that would provide guidance to the States and facilities on implementing such provisions as nurse aide training programs and preadmission screening for the mentally ill and mentally retarded. Nursing home groups and States argued that HCFA resources should have been devoted to developing regulations for provisions that became effective for the States and facilities in 1988 and the first half of 1989.

In July 1989, HCFA issued notice that it would delay implementation of the February 1989 regulations from August 1, 1989 to January 1, 1990. HCFA also indicated that it expected to issue regulations on other portions of OBRA nursing home reform provisions in 1989 (not yet issued).

In budget reconciliation legislation considered in 1989, both the House and Senate addressed a number of nursing home reform issues, including a moratorium on HCFA's February regulations. The House included in its reconciliation bill, H.R. 3299, a provision that would prohibit the Secretary of HHS from implementing the Medicaid portions of HCFA's February 2 regulation before October 1, 1990. The Senate Finance Committee had reported a reconciliation bill that contained a similar provision applying to both Medicare and Medicaid. However, in the bill as passed by the Senate, S. 1750, the moratorium provision was deleted. The enacted OBRA 89, P.L. 101-239, included the moratorium provision, applying it to both the Medicare and Medicaid regulations of the HCFA's February publication.

### **Preadmission Screening and Annual Resident Review for the Mentally Ill and Mentally Retarded**

OBRA 87 establishes requirements for the preadmission screening of mentally ill and mentally retarded persons who are seeking nursing home admission and annual resident review for those who are residing in nursing homes. These requirements originated out of concern that many mentally ill and mentally retarded persons are inappropriately placed in nursing homes where they do not receive the care and, particularly, the active treatment services needed for their conditions. A 1987 General Accounting Office (GAO)

report, *Medicaid: Addressing the Needs of Mentally Retarded Nursing Home Residents*, found that the active treatment needs of mentally retarded residents of SNFs and ICFs in three States had generally not been identified and met. States used placements in nursing homes in order to reduce overcrowding in large State-operated intermediate care facilities for the mentally retarded (ICF/MR).<sup>2</sup> In addition, States have a financial incentive to place the mentally retarded in nursing homes rather than ICFs/MR, since the costs for ICF/MR care are generally much higher than costs for SNF and ICF care (in part because of the costs of active treatment which must be provided in ICFs/MR).<sup>3</sup> Similarly, States have an incentive to place the mentally ill in Medicaid-certified SNFs and ICFs where the Federal Government will share in the cost of their care.<sup>4</sup>

For this reason, OBRA 87 requires that States establish preadmission screening programs to determine for mentally ill or mentally retarded individuals seeking admission to a nursing home that they require the level of services provided by a nursing home and, if so, whether they require active treatment. OBRA also requires that all nursing home residents who are mentally ill or mentally retarded and who were admitted prior to January 1, 1989, be reviewed on an annual basis to determine whether their continued placement is appropriate and whether they require active treatment. (These preadmission screening and annual resident review requirements are often referred to as PASARR requirements.) The law requires that certain residents be discharged if their placement in a nursing facility is found to be inappropriate. These include persons who have not resided in the nursing home for at least 30 months and those who do not require active treatment.

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<sup>2</sup>U.S. General Accounting Office. *Medicaid: Addressing the Needs of Mentally Retarded Nursing Home Residents*. GAO/HRD-87-77, Apr. 1987. p. 11.

<sup>3</sup>U.S. Congress. House. Committee on Energy and Commerce. *Medicaid Source Book: Background Data and Analysis*. Committee Print 100-AA, Nov. 1988. p. 399, 401, 476. (Hereafter cited as House Committee on Energy and Commerce, *Medicaid Source Book*.)

<sup>4</sup>State Medicaid programs may, at their option, cover services in two types of institutions for the mentally ill: institutions for mental diseases, or IMDs, and inpatient psychiatric hospitals. Services in IMDs may be covered only for beneficiaries aged 65 and older. Services in inpatient psychiatric hospitals may be covered only for beneficiaries under age 21. The effect of these rules for the two types of institutional mental health providers is to exclude Medicaid coverage of services in mental institutions for persons between the ages of 21 and 65 years. HCFA has contended that Medicaid programs are reimbursing, as SNF and ICF services, care that is actually being furnished by IMDs, with some States improperly claiming Federal funds for IMD services provided to beneficiaries between 21 and 65.

OBRA required the Secretary to develop by October 1, 1988, minimum criteria for States to use in making determinations as to whether a mentally ill or mentally retarded individual requires the level of care provided by a nursing home. By that date, the Secretary was also required to develop minimum criteria for States' appeals processes for persons adversely affected by screening decisions. Preadmission screening requirements became effective January 1, 1989, regardless of whether the Secretary issued guidance to the States or not.

Nursing home groups and advocates of the mentally ill and mentally retarded have expressed concern with HCFA's implementation of these requirements. During 1988, only drafts of program guidelines were available to the States for implementing their own programs for screening the mentally ill and mentally retarded. In May, 1989, HCFA issued interim guidelines to the States to use for screening and review, but indicated that it intends to use the formal rule-making process, with a comment period, before making the guidelines' criteria binding on the States. Final regulations on preadmission screening are, therefore, not yet in effect.

At a hearing before the Senate Special Committee on Aging May 18, 1989, nursing home groups pointed out that HCFA's various drafts have differed in their definitions of mental illness and, by implication, who should be screened for the appropriateness of nursing home care. The drafts have also had different definitions of active treatment and the services that must be provided by the States for those who require this level of care. These groups are concerned that they will once again have to redesign screening programs when the criteria are published as regulations. Nursing home groups also objected to the application of these requirements to all persons, regardless of whether they are private payers, Medicare beneficiaries, or Medicaid-eligible individuals, so long as they are applying for admission to, or residing in, a Medicaid-certified nursing home. For lack of timely guidance and other reasons, two nursing home industry associations, the American Association of Homes for the Aging and the American Health Care Association, have entered into a suit against the Secretary of HHS, to stop implementation of the preadmission screening requirements of OBRA.

In addition to these implementation issues, nursing home groups and advocates for the elderly, mentally ill, and mentally retarded are also concerned about those persons who are deflected from nursing home care in the preadmission screening process and whether they are directed to other appropriate sources of care. OBRA does not address this issue, except for requiring an appeals process for those adversely affected in the screening. For those who are actually discharged, there is also concern about whether they receive the active treatment and other services they might need. In many cases, such persons will not be eligible for Medicaid services, and States alone will be responsible for paying for the costs of their care. These issues

reflect more general problems in providing and paying for care for the chronically mentally ill and mentally retarded.<sup>5</sup>

In budget reconciliation legislation considered in 1989, both the House and Senate addressed a number of PASARR issues. The House's reconciliation bill, H.R. 3299, included a number of provisions related to PASARR, including those that would (1) prohibit the Secretary from taking any compliance action against any State that, prior to the effective date of HCFA's May 1989 guidelines, made a good faith effort to comply with the statute; (2) require the Secretary to promulgate proposed regulations implementing PASARR requirements within 90 days of enactment of the bill; (3) provide that private pay patients would not be subject to PASARR until they become eligible for Medicaid; (4) revise the definition of mental illness for purposes of applying PASARR requirements from "a primary or secondary diagnosis of mental disorder" to "serious mental illness as defined by the Secretary"; and (5) substitute the phrase "specialized services" for the phrase "active treatment." The Senate Finance Committee had reported a reconciliation bill with many of these same provisions, but the bill as passed by the Senate contained no amendments to the PASARR requirements.

In the enacted OBRA 89, signed into law on December 19, 1989, only one PASARR provision was included. This provision requires the Secretary to issue proposed regulations on PASARR requirements not later than 90 days after enactment of OBRA 89.

### **Nurse Aide Training**

For its report, *Improving the Quality of Care in Nursing Homes*, the Institute of Medicine (IOM) found that over 70 percent of the nursing personnel in long-term care facilities are nurse aides, and as much as 90 percent of resident care in nursing homes is delivered by them.<sup>6</sup> IOM also found that a majority of States had no specific training requirements for aides, and in those States with some kind of training requirements, programs followed no consistent educational model in content, goal, or organization. Given the importance of their role in the nursing home, IOM recommended that the Federal Government should mandate training of nurse aides prior to employment.

OBRA 87 establishes new requirements for nurse aide training. On or after January 1, 1990, nursing homes will be able to use as nurse aides (for more than 4 months) only those persons who have completed a training and/or competency evaluation program and are competent to provide care.

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<sup>5</sup>House Committee on Energy and Commerce, *Medicaid Source Book*, Appendices D and E.

<sup>6</sup>Institute of Medicine. *Improving the Quality of Care in Nursing Homes*. National Academy Press, Washington D.C., 1986. p. 89, 90.

For those nurse aides hired before July 1, 1989, nursing homes participating in Medicare and/or Medicaid must provide for a competency evaluation program and the preparation necessary for the aide to complete this program by January 1, 1990. OBRA specifies that the training program include a minimum of 75 hours of initial training. Approved training and competency evaluation programs may include those offered by or in nursing homes. OBRA also requires that Medicare and Medicaid reimbursements to nursing homes recognize the costs of nurse aide training incurred by facilities.

Nursing home groups have expressed concern with HCFA's delay in specifying criteria for training and competency evaluation programs. They have pointed out that programs they were required to develop in the absence of regulations will require extensive revamping once Federal regulations are finally published. The Secretary was required to establish requirements for approval of these programs by September 1, 1988. In April 1989, HCFA issued program guidelines for approval of training and competency evaluation program, but these are intended to provide only temporary guidance until HCFA publishes regulations on these OBRA provisions later in 1989.

The April 1989 guidelines specify that the 75 hours of initial training include at least 16 hours of classroom instruction prior to the trainee's direct involvement with a nursing home resident. This classroom instruction should include communication and interpersonal skills; infection control; safety/emergency procedures; promoting residents' independence; and respecting residents' rights. Initial training should include another 16 hours of skills training that should ensure, at a minimum, competency in basic nursing skills, personal care skills, mental health and social service needs, basic restorative services, and residents' rights. The remaining hours of initial training, according to the guidelines, can be used at the discretion of the designers of the training program.

In their consideration of budget reconciliation legislation in 1989, both the House and Senate considered a number of nurse training issues. The House included in its reconciliation bill, H.R. 3299, provisions that would, among other things, delay the effective dates of Medicaid training and competency evaluation requirements for nurse aides; require the Secretary of HHS to promulgate proposed regulations on the law's training requirements within 90 days of enactment of the bill; and consider nurse aides as having completed training and competency evaluation requirements if they had received certain other training. The Senate Finance Committee reported a reconciliation bill with similar provisions. However, the Senate-passed bill, S. 1750, contained only two provisions related to nurse aide training: (1) a delay in the effective date for training and/or competency evaluation requirements for nurse aides; and (2) a provision allowing States to waive training and competency evaluation requirements for certain nurse aides that have had certain experience and training.

The enacted OBRA 89, signed into law December 19, 1989, as P.L. 101-239, included a number of nurse aide training amendments that apply to both Medicare and Medicaid requirements. These include provisions that:

- delay from January 1, 1990, until October 1, 1990, the date by which nurse aides must complete training and/or competency evaluation programs and must be determined to be competent to provide services; for aides employed as of January 1, 1990, nursing homes must provide for competency evaluation to be completed by October 1, 1990;
- require the Secretary to issue proposed regulations on nurse aide training and competency evaluation programs not later than 90 days after enactment;
- consider nurse aides to have completed a training and competency evaluation program if, as of July 1, 1989, the aide had received 60 hours of initial training, and at least 15 hours of supervised practical nurse aide training or regular in service education;
- consider nurse aides to have completed a training and competency evaluation program if they were found competent (whether or not by the State) before July 1, 1989, after the completion of a course of nurse aide training of 100 hours;
- permit States to waive competency evaluation requirements for aides who can demonstrate to the satisfaction of the State that they have served as a nurse aide at one or more facilities of the same employer in the State for at least 24 months before enactment of OBRA 89;
- provide that nurse aides may establish competency through procedures or methods other than the passing of a written examination, and at the nursing facility at which the aide is (or will be) employed, unless the facility is out of compliance with requirements for participation; and
- prohibit the imposition on nurse aides of any charges (including any charges for textbooks and other required course materials) for training and competency evaluation programs.

### **Licensed Nurse Staffing**

One of the main differences that distinguishes the requirements for SNFs participating in Medicare and Medicaid from those for Medicaid ICFs is the licensed nurse staffing requirement. Medicare has required that SNFs have on duty 24 hours a day licensed nurses, including the services of a registered professional nurse at least during the day tour of duty 7 days a week. Licensed nurses include registered nurses or practical (vocational) nurses licensed by the State in which they practice. Certain rural SNFs may receive

a waiver for the registered nurse requirement for a 48-hour period. OBRA 87 retained these same licensed nursing requirements for SNFs participating in Medicare. Effective October 1, 1990, SNFs must provide 24-hour licensed nursing care and must use a registered professional nurse at least 8 consecutive hours a day 7 days a week (with waivers permitted for the registered nurse requirement for certain rural facilities).

For ICFs, on the other hand, Medicaid has only required that a licensed nurse be on duty on the day shift 7 days a week. This licensed nurse could be a registered nurse or a licensed practical or vocational nurse. As a practical matter, this requirement would allow ICFs to use nurse aides to provide all care for the remaining 18 hours of the day.

In its report, IOM observed that one of the major factors affecting quality of care and quality of life in nursing homes is the number and quality of nursing staff; greater numbers of nurses have been associated with improved resident outcomes.<sup>7</sup> IOM also stated that staffing patterns vary across facilities, regions, and States, but for the most part there are inadequate numbers of nurses to provide the minimum care needed.

IOM also looked at the differences between SNFs and ICFs and found that administrative distinctions between the two do not in practice display clear differences in the residents they serve.<sup>8</sup> According to IOM, both kinds of facilities are nursing homes that admit and care for residents with a wide range of disabilities and service needs. For these various reasons, IOM recommended that the distinction between the two types of facilities be eliminated and that participating facilities be subject to the same quality assurance criteria and procedures, with SNF minimum staffing standards applied to all nursing homes.

Largely as a result of these recommendations, OBRA 87 includes in its Medicaid amendments provisions that eliminate the distinction between SNFs and ICFs. In their place, OBRA creates, effective October 1, 1990, a new category of nursing home provider referred to as a nursing facility (NF). At that time, nursing facilities will have to meet a single set of requirements in order to participate in Medicaid. In general, these are almost identical to Medicare's requirements for facilities participating in that program.

For licensed nursing staff, OBRA requires that NFs meet Medicare's requirements; that is, 24-hour licensed nursing care, with a registered professional nurse at least 8 consecutive hours a day, 7 days a week. However, OBRA provides a broader waiver authority for NFs than it does for Medicare SNFs. OBRA permits waivers for both the registered nurse and the licensed nurse requirements. In addition, States will provide the waivers, and

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<sup>7</sup>Ibid., p. 101.

<sup>8</sup>Ibid., p. 72 and 73.

not HCFA. Specifically, OBRA authorizes States to waive registered nurse and licensed nurse requirements if (1) the facility demonstrates that it has been unable to recruit appropriate personnel; (2) the State determines that a waiver will not endanger the health or safety of individuals staying in the facility, and; (3) the State finds that, for periods when licensed services are not available, a registered nurse or physician is obligated to respond immediately to telephone calls from the facility.

How frequently States will provide waivers to NFs to allow them to provide less licensed nursing care is, of course, not known at the present time. Regulations implementing these requirements can also affect States' willingness to provide waivers. These are currently being drafted by HCFA.

It should be noted that the Nation as a whole is experiencing shortages of registered nurses and that health care providers of all kinds are faced with the need to pay higher salaries to registered nurses in order to recruit and retain these personnel. These higher salary costs, as well as OBRA's requirements for increased licensed nurse staffing, will lead to increases in States' Medicaid budgets. States, therefore, will have an incentive to provide waivers to NFs. For this reason, OBRA contains a provision requiring the Secretary of HHS to review State waivers and to assume this waiver authority if he/she finds a clear pattern and practice by States of allowing waivers in the absence of diligent efforts by NFs to meet the staffing requirements.

The Senate Finance Committee included in its reported reconciliation bill provisions to require States to inform ombudsmen and other State and private agencies of waivers they grant for nurse staffing requirements under Medicaid. The bill also required nursing facilities to inform present and prospective residents of any waivers granted for these purposes. In addition, the bill required the Secretary to study and report on the appropriateness of establishing minimum caregiver to resident ratios and minimum supervisor to caregiver ratios for nursing facilities receiving Medicaid payments. These provisions, however, were not included in the Senate-passed bill, S. 1750. Nor were they included in the enacted OBRA 89, P.L. 101-239.

### **Surveying Nursing Homes' Compliance with OBRA 87s Requirements**

Prior to the consideration of nursing home reform legislation, the survey process for determining a nursing home's compliance with Medicare and Medicaid requirements for participation had been criticized on a number of grounds. IOM found the survey process to be too predictable; facilities could predict the timing of an annual survey visit within weeks of the actual visit, because certification lasts exactly 12 months and an annual survey is required by regulation at least 90 days before certification expires.<sup>9</sup> IOM also found the survey process to be inefficient, subjecting all nursing homes to the same

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<sup>9</sup>Ibid., p. 106-108.

survey intensity regardless of their past record of compliance. In addition, IOM and others had criticized the survey process for its focus on paper compliance and theoretical facility capability based on reviews of records and procedures, rather than actual performance based on direct observation and contact with residents.

To address these problems, IOM recommended a resident-centered, outcome-oriented survey process that would require surveyors to observe care being provided and its effect on residents.<sup>10</sup> It also recommended a two-stage process that would allow survey agencies to concentrate their efforts on facilities providing poor or marginal care. OBRA 87 included many of IOM's specific recommendations: unannounced standard surveys that include a review of the quality of care furnished to a sample of residents with varying care needs; an audit of the facility's resident assessment reports; and an extended survey for facilities that provide substandard care.

These requirements reinforce changes in the survey process that HCFA has been implementing as the result of a court orders in 1985 and 1987. Final regulations on a resident-centered survey process were published by HCFA June 17, 1988, with an effective date of July 18, 1988. OBRA's new survey process, to become effective October 1, 1990, will require new regulations that are scheduled to be published as a proposed regulation later in 1989. At the current time, nursing home groups are concerned with the impact the February 1989 regulations on nursing home requirements will have on the survey process and the ability of nursing homes to be found in compliance. From the point of view of these groups, the new requirements and their interpretative guidelines that HCFA has prepared for surveyors to use in their inspections of nursing homes provide, in certain cases, insufficient detail to determine compliance, and, in others, content that should have been subject to public comment.

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<sup>10</sup>Tbid., p. 109-111.

**APPENDIX: DETAILED SUMMARY OF NURSING HOME REFORM PROVISIONS CONTAINED IN MEDICARE AND MEDICAID LAWS****Medicare Nursing Home Reform Provisions, As Amended*****Requirements for Skilled Nursing Facilities (unless otherwise specified, effective October 1, 1990)***

The revised law, in a new section 1819 of Medicare, defines a skilled nursing facility (SNF) as an institution (or a distinct part of an institution) which (1) is primarily engaged in providing to residents skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases; (2) has in effect a transfer agreement (meeting requirements of Medicare law) with one or more hospitals having Medicare provider agreements with the Secretary; and (3) meets the various requirements described below.

***Provision of Services.*** SNFs must (1) care for residents in a manner and in an environment that promotes the quality of life of each resident and operate a quality assessment and assurance committee; (2) provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care; (3) conduct a comprehensive assessment of each resident's functional capacity, no later than 4 days after the date of admission, or after a significant change in a resident's physical or mental condition, and, in no case less often than once every 12 months; (4) provide directly, or under arrangements with others, nursing services and specialized rehabilitative services; medically-related social services; pharmaceutical services; dietary services; an on-going activities program, directed by a qualified professional; and routine and emergency dental services (for which the facility is not prohibited from making an additional charge).

***Required Nursing Services.*** SNFs must provide 24-hour licensed nursing care sufficient to meet the nursing needs of residents and must use a registered professional nurse at least 8 consecutive hours a day 7 days a week. The Secretary of HHS may waive the requirement for a SNF to have on duty a registered nurse for more than 40 hours a week if:

- the facility is located in a rural area and the supply of SNF services in the area is not sufficient to meet the needs of the area;
- the facility has one full-time registered professional nurse who is regularly on duty 40 hours a week; and
- the facility either has only residents whose physicians have indicated that they do not require a registered nurse or a physician for a 48-hour period, or has made arrangements for a registered nurse or physician to spend the time necessary to provide skilled nursing

services on days when the regular full-time registered nurse is not on duty.

These waivers are subject to annual renewal.

***Nurse Aide Training.*** SNFs must not use (on a full-time, temporary, per diem, or other basis) any individual as a nurse aide for more than 4 months, on or after October 1, 1990, unless the individual has completed a training and competency evaluation program, or a competency evaluation program, approved by the State, and is competent to provide nursing or nursing-related services. For individuals used as nurse aides as of January 1, 1990, SNFs must provide for an approved competency evaluation program and the preparation necessary for the aide to complete this program by October 1, 1990. Certain nurse aides are exempted from training and competency evaluation requirements if they have had other specified training or work experience.

***Physician Supervision.*** SNFs must require that the medical care of every resident be provided under the supervision of a physician and must have a physician available to furnish necessary medical care in case of emergency.

***Social Workers.*** SNFs with more than 120 beds must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

***Residents' Rights.*** SNFs must protect and promote a resident's rights, including the following: (1) the right to choose a personal attending physician and to be fully informed about care and treatment and to participate in planning care and treatment; (2) the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms; (3) psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan designed to eliminate or modify symptoms for which the drugs are prescribed; (4) the right to privacy; (5) the right to confidentiality of personal and clinical records; (6) the right to reside and receive services with reasonable accommodation of individual needs and preferences and to receive notice before the room or room-mate of the resident is changed; (7) the right to voice grievances about treatment or care and the right to prompt effort by the facility to resolve grievances; (8) the right to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents; (9) the right to participate in social, religious, and community activities; (10) the right to examine, upon reasonable request, the results of the most recent survey of the facility and any plan in effect to correct deficiencies; and (11) any other right established by the Secretary.

Facilities must inform each resident, orally and in writing at the time of admission, of the resident's legal rights, and make available to each resident, upon reasonable request, a written statement of rights. SNFs must also inform each resident of services available and related charges for services, including any charges not covered under Medicare or by the facility's basic per diem charge.

***Transfer and Discharge Rights.*** SNFs must permit residents to remain in the facility and must not transfer or discharge residents unless: (1) the transfer or discharge is necessary to meet the resident's welfare which cannot be met in the facility; (2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility; (3) the safety of individuals in the facility is endangered; (4) the health of individuals in the facility would be endangered; (5) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under Medicare or Medicaid) for a stay at the facility; or (6) the facility ceases to operate. SNFs must notify the resident (and, if known, a family member of the resident or legal representative) of a transfer or discharge. This notice must include information about the resident's right of appeal, and the name, mailing address, and telephone number of the State long-term care ombudsman. In general, notice of a transfer or discharge must be made at least 30 days in advance, except under certain specified circumstances when notice must be given in advance as many days as is practicable.

***Access and Visitation Rights.*** SNFs must permit immediate access to any resident by Federal and State officials, by the State ombudsman, and by the resident's physician (effective July 1, 1988). SNFs must also permit immediate access for the immediate family or other relatives of the resident. Facilities must also allow representatives of the State ombudsman, with the permission of the resident or the legal representative of the resident, to examine a resident's clinical records.

***Equal Access to Quality Care.*** SNFs must establish and maintain identical policies and practices with regard to transfer, discharge, and Medicare covered services for all individuals regardless of source of payment.

***Admissions Policy.*** SNFs must not require individuals applying to reside or residing in the facility to waive their rights to benefits under Medicare or Medicaid. Nor can they require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility.

***Protection of Resident Funds.*** SNFs cannot require residents to deposit their personal funds with the facility. If the facility accepts the resident's written authorization to hold personal funds, it must manage and account for these funds by: (1) depositing any amount in excess of \$50 in an interest bearing account that is separate from any of the facility's operating accounts; (2) assuring a full and complete separate accounting of each

resident's personal funds; (3) conveying promptly personal funds to the resident's estate upon death of the resident; and (4) purchasing a surety bond, or providing other satisfactory assurance to the Secretary, that establishes the security of all personal funds of residents deposited with the facility. The facility cannot impose a charge against a resident's personal funds for items or services paid for by Medicare or Medicaid.

***Administration and Other Matters.*** SNFs must (1) be licensed under State and local law; (2) meet the nursing home requirements of the Life Safety Code of the National Fire Protection Association; (3) operate and provide services in compliance with all applicable Federal, State, and local laws and regulations and with accepted professional standards and principles; (4) employ as administrator of the facility an individual who has met standards established by the Secretary of HHS; (5) meet other requirements pertaining to the health, safety, and well-being of residents or to the physical plant as the Secretary of HHS may find necessary. SNFs must also notify the State licensing agency of any change in (1) the ownership or controlling interest of the facility, (2) officers, directors, agents, or managing employees, (3) the corporation, association, or other company responsible for the management of the facility, or (4) the administrator or director of nursing.

***State Responsibilities Relating to SNF Requirements.*** States must take a number of actions in connection with the new statutory requirements for SNFs:

- specify approved nurse aide training and competency evaluation programs (January 1, 1989);
- begin review and reapproval of these programs (January 1, 1990);
- establish and maintain nurse aide registries of all persons who have satisfactorily completed training and evaluation programs and those who have been involved in resident neglect or abuse (January 1, 1989);
- provide for an appeals process for transfers and discharges (October 1, 1989);
- implement and enforce standards for administrators of SNFs (January 1, 1990); and
- specify an instrument to be used by facilities for resident assessments (July 1, 1990).

***Responsibilities of the Secretary of HHS Relating to SNF Requirements.*** The Secretary must take a number of actions in connection with the new statutory requirements for SNFs:

- establish requirements for the approval of nurse aide training and competency evaluation programs, including areas to be covered in programs, content of curriculum, minimum hours of initial (75 hours) and ongoing training and retraining, qualifications of instructors, and procedures for determining competency (September 1, 1988); OBRA 89 requires the Secretary to issue proposed regulations on these requirements by March 19, 1990;
- establish guidelines for States' appeals processes for transfers and discharges of residents from SNFs (October 1, 1988);
- develop standards for assuring the qualifications of SNF administrators (March 1, 1989);
- specify a minimum data set of core elements and common definitions for use by facilities in conducting resident assessments (January 1, 1989);
- designate one or more resident assessment instruments (April 1, 1990);
- specify nursing home costs which may be charged to residents' personal funds and those which are covered by Medicare (July 1, 1988);
- provide in regulations that reimbursement to SNFs take into account the costs of complying with the new requirements that facilities must meet as the result of the nursing home reform legislation (including the costs of conducting nurse aide training and competency evaluation programs); and
- evaluate and report to Congress on the implementation of the resident assessment process for residents of SNFs (January 1, 1992).

***Survey and Certification Process (unless otherwise specified, effective October 1, 1990)***

OBRA 87 establishes a new process for surveying SNFs to determine their compliance with the requirements described above. Under the new law, the Secretary of HHS will be responsible for surveying and certifying the compliance of State-owned SNFs with these requirements, and States will be responsible for surveying and certifying the compliance of all other facilities. The new law provides for two different surveys for certification: a standard survey and an extended survey.

***Standard Survey.*** Every SNF will be subject to an unannounced standard survey, conducted by a multidisciplinary team. This standard survey must be conducted not later than 15 months after the date of the previous standard survey. The average interval between standard surveys in a State

must not exceed 12 months. Standard surveys must include, for a case-mix stratified sample of residents, a review of the quality of care furnished by the facility (as measured by certain indicators), residents' written plans of care and assessments, and the facility's compliance with residents' rights requirements. A standard survey (or an abbreviated standard survey) may also be conducted within 2 months of any change of ownership, administration, management, or director of nursing, in order to determine whether the change has resulted in any decline in the quality of care provided by the facility.

***Extended Survey.*** Each SNF found under a standard survey to have provided substandard care will be subject to an extended survey. This survey must be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the standard survey) and must identify the policies and procedures that resulted in substandard care. The extended survey must also determine compliance with every requirement for participation in Medicare, and must include an expanded sample of residents' assessments, a review of staffing, in-service training, and, if appropriate, contracts with consultants. At the discretion of the Secretary or the State, any other facility, besides those found to be providing substandard care, can be subject to an extended survey (or a partial extended survey).

***Survey Protocol.*** Standard and extended surveys must be based on a protocol developed, tested, and validated by the Secretary not later than January 1, 1990. They must be conducted by individuals who meet minimum qualifications specified by the Secretary. The Secretary and the States must implement programs to measure and reduce inconsistency of survey results among surveyors.

***Validation Surveys.*** The Secretary must conduct onsite validation surveys of a representative sample of each State's SNFs, to determine the adequacy of State survey activities. Validation surveys must amount to at least 5 percent of the number of SNFs surveyed by the State in a year, but in no case less than 5 facilities. The Secretary's finding of a facility's noncompliance with the requirements for participation is binding and supersedes a State's finding of compliance. If the Secretary finds, on the basis of validation surveys, that a State has failed to perform surveys as required or that its performance is inadequate, the Secretary must provide for an appropriate remedy, which may include training of survey teams in the State.

***Investigation of Complaints and Monitoring Compliance.*** Every State must maintain procedures and adequate staff to investigate complaints of violations of requirements for SNFs. States must review and investigate, through the State agency responsible for surveys and certification, allegations of resident neglect and abuse and misappropriation of resident property by nurse aides. States must also monitor onsite, on a regular, as needed basis, noncompliant SNFs.

***Disclosure of Results of Inspections and Activities.*** SNFs must post survey results in a place readily accessible to residents and residents' representatives. The Secretary and the States must make available to the public (1) information about all surveys and certifications, including deficiencies and plans of correction, (2) copies of cost reports filed by facilities under Medicare or Medicaid, (3) copies of statements of ownership, and (4) information that must be reported to the Secretary about facilities' owners and certain other individuals who have been convicted of certain offenses. States must also notify the State long-term care ombudsman of the State's findings of a SNF's noncompliance with requirements, and must also provide to its State Medicaid fraud and abuse control unit all survey and certification information. If a State finds that a SNF has provided substandard quality of care, it must notify the attending physician of each resident and the State board responsible for the licensing of the SNF's administrator.

***Enforcement Process (effective January 1, 1988)***

OBRA 87 revises and expands the sanctions that States and the Secretary may impose against noncompliant SNFs. The sanctioning process of the new law distinguishes between nursing homes with deficiencies which do and do not immediately jeopardize the health or safety of residents.

If a State finds after a survey that a facility is not in compliance with the requirements for participation, and that its deficiencies immediately jeopardize the health or safety of its residents, the State must recommend to the Secretary that the Secretary either (1) take immediate action to remove the jeopardy and correct the deficiencies through the appointment of temporary management, or (2) terminate the facility's participation in Medicare. In addition, the Secretary may impose other sanctions, including civil money penalties for each day of noncompliance, and denial of payment for Medicare beneficiaries already in the facility or for new admissions to the facility. Similar authority is provided to the Secretary if comparable deficiencies are found in a survey made by the Secretary.

If a State finds that a facility is not in compliance and that its deficiencies do not immediately jeopardize the health or safety of its residents, then the State may recommend to the Secretary that the Secretary impose any of the following sanctions: denial of payment for current Medicare residents of the facility or for new admissions; civil money penalties for each day of noncompliance; and appointment of temporary management. Similar authority is provided the Secretary for a finding of comparable deficiencies.

If a facility has not complied with the law's requirements within 3 months after a finding of noncompliance, the Secretary must deny payments for new admissions. For facilities found on three consecutive standard surveys to have provided substandard care, the Secretary must deny payment for current Medicare residents and new admissions and monitor the facility until it has demonstrated that it is in compliance and will remain in compliance. For facilities that are taking steps to eliminate deficiencies

according to a plan of correction submitted by the State and approved by the Secretary, the Secretary may continue Federal Medicare payments to the facility for no longer than 6 months.

### **Medicaid Nursing Home Reform Provisions, As Amended**

#### ***Requirements for Nursing Facilities (unless otherwise specified, effective October 1, 1990)***

Effective October 1, 1990, OBRA 87 eliminates the Medicaid program's distinction between SNFs and ICFs and establishes a single category of nursing home provider and nursing home benefit, referred to as "nursing facility." (OBRA 87 did not amend Medicaid law pertaining to intermediate care facilities for the mentally retarded (ICFs/MR), or institutions for mental diseases.) The new law combines current law definitions of SNFs and ICFs into a definition for nursing facility (NF). A NF is defined in section 1919 of Medicaid law as an institution (or a distinct part of an institution) which is primarily engaged in providing to residents (1) skilled nursing care and related services for residents who require medical or nursing care, or (2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or (3) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities. NFs must meet a single set of requirements which are very similar to those described above for SNFs participating in Medicare.

***Provision of Services.*** NFs must (1) care for residents in a manner and in an environment that promotes the quality of life of each resident and operate a quality assessment and assurance committee; (2) provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care; (3) conduct a comprehensive assessment of each resident's functional capacity, no later than 4 days after the date of admission, after a significant change in a resident's physical or mental condition, and in no case less often than once every 12 months; (4) provide directly, or under arrangements with others, nursing services and specialized rehabilitative services; medically-related social services; pharmaceutical services; dietary services; an on-going activities program, directed by a qualified professional; and routine and emergency dental services.

***Required Nursing Services.*** NFs must provide 24-hour licensed nursing care sufficient to meet the nursing needs of residents and must use a registered professional nurse at least 8 consecutive hours a day 7 days a week. States may waive these requirements if:

- the facility demonstrates that it has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities) to recruit appropriate personnel;

- the State determines that a waiver will not endanger the health or safety of individuals staying in the facility; and
- the State finds that, for periods when licensed services are not available, a registered nurse or physician is obligated to respond immediately to telephone calls from the facility.

These waivers are subject to annual renewal and to review by the Secretary of HHS. If the Secretary finds a clear pattern and practice by States of allowing waivers in the absence of diligent efforts by facilities to meet the staffing requirements, the Secretary must assume and exercise the State's waiver authority.

***Nurse Aide Training.*** NFs must not use (on a full-time, temporary, per diem, or other basis) any individual as a nurse aide for more than 4 months, on or after October 1, 1990, unless the individual has completed a training and competency evaluation program, or a competency evaluation program, approved by the State, and is competent to provide nursing or nursing-related services. For individuals used as nurse aides as of January 1, 1990, NFs must provide for an approved competency evaluation program and the preparation necessary for the aide to complete this program by October 1, 1990. Certain nurse aides are exempted from training and competency evaluation requirements if they have had other specified training or work experience.

***Physician Supervision.*** NFs must require that the medical care of every resident be provided under the supervision of a physician and must have a physician available to furnish necessary medical care in case of emergency.

***Social Workers.*** NFs with more than 120 beds must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

***Residents' Rights.*** NFs must protect and promote a resident's rights, including the following: (1) the right to choose a personal attending physician and to be fully informed about care and treatment and to participate in planning care and treatment; (2) the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms; (3) psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan designed to eliminate or modify symptoms for which the drugs are prescribed; (4) the right to privacy; (5) the right to confidentiality of personal and clinical records; (6) the right to reside and receive services with reasonable accommodation of individual needs and preferences and to receive notice before the room or room-mate of the resident is changed; (7) the right to voice grievances about treatment or care and the

right to prompt effort by the facility to resolve grievances; (8) the right to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents; (9) the right to participate in social, religious, and community activities; (10) the right to examine, upon reasonable request, the results of the most recent survey of the facility and any plan in effect to correct deficiencies; and (11) any other right established by the Secretary.

Facilities must inform each resident, orally and in writing at the time of admission, of the resident's legal rights, and must make available to each resident, upon reasonable request, a written statement of rights. NFs must inform each resident of the requirements and procedures for establishing eligibility for Medicaid, including rules pertaining to the special treatment of income and resources of couples when one spouse is institutionalized and the other remains in the community. NFs must also inform each Medicaid beneficiary of items and services covered by Medicaid and other items and services offered for which the resident may be charged and the amount of these charges. NFs must inform each other resident of services available and related charges for services, including any charges not covered under Medicare or by the facility's basic per diem charge.

***Transfer and Discharge Rights.*** NFs must permit residents to remain in the facility and must not transfer or discharge residents unless: (1) the transfer or discharge is necessary to meet the resident's welfare which cannot be met in the facility; (2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility; (3) the safety of individuals in the facility is endangered; (4) the health of individuals in the facility would be endangered; (5) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under Medicaid or Medicare) for a stay at the facility; or (6) the facility ceases to operate. NFs must notify the resident (and, if known, a family member of the resident or legal representative) of a transfer or discharge. This notice must include information about the resident's right of appeal, and the name, mailing address, and telephone number of the State long-term care ombudsman. In general, notice of a transfer or discharge must be made at least 30 days in advance, except under certain specified circumstances when notice must be given in advance as many days as is practicable. Before a resident is transferred for hospitalization or therapeutic leave, NFs must provide written information about the State's and facility's policies on the period (if any) during which the resident will be permitted to return and resume residence in the facility (often referred to as bed-hold policy).

***Access and Visitation Rights.*** NFs must permit immediate access to any resident by Federal and State officials, by the State ombudsman, and by the resident's physician (effective July 1, 1988). NFs must also permit immediate access for the immediate family or other relatives of the resident. Facilities must also allow representatives of the State ombudsman, with the

permission of the resident or the legal representative of the resident, to examine a resident's clinical records.

***Equal Access to Quality Care.*** NFs must establish and maintain identical policies and practices with regard to transfer, discharge, and the provision of Medicaid covered services for all individuals regardless of source of payment.

***Admissions Policy.*** NFs must not require individuals applying to reside or residing in the facility to waive their rights to benefits under Medicaid or Medicare. Nor can they require a third party guarantee, or gift, money, donation, or other consideration, as a condition of admission (or expedited admission) to, or continued stay in, the facility.

***Protection of Resident Funds.*** NFs cannot require residents to deposit their personal funds with the facility. If the facility accepts the resident's written authorization to hold personal funds, it must manage and account for these funds by: (1) depositing any amount in excess of \$50 in an interest bearing account that is separate from any of the facility's operating accounts; (2) assuring a full and complete separate accounting of each resident's personal funds; (3) notifying the resident of balances that might affect the person's continued Medicaid eligibility; (4) conveying promptly personal funds to the resident's estate upon death of the resident; and (5) purchasing a surety bond, or providing other satisfactory assurance to the Secretary, that establishes the security of all personal funds of residents deposited with the facility. The facility cannot impose a charge against a resident's personal funds for items or services paid for by Medicaid or Medicare.

***Administration and Other Matters.*** NFs must (1) be licensed under State and local law; (2) meet the nursing home requirements of the Life Safety Code of the National Fire Protection Association; (3) operate and provide services in compliance with all applicable Federal, State, and local laws and regulations and with accepted professional standards and principles; (4) employ as administrator of the facility an individual who has met standards established by the Secretary of HHS; (5) meet other requirements pertaining to the health, safety, and well-being of residents or to the physical plant as the Secretary of HHS may find necessary. NFs must also notify the State licensing agency of any change in (1) the ownership or control interest of the facility, (2) officers, directors, agents, or managing employees, (3) the corporation, association, or other company responsible for the management of the facility, or (4) the administrator or director of nursing.

***State Responsibilities Relating to Nursing Facility Requirements.*** States must take a number of actions in connection with the new statutory requirements for NFs:

- specify approved nurse aide training and competency evaluation programs (January 1, 1989);

- begin review and reapproval of these programs (January 1, 1990);
- establish and maintain nurse aide registries of all persons who have satisfactorily completed training and evaluation programs and those who have been involved in resident neglect or abuse (January 1, 1989);
- provide for an appeals process for transfers and discharges (October 1, 1989);
- implement and enforce standards for administrators of NFs (January 1, 1990);
- specify an instrument to be used by facilities for resident assessments (July 1, 1990);
- take into account in their payments to NFs the costs of complying with the new requirements that facilities must meet as the result of the nursing home legislation;
- provide for a reduction in payment to NFs with waivers for licensed nurse staffing to take into account the lower costs (if any) of nursing care at the facility; and
- make available to the public the data and methodology used in establishing payment rates for NFs.

***Responsibilities of the Secretary of Health and Human Services Relating to Nursing Facility Requirements.*** The Secretary must take a number of actions in connection with the new statutory requirements for NFs:

- establish requirements for the approval of nurse aide training and competency evaluation programs, including areas to be covered in programs, content of curriculum, minimum hours of initial (75 hours) and ongoing training and retraining, qualifications of instructors, and procedures for determining competency (September 1, 1988); OBRA 89 requires the Secretary to issue proposed regulations on these requirements by March 19, 1990;
- provide enhanced Federal matching payments (the Federal Medical Assistance percentage for a State plus 25 percentage points, not to exceed 90 percent) for State activities required in connection with nurse aide training and competency evaluation programs for the 8 calendar quarters beginning July 1, 1988 (in subsequent years the rate becomes 50 percent for these activities);
- establish guidelines for States' appeals processes for transfers and discharges of residents from NFs (October 1, 1988);

- develop standards for assuring the qualifications of NF administrators (March 1, 1989);
- specify a minimum data set of core elements and common definitions for use by facilities in conducting resident assessments (January 1, 1989);
- designate one or more resident assessment instruments (April 1, 1990);
- specify nursing home costs which may be charged to residents' personal funds and those which are covered by Medicaid (July 1, 1988);
- develop criteria and procedures for monitoring waivers granted NFs by States for licensed nurse staffing requirements (October 1, 1988);
- review and approve or disapprove States' plans to provide for an appropriate adjustment in payment amounts for NF services;
- provide, upon request, technical assistance to the States for the development and implementation of case mix reimbursement systems; and
- evaluate and report to Congress on the implementation of the resident assessment process for residents of NFs (January 1, 1993).

***Survey and Certification Process (unless otherwise specified, effective October 1, 1990)***

OBRA 87 establishes a new process for surveying NFs to determine their compliance with the requirements described above. Under the new law, the Secretary of HHS will be responsible for surveying and certifying the compliance of State-owned NFs with these requirements, and States will be responsible for surveying and certifying the compliance of all other facilities. The new law provides for two different surveys for certification: a standard survey and an extended survey.

***Standard Survey.*** Every NF participating in Medicaid will be subject to an unannounced standard survey, conducted by a multidisciplinary team. This standard survey must be conducted not later than 15 months after the date of the previous standard survey. The average interval between standard surveys in a State must not exceed 12 months. Standard surveys must include, for a case-mix stratified sample of residents, a review of the quality of care furnished by the facility (as measured by certain indicators), residents' written plans of care and assessments, and the facility's compliance with residents' rights requirements. A standard survey (or an abbreviated standard survey) may also be conducted within 2 months of any change of ownership, administration, management, or director of nursing, in order to determine

whether the change has resulted in any decline in the quality of care provided by the facility.

**Extended Survey.** Each NF found under a standard survey to have provided substandard care will be subject to an extended survey. This survey must be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the standard survey) and must identify the policies and procedures that resulted in substandard care. The extended survey must also determine compliance with every requirement for participation in Medicaid, and must include an expanded sample of residents' assessments, a review of staffing, in-service training, and, if appropriate, contracts with consultants. At the discretion of the Secretary or the State, any other facility, besides those found to be providing substandard care, can be subject to an extended survey (or a partial extended survey).

**Survey Protocol.** Standard and extended surveys must be based on a protocol developed, tested, and validated by the Secretary not later than January 1, 1990. They must be conducted by individuals who meet minimum qualifications specified by the Secretary. The Secretary and the States must implement programs to measure and reduce inconsistency of survey results among surveyors.

**Validation Surveys.** The Secretary must conduct onsite validation surveys of a representative sample of each State's NFs, to determine the adequacy of State survey activities. Validation surveys must amount to at least 5 percent of the number of NFs surveyed by the State in a year, but in no case less than 5 facilities. The Secretary's finding of a facility's noncompliance with the requirements for participation is binding and supersedes a State's finding of compliance. If the Secretary finds, on the basis of validation surveys, that a State has failed to perform surveys as required or that its performance is inadequate, the Secretary must reduce matching payments to the State for survey and certification activities. This reduction must be equal to 33 percent of the ratio of the total number of residents in noncompliant facilities to the total number of residents in facilities surveyed by the Secretary. The Secretary may also provide for the training of survey teams in the State.

**Enhanced Federal Matching for Survey and Certification.** Federal matching payments for State survey and certification activities will be made at the rate of 90 percent in FY 1991, 85 percent in FY 1992, 80 percent in FY 1993, and 75 percent in FY 1994 and thereafter.

**Investigation of Complaints and Monitoring Compliance.** Every State must maintain procedures and adequate staff to investigate complaints of violations of requirements for NFs. States must review and investigate, through the State agency responsible for surveys and certification, allegations of resident neglect and abuse and misappropriation of resident property by nurse aides. States must also monitor onsite, on a regular, as needed basis, noncompliant NFs.

***Disclosure of Results of Inspections and Activities.*** NFs must post survey results in a place readily accessible to residents and residents' representatives. The Secretary and the States must make available to the public (1) information about all surveys and certifications, including deficiencies and plans of correction, (2) copies of cost reports filed by facilities under Medicaid or Medicare, (3) copies of statements of ownership, and (4) information that must be reported to the Secretary about facilities' owners and certain other individuals who have been convicted of certain offenses. States must also notify the State long-term care ombudsman of the State's findings of a NF's noncompliance with requirements, and must also provide to its State Medicaid fraud and abuse control unit all survey and certification information. If a State finds that a NF has provided substandard quality of care, it must notify the attending physician of each resident and the State board responsible for the licensing of the NF's administrator.

***Enforcement Process (effective January 1, 1988)***

OBRA 87 revises and expands the sanctions that States and the Secretary may impose against noncompliant nursing homes. The Secretary's new sanction authority is effective January 1, 1988, with regard to noncompliant SNFs and ICFs. States must amend their Medicaid plans to include the law's new sanctions by October 1, 1989. The Secretary must provide through regulations guidance to the States on these new sanctions by October 1, 1988. This same expanded authority will also apply to NFs beginning October 1, 1990. The sanctioning process of the new law distinguishes between nursing homes with deficiencies which do and do not immediately jeopardize the health or safety of residents.

If a State finds after a survey that a facility is not in compliance with the requirements for participation, and that its deficiencies immediately jeopardize the health or safety of its residents, the State must either (1) take immediate action to remove the jeopardy and correct the deficiencies through the appointment of temporary management, or (2) terminate the facility's participation in Medicaid. In addition, the State may impose other sanctions, including civil money penalties for each day of noncompliance, denial of payment for new Medicaid admissions to the facility, and, in the case of emergency, closing the facility or transferring residents to other facilities. Similar authority is provided to the Secretary if comparable deficiencies are found in a survey made by the Secretary.

If a State finds that a facility is not in compliance and that its deficiencies do not immediately jeopardize the health or safety of its residents, then the State may terminate the facility's participation in Medicaid and/or impose one or more sanctions. These include denial of payment for new Medicaid admissions; civil money penalties for each day of noncompliance; appointment of temporary management; and, in the case of an emergency, authority to close the facility or transfer residents, or both. Similar authority is provided the Secretary for a finding of comparable deficiencies. The new

law also specifies procedures to be followed where the State and Secretary do not agree on findings of noncompliance.

If a facility has not complied with the law's requirements within 3 months after a finding of noncompliance, the State must deny payments for new admissions. For facilities found on three consecutive standard surveys to have provided substandard care, the State must deny payment for new Medicaid admissions and monitor the facility until it has demonstrated that it is in compliance and will remain in compliance. For facilities that are taking steps to eliminate deficiencies according to a plan of correction submitted by the State and approved by the Secretary, the Secretary may continue Federal Medicaid matching payments to the State for no longer than 6 months.

In addition to establishing new sanction authority for noncompliance, OBRA 87 also authorizes States to establish a program to reward, through public recognition or incentive payments, or both, NFs that provide the highest quality care to residents who are Medicaid beneficiaries. These programs would be eligible for Federal matching payments at the rate of 50 percent.

***Preadmission Screening and Annual Resident Review for the Mentally Ill and Mentally Retarded (PASARR)***

OBRA 87 establishes requirements for the preadmission screening and annual resident review for the mentally ill and mentally retarded who are either seeking nursing home admission or already residing in a nursing home. These requirements, often referred to as PASARR requirements, apply to nursing facilities (including current law SNFs and ICFs and future NFs), the States, and the Secretary of HHS.

***Nursing Facility Requirements for Preadmission Screening for the Mentally Ill and Mentally Retarded.*** For new admissions occurring on or after January 1, 1989, nursing facilities must not admit any new resident who is mentally ill or mentally retarded, unless the State mental health or State mental retardation authority has determined, prior to admission, that the prospective resident requires the level of services provided by a nursing facility. In addition, if the individual requires nursing facility services, a determination must be made as to whether the resident requires active treatment for mental illness or mental retardation. The State's determination must be based on an independent physical and mental evaluation performed by a person or entity other than the State mental health or mental retardation authority.

***State Requirements for Preadmission Screening and Annual Resident Review for the Mentally Ill and Mentally Retarded.*** Effective January 1, 1989, each State must have in effect a preadmission screening program for the mentally ill and mentally retarded seeking admission to a nursing facility.

For current residents who are mentally ill or mentally retarded (and who were admitted prior to January 1, 1989), each State must have reviewed and determined, as of April 1, 1990:

- whether or not the resident requires the level of services provided by the nursing facility, or the level of services provided by an inpatient psychiatric hospital for individuals under age 21 or an institution for mental diseases for persons 65 years of age or older; and
- whether or not the resident requires active treatment for mental illness or mental retardation.

These reviews and determinations must be made on an annual basis for nursing facility residents who are mentally ill or mentally retarded. They must be based on an independent physical and mental evaluation performed by a person or entity other than the State mental health or mental retardation authority.

For persons who have resided in the nursing home for at least 30 months and who are found not to require the level of services provided by a nursing facility, but who require active treatment for mental illness or mental retardation, the State must, in consultation with the resident's family or legal representative and care-givers:

- inform the resident of the institutional and noninstitutional alternatives covered under the State plan for the resident;
- offer the resident the choice of remaining in the facility or of receiving covered services in an alternative appropriate institutional or noninstitutional setting;
- clarify the effect on eligibility for services under the State plan if the resident chooses to leave the facility (including its effect on readmission to the facility); and
- regardless of the resident's choice, provide or arrange for needed active treatment.

If these persons choose to remain in the nursing facility, States will receive Federal matching payments for the costs of their nursing facility services.

For persons who have not resided continuously in the nursing home for at least 30 months and who do not require the level of services provided by a nursing facility and who require active treatment, the State must:

- arrange for the safe and orderly discharge of the resident from the facility;

- prepare and orient the resident for discharge, and
- provide or arrange for needed active treatment.

For persons, regardless of their length of stay, who do not require the level of services provided by a nursing facility and who do not require active treatment, the State must:

- arrange for the safe and orderly discharge of the resident, and
- prepare and orient the resident for discharge.

States must have in place by January 1, 1989, an appeals process for individuals adversely affected by screening determinations.

***Federal Matching Payments for Screening Activities.*** Federal matching payments will be made for State screening activities at the rate of 75 percent. No Federal matching payments will be available for persons who are determined not to need nursing facility care.

***Alternative Disposition Plans.*** States will be considered to be in compliance with the requirements for persons who do not require nursing home care but do require active treatment, if the States have entered into an agreement with the Secretary for the disposition of these residents and the State is in compliance with the agreement. These agreements may provide for additional time for the States to discharge and/or provide active treatment.

***Definitions.*** OBRA 87 defines the terms "mentally ill," "mentally retarded," and "active treatment."

An individual is considered "mentally ill" if the individual has a primary or secondary diagnosis of mental disorder (*as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition*) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

An individual is considered to be "mentally retarded" if the individual is mentally retarded or a person with a related condition (such as cerebral palsy or epilepsy, as described in Medicaid regulations pertaining to intermediate care facilities for the mentally retarded).

"Active treatment" has the meaning given the term by the Secretary in regulations, but does not include, in the case of a resident of a nursing facility, services that must be provided under the new law.

***Federal Requirements for Preadmission Screening for the Mentally Ill and the Mentally Retarded.*** The Secretary must develop by October 1, 1988, minimum criteria for States to use in making determinations as to whether a mentally ill or mentally retarded individual requires the level

of services provided by a nursing facility. The failure of the Secretary to develop these criteria does not relieve the States of their responsibility to conduct the screening activities described above. (OBRA 89 requires the Secretary to issue proposed regulations on these minimum criteria by March 19, 1990.) By October 1, 1988, the Secretary must also develop minimum criteria for States' appeals processes for persons adversely affected by screening decisions. The Secretary must also review a sufficient number of cases to determine a State's compliance with the requirements to provide active treatment to those residents of nursing facilities who must be discharged.

# Maturing America looks to quality long-term care for elderly



PETER MAIN - STAFF

Mr. and Mrs. Herb Edmonds: she's a volunteer worker at center for elderly

By Robert P. Hey

Staff writer of The Christian Science Monitor

St. Petersburg, Fla.

SEVERAL elderly couples stroll the banks of Mirror Lake here, enjoying the warmth of a welcome spring sun. Across the street, the shuffleboard courts are packed. And a bowling-ball game is in progress at the nearby lawn bowling club.

Everywhere, it seems, the elderly are in motion.

But while these active oldsters don't seem to have a care in the world, appearances can be deceptive. Many have at least one major concern — that someday they might need long-term care.

"Everybody I know is thinking about it," insists a retired Pinellas County, Fla., employee who prefers not to give her name.

Every day an average of 1.5 million Americans, nearly 90 percent of them elderly, are being

cared for in nursing homes. Many are receiving long-term assistance. Perhaps three times that number get similar aid at home.

Quality and cost vary widely, but nursing-home care is expensive. Experts project that by the year 2000 several times the current number of elderly will need financial assistance, and that Americans will be paying \$129 billion a year to nursing homes by then.

Yet long-term care is a subject that many older Americans seem to want to discuss only in the abstract. When asked about their own concerns, they quickly change the subject. But they are more willing to talk about what they are doing to help others — which is, in fact, how many of the needs of the elderly are being met.

Here in St. Petersburg's cheery yellow-brick Sunshine Center for the elderly, Mrs. Herb Edmonds,

Please see CARE back page



## CARE from front page

a 76-year-old long-time volunteer, says, "What I like to do is take care of the old people. I think they need a friend."

For years America turned an unseeing eye to the problem of long-term care. Every year as many as a million people were spending themselves into poverty trying to pay nursing-home costs.

Untold hundreds of thousands of relatives and friends have been laboring, often without relief, to care for people in their homes.

The elderly and their families are no longer the only ones concerned about long-term care. Government officials recognize the problem. So do national political candidates and a growing number of "sandwich" generation Americans - middle-age people with children in college and with parents who require or may need expensive or time-consuming care.

"I believe that long-term care is going to be one of the major national issues in the next few years," says Alice Rivlin, an economist with the Brookings Institution. She recently completed a study and a book on the subject.

### Promising developments

Developments are under way that should ultimately lead to better care, financial aid to those who need it, and help for those who labor unrecognized outside their immediate families.

For one thing, Americans of all ages now realize that neither Uncle Sam's medicare program nor most general-purpose health-insurance plans cover long-term care. That knowledge is a necessary first step to improvement.

Most experts say a combination of private insurance and government programs should provide most of the funding, but they disagree widely on the blend.

Virtually every expert says long-term care is a problem that can be insured against by spreading the risk - by encouraging many people to purchase insurance that only a small percentage will ever need.

Small but quickly growing numbers are buying specific insurance to cover long-term care. About 70 insurance companies now offer improved, though far from perfect, plans.

"Over half a million people are covered at this time," says Bruce Boyd, chairman of the long-term-care task force of the Health Insurance Association of America. That's 2½ times more than just three years ago.

Congress has begun looking at the is-

sue. Most experts say 1988 will be a year of exploration, with actual changes in federal law likely in the next administration.

In a few weeks the US House of Representatives is scheduled to vote on a proposal by Reps. Claude Pepper (D) of Florida and Edward Roybal (D) of California that would provide financial help to people being cared for at home.

A number of very different proposals are being introduced into Congress that would craft government's response to helping Americans with the cost. Several hearings will explore the issue this year.

Meanwhile, two Florida metropolitan areas, Orlando and Fort Myers, are slowly expanding a telephone hot line that links a broad array of previously unconnected services, from health care to housework, which can help senior citizens stay at home.

The American Association of Retired Persons is working on plans for a nationwide hot line that will offer people information and referrals on health services available in their communities. For the past year the 28 million-member AARP has made long-term care one of its main focuses. Its campaign was instrumental in bringing the issue into the national spotlight this year.

### More need for long-term care

Relatively few people in their 60s require nursing-home care. But 3 in 10 Americans over 85 - the fastest-growing age group - now spend at least part of every year in nursing homes.

Demographers say the number of Americans over 65, now nearly 30 million, will double in the next 40 years. More important, the number of Americans over 85 will keep growing at the fastest rate: 1 percent is now over 85; by 2030 nearly 3 percent (8.6 million people) are expected to be.

"We will have more people needing long-term care" than America can now aid, says Dr. William Roper, administrator of the Health Care Finance Administration of the United States Department of Health and Human Services. His agency handles medicare and medicaid.

Nationally, individual Americans pay nearly half the cost of nursing-home care from their own pockets. Medicaid, the program that is supposed to help the poor with medical expenses, pays a little more than 40 percent. Private health insurance and medicare - the federal program supposed to provide dollars for the elderly's health care - together pay less than 3 percent. At-home care costs vary from case to case but are usually less.

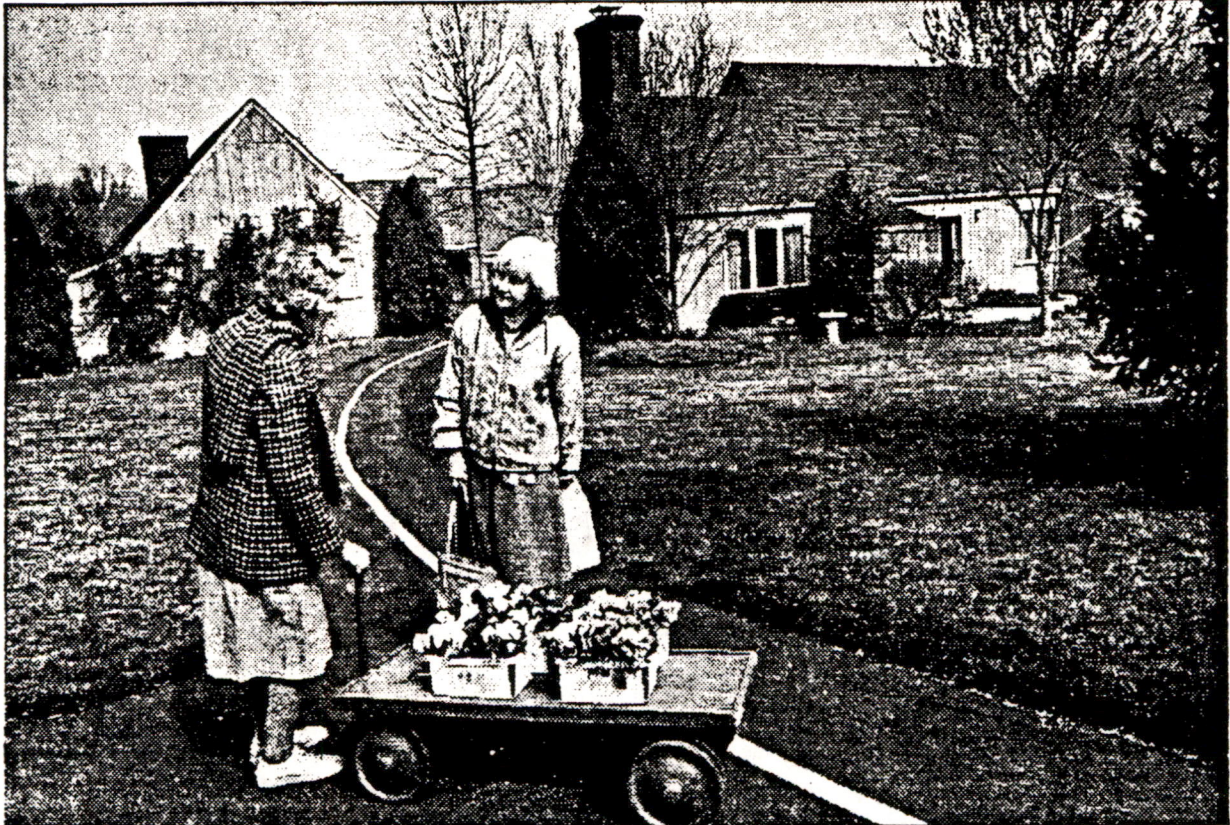
In recent years US health-care costs have been rising faster than the inflation rate: Now at 12 percent of the gross national product, they are expected to reach 15 percent by the turn of the century. Given today's massive federal deficit problems, can Uncle Sam afford to pay any additional health-care costs, even for a purpose as worthy as this? Experts disagree.

### Many spouses left destitute

At present, couples must virtually spend themselves into poverty before medicaid will help pay for long-term care. No one wants to leave a spouse destitute. But this happens every year to hundreds of thousands of Americans in nursing homes, where the average annual cost is \$22,000. Congressman Pepper says that "a million Americans become pauperized" this way annually. Even middle-class America, he adds, is "not able to meet the [financial] demand" of long-term nursing-home care.

And nursing homes are not even half the story. "Seventy-five percent" of all long-term care takes place in the home, says Thomas Burke, chief of staff of the Department of Health and Human Services.

Nearly all of that is provided by family members or friends. Dr. Rivlin says the evidence shows "that the family system in the United States has responded" to the long-term care needs of relatives "quite remarkably." She says the overall "burden on the family has increased enormously" in recent years, as middle-age couples have to raise children, work outside the home, scrape up college-tuition payments, and care for older relatives, often all at the same time.



Mrs. Sidney Forstall and Mrs. Loraine Cook chat outside a typical housing wing at Kendal at Longwood

## New 'barons' emerge in the House

By Robert P. Hey  
Staff writer of The Christian Science Monitor

Kennett Square, Pa.

Kendal at Longwood is a splendid site for a retirement community. The hills around it have inspired three generations of painting Wyeths and a whole school of American landscapists.

History flows through the area. A stone's throw away is the Revolutionary War battlefield of Brandywine, where Washington vainly sought to block the British advance on Philadelphia, now less than an hour's drive away.

Kendal is home to about 360 retirement-age Americans. Called a continuing-care retirement community, it is gaining favor across the United States.

Typical residents are vigorous and healthy, and they are past retirement age. As in other retirement facilities they eat most meals together, and take part in activities, retiring to the privacy of their rooms when they choose.

Entrance and monthly fees entitle the few requiring long-term care to receive it in the medical wing, at no added cost. It's a classic example of insurance: All residents pay for care that only a few will use.

A facility "is definitely in the long-term care insurance business," says Lloyd Lewis, Kendal's executive director. He says the medical wing of facilities that are similar to Kendal provide "one of the most viable, cost-effective" kinds of long-term care available.

Residents have "a lifetime contractual guarantee" of accommodations, meals, and medical aid, says Anne Somers, a geriatrician and professor at the Robert Wood Johnson Medical School in Princeton, N.J.

A decade ago there were few such facilities across America. But the number is "growing by leaps and bounds," says Alice Biache, vice-president of Goodwin House, a continuing-care retirement facility in Alexandria, Va. "Everyone is jumping on the bandwagon," she says. Yet fewer than 5 percent of America's elderly live

in retirement homes, and only a modest percentage of them are in continuing-care facilities.

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Professor Somers says there is vast potential for growth. "My own guess is that at least 25 percent of the elderly" are willing and able to pay the money required to live in such facilities. "Provided," she adds, "they have confidence in the [financial] integrity of the institution."

It's not cheap. Somers says an applicant must pay a \$35,000-to-\$90,000 entrance fee. Additional monthly payments run from about \$1,000 to \$1,600.

Skeptics say high fees automatically limit growth. They note that 1 of every 8 older Americans lives in poverty, despite improvements in care for the elderly made in the past two decades. At least an equal number live just above poverty's edge.

Advocates note that most Americans over 65 own homes. Thus, Somers says, by selling their houses most could come up with the entrance fees. But, she concedes, it is "more speculative" as to how many could afford the monthly fee.

Some of these facilities, like Kendal, are spread out like campuses. Others, in urban settings like Goodwin House, are high-rises that look like apartment buildings.

Many residents find a sense of home and extended family in their continuing-care communities. Says Marjorie Trent, a former teacher and school administrator who has lived for 14 years at Kendal: "I think it's the ability to be independent and yet to have backing, as if you had a family. To have somebody to fall back on, that makes this place so attractive. You feel secure."

Yet Ms. Biache warns such a facility "isn't for everyone. Not everyone could adjust to congregate living." Then there's the matter of location - "a big factor," she says. It's something anyone planning retirement ought to consider. "Nearness to family," for one thing. And does a person prefer the city or the country?

The vast majority of continuing-care retirement communities are nonprofit. But profitmaking corporations, eyeing the prospects for a greatly expanded market, are beginning to enter the field.

Experts warn that the elderly check: (1) the commitment of the sponsoring organization to the needs of the elderly and not merely to the financial bottom line; (2) the financial stability of the sponsoring organization.

And when these facilities are built for those with no expertise, Alan Hunt warns, "in most cases, those have been just trouble." The costs have been too high; some have gone bankrupt. Mr. Hunt chairs the legal committee of the American Association of Homes for the Aging.

But well-run facilities can provide residents with protection from a deep concern of many elderly: how to pay for long-term care, should they need it.

The very affluent have sufficient financial resources; the very poor have Medicaid. But the majority of middle-class Americans are still looking for a way to protect the bulk of their estate, however modest, so they can give it to family or friends.

Fortunately the stirrings of progress are now present. Organizations that speak for the elderly are insisting on progress, as are the elderly and their children.

The insurance industry is offering a host of new programs. Government is moving toward decisions on care.

How the situation will be resolved is not yet clear. What is apparent is that the old answer - that nothing can be done - no longer suffices.

R. NORMAN MATHENY - STAFF



Mary Bowden (right) chats with nurse and friend Carolyn Anthony

# The challenges of caring for a relative at home

By Robert P. Hey  
Staff writer of The Christian Science Monitor

Washington

Earl Smith and Mary Bowden and her mother are three in 6 million.

That's how many Americans have received care at home this year, rather than in nursing institutions. Some, like Mr. Smith and Ms. Bowden, are physically ailing; others, like Ms. Bowden's mother, have mental problems.

Contrary to popular belief, four times as many elderly Americans are cared for at home or in someone else's as are in nursing homes - 6 million vs. fewer than 1½ million. Like Mr. Smith, more than half are being helped by wives or daughters. He was assisted by both.

"People would rather stay in their own homes than go to a nursing home," says Eric Shulman, legislative director of the National Council of Senior Citizens.

The annual cost of home health care in America has risen an estimated 20 to 25 percent in recent years. Three years ago individual Americans and medicaid together paid about \$9 billion. By 1990 the annual cost of home care is expected to reach \$16 billion, with no end in

sight as America's population continues to grow older.

In every corner of the United States, people, like the Smiths and the Bowdens, are dealing with long-term care. (Caring for your parents, Page 24.) In a poll taken last year, 47 percent of the respondents said they had had some experience with long-term care. They were answering a poll taken for Long Term Care '88, a joint effort by the American Association of Retired Persons and the Villers Foundation to put long-term care on the national agenda.

Until recently Smith spent his days in a recliner watching through the sliding glass door as Washington's seasons marched past. "For the last six years, really, I've been caring" for him, his wife said a few weeks before he died earlier this month.

The emotional, physical, and financial challenges the Smiths faced are typical for those caring for relatives at home.

The federal medicare program is supposed to help the elderly with medical costs. But it does not pay for most long-term home care or nursing-home care - only for skilled assistance, as from a physician or



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nurse. In cases like Smith's, the bulk of the help required is in ordinary activities like walking, dressing, and feeding.

That's why women like Mrs. Smith devote years, with little or no help, to caring for their husbands. They cannot afford any aid. And the government and most insurance companies have been unwilling to provide money unless these people spend so much of their own funds first that they become impoverished.

Mary Bowden and her mother are a case in point. They live in a modest public-housing apartment almost within sight of the gleaming buildings that house Congress and the Supreme Court.

Weekdays, a publicly provided aide cares for them, which isn't easy because Ms. Bowden's mother, who is in her 90s, is blind, incontinent, very confused, and has great difficulty walking.

At night and on weekends, Ms. Bowden provides the care, which is even more difficult: She is in her late 70s, has various health problems, and is also sightless. But she doesn't complain.

Many families cannot afford anything beyond what public funds can pay. Those families who can pay for home assistance, usually wind up with a blend of paid help and volunteer aid by relatives. One is the family of Alice L. of suburban New York. She can get around her apartment but needs a constant companion. From breakfast to supper during the week, a nurse aids her, paid for by the family. To keep the budget from breaking, her two daughters alternate caring for her, at night and on weekends. No one complains, but it's not easy: Both are married, have teen-age children, and work full time.

And that's part of the problem with trying to care for relatives at home. In many families, both husband and wife now have full-time jobs. When the need arises for someone to care for a relative at home, often the care-giver often has to quit working.

That's why one of the fastest-growing areas in health care is in organizations that, for a price, provide home care. Until recently, only a few of them existed; most were nonprofit like the Visiting Nurse Association of Washington, D.C. For instance, Judy Hyatt, a registered nurse with the association, regularly checked on Smith.

Today nearly 11,000 US organizations provide home care, says Val Halamandaris, president of the National Association of Home Care. "We've known for years what to do" to help people at home, he says. "It's just a question of having the will to do it, and finding some method of financing it."

The US House of Representatives is expected to vote shortly on the first of several major bills that deal, at least in part, with at-home care. Sponsored by Reps. Claude Pepper (D) of Florida and Edward Roybal (D) of California, it would provide federal funding through medicare for home care, not only for the elderly but for Americans of all ages. But most such proposals would carefully limit what care could be financed.

Such a government program would require a new bureaucracy, says Peter Ferrera, a policy analyst at the Heritage Foundation. He and others worry about costs and the quality of care. Checking on both quality and cost in millions of homes would be difficult for "bureaucracy to cope with," he says. "This is where a private-sector initiative properly could better deal with it."

In many states there is little if any regulation of at-home care agencies and reports of poor care or even mistreatment by unqualified aides occasionally arise. Many experts are concerned that as services expand the quality could seriously deteriorate.

Mr. Halamandaris says care has generally been good: "Only seven home-care providers have been convicted of fraud and abuse in the whole history" of at-home care. But he concedes that "we're starting to see some breakdown in quality" among those organizations that essentially are brokers between people who need care and individuals who say they can provide it.

But for many families the quality of such care is irrelevant: They cannot afford anything beyond what public funds pay for, and that's often too little.

Early this spring the Smiths had moved into their daughter's apartment. Until then, Mrs. Smith says, she was so house bound "I felt like climbing the walls. . . . He just don't want me to get out

of his sight five minutes." It's a typical problem: Many people who are dependent on care-givers become uneasy when they are not in view.

Efforts are under way in Congress to provide funds that would, in part, provide the Mrs. Smiths across America with time to do something outside the home — perhaps only an hour or two a week to shop, eat lunch with a friend, or just take a walk. Some new private insurance plans would also provide reimbursement for such respites.

But a family's decision to care for a loved one at home is not based on cost or personal effort or what the government does or does not do to help. It's based on love.

"Maybe I've just got a good heart. "I love him. As long as I can stand up and I can take care of him, I'm going to . . . 'cause I want to be with him as long as he's here," Mrs. Smith said recently.

How did Smith feel about that? "I'm married to the most wonderful woman in the world," he said.

# The high cost of long-term care

## Congress is looking to restitch US patchwork of private, public aid

By Robert P. Hey  
Staff writer of The Christian Science Monitor

Washington

Who pays the bill? For elderly Americans, that may be the most challenging aspect of long-term care.

Nursing-home care averages \$22,000 a year, well beyond the means of the average American.

Care at home, while generally less, can also be expensive. US Rep. Claude Pepper (D) of Florida says that it accounts for more than 80 percent of the cost of long-term health care in the United States.

"We simply don't have an organized way of paying for long-term care, either privately or publicly," says Alice Rivlin, who with fellow Brookings Institution scholar Josh Weiner has just completed a study and a book on the subject.

Over the years a patchwork of payments has been stitched together: Individual Americans pay for a little more than half of this custodial care, such as help with washing and dressing. Medicaid, which was designed to aid the poor, pays about 40 percent, while private insurance and medicare, intended to aid the elderly, combine to pay for less than 3 percent.

About a million elderly Americans sink into poverty every year trying to pay for nonmedical long-term care. Some Americans, concerned they are spending their way into poverty - and medicaid eligibility - by paying for long-term care, violate attempt to pass some of their assets on to their children. "It's a terrible moral and ethical dilemma," says a lawyer who specializes in estate planning.

There is indeed "widespread abuse of the system, driven by people's conviction that ... everybody else does it," says William Roper, Washington's top administrator for medicare and medicaid.

As the number of elderly continues to grow, greater demands will be placed on nursing homes and organizations that provide home care, both stretched to the limit. And new federal rules, intended to improve the nursing-home quality, will also increase costs. And most experts say a significant pay raise will solve the severe nursing shortage in the field.

Everyone agrees that the present haphazard mix of funding must be changed. But there is wide disagreement on how.



Caroline Anderson's nursing-home bill is about \$22,000 a year

"There are going to be no easy solutions," says Daniel P. Bourque, "and perhaps no single solution. And therefore we need to look everywhere we can for solutions." Mr. Bourque is corporate senior vice-president of the Voluntary Hospitals of America, an association of nonprofit hospitals.

Edmund F. Haislmaier favors emphasizing private insurance. Very few health-insurance policies cover long-term care. But financing such care through private policies, he says, is "a perfect example of what insurance is designed for" - with many people paying, through premiums, a portion of the cost of financing the long-term care that only a few will ever need.

Although long-term care is insurable, "the question is how you get people to buy" such insurance, says Judith Feder, co-director of the Center for Health Policy Studies at Georgetown University. When people are elderly, the premiums can be too high for them. When they are young,

such care seems a remote prospect.

Two years ago about 5,000 Americans held such policies; today some 440,000 policies are in force. Many people say the industry is on the verge of a major surge in these policies, as they are improved and are offered in job benefit packages. So far, most insurance policies have been purchased by individuals.

But most experts say policies will not be widely purchased until there is affordable protection against inflation. "It's almost ludicrous" to offer a 20-year-old a policy with no inflation increment, for possible use 60 years later, says Robert

Hall of the Aetna Insurance Company.

Some insurance companies offer plans that take inflation into account, but for higher premiums. Says Dr. Feder: "They are improving the benefits and protection - but that raises the price. . . . The better it is, the fewer people can afford it."

Dr. Rivlin says only a third of America can afford private insurance. Thus, she concludes, some form of government financing will be needed, even if effective private plans become widely available.

Dr. Roper is skeptical about establishing a federal program now: "I don't think we know enough to craft a uniform national policy [for financing] at the moment."

A number of proposals are being introduced into Congress that would provide substantial federal payments for long-term care and protect more assets of the middle class.

Many proposals would finance the cost through a tax on the wealthy by requiring that social security taxes be collected on all wages, instead of the first \$45,000 each year, as under current law. But higher taxes are as unpopular with Congress as they are with the public.

Yet funding must be figured out in advance if any proposal is to have a change to become law. "The days are over," says Sen. George Mitchell (D) of Maine; "when we can simply add new benefits to programs and let someone else figure out" where the money will come from. Senator Mitchell chairs the Senate Finance Subcommittee on Health. He will likely be a key congressional player.

Mr. Mitchell has scheduled hearings for Friday on his bill to provide limited government assistance to people requiring long-term care. His proposal, like most, envisions a combination of government program and private insurance. He would have individuals, presumably through insurance, pay the cost of long-term care for the first two years. A new government program would pay it thereafter.

The health insurance industry opposes his proposal, calling it premature. Instead the Health Insurance Association of America seeks changes in tax law and gov-

ernment policy that, it says, would stimulate innovation in private long-term insurance.

At the same time, it does not rule out an agreement with Mitchell. "There is room for compromise," says Susan Van Gelder, the group's associate director of research and policy development.

A proposal by the American Association of Retired Persons (AARP) would also require individuals to pay part of the cost. It would provide financial aid to the elderly, the disabled, and to children under 18. People in nursing homes would pay 30 percent of room and care costs; those receiving home care would pay 20 percent.

Representative Pepper, Congress's best-known advocate for the elderly, would revamp medicare to pay the home-care costs for the elderly, the disabled, and children.

Sen. Edward Kennedy (D) of Massachusetts proposes paying the full costs of care at home and the first six months in nursing homes. Longer nursing home stays would be partly reimbursed.

Sen. David Durenberger (R) of Minnesota says: "In the short term it's a matter of" changing programs like medicare and medicaid "to expand the options for reimbursement at the community level," such as home care. "In the longer term, the emphasis is on individual responsibility" to finance long-term care, privately.

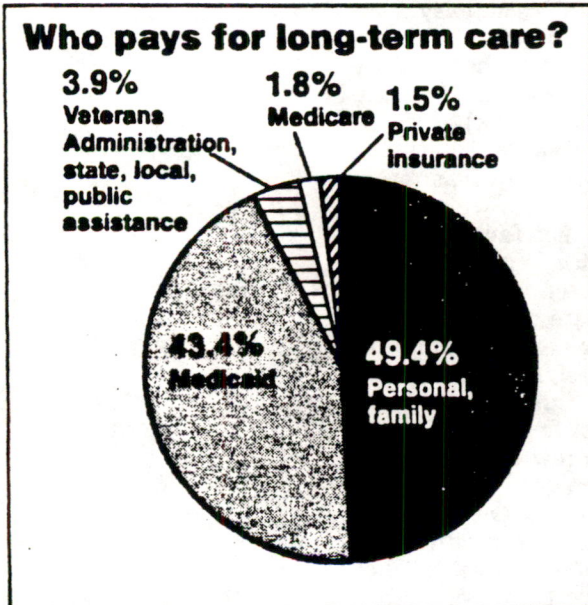
As serious as the problem is, some US officials wonder whether Americans really want to give priority to an expensive new program for long-term care over other major domestic issues, notwithstanding polls that report a willingness to pay higher taxes in return.

"Yes, we can have a [higher] payroll tax," admits Thomas Burke, chief of staff of the Department of Health and Human Services, "but is this all we have to worry about?" At a meeting of the AARP's legislative council, he ticked off other problems: AIDS, a 25 percent school dropout rate, a \$1 trillion unfunded US health-care liability. "We have a drug problem that is getting worse. . . . We lose \$117 billion [annually] to alcohol problems in the US." Then there's teen pregnancy.

"Long-term care - you don't get it free," he warned. "You get it at the expense of something else."



JOAN RAPAPORT - STAFF



Source: Senate Special Committee on Aging

## NATIONAL



R. NORMAN MATHENY - STAFF

Nursing-home resident Frances Stokes gets hug from aide Angela Lester: many aides are underpaid, overworked

## Fewer nurses for fuller nursing homes

By Robert P. Hey

Staff writer of The Christian Science Monitor

Providence, R.I.

When Rhode Island held a job fair at the Providence Civic Center a few weeks ago, Judith Robidoux was there.

As director of nursing at the Waterman Heights Nursing Home in nearby Greenville, she was seeking to recruit nurses and nurse's aides. So were the representatives of half a dozen other health organizations.

Ms. Robidoux was making an effort to deal with one of the most serious problems facing nursing homes and other groups that provide long-term care to elderly Americans: not enough nurses.

"There is a real shortage," says Paul Willing, executive vice-president of the American Health Care Association, which primarily represents nursing homes across the United States. "Two-thirds of our members have nursing vacancies; one-third of them have vacancies that" force them to have staff members to work double shifts or take similarly extraordinary measures to meet state and federal standards.

Experts say today's problems will worsen unless

more Americans enter and remain in the fields of nursing and nursing aides. Health-care facilities "will need 29 percent more employees by 1995" just as the pool of prospects for low-skilled jobs, such as nurse's aides, is shrinking, says James Paxton. As vice-president for human resources of Beverly Enterprises, he works for America's largest nursing-home chain, with nearly 1,100 facilities.

"We compete for unskilled employees" with hotels, schools, government, and restaurants, Mr. Paxton says.

The US Department of Labor forecasts that the demand for nurses and nurse's aides will rise much faster than the average for all occupations through the year 2000. Behind this demand is the immense growth forecast in the number of elderly Americans: They make up 90 percent of those requiring long-term care, such as help in walking, dressing, and caring for themselves.

Moreover, new federal and state regulations will soon require added nurses and better trained aides in nursing homes. Yet "nursing schools are closing," Mr. Willing says. "Enrollment is dropping dramatically."



Please see CARE next page

**CARE** from preceding page

Nursing homes and other long-term care facilities face other serious problems: the amount government programs pay them; the paper work these programs require; and the slow pace of construction of care facilities. There's also the persistent issue of the quality of care, widely agreed to be much better than in the 1970s but still far from first rate in many places.

Finally, there is the challenge of planning for the future. Will technological improvements in medical care mean that, as some experts say, many more Americans, such as accident victims, will be cared for in nursing homes, with a resultant need for bigger staffs? Or will it mean a dramatic increase in at-home care, meaning a lower-than-expected demand for institutional staffs?

Will the US develop a policy on long-term care, as the result of the many proposals now being considered? If so, how will this policy affect nursing homes?

The heart of a nursing home is its staff — the nurses who are largely responsible for planning care and supervising it; and the aides, who provide 90 percent of the day-to-day care. Without enough trained staff members, the quality of assistance is compromised.

In the short run, the efforts of resourceful institutions like Waterman Heights Nursing Home can pay off. Judith Robidoux called her day at the Rhode Island job air very successful. She talked with more than 100 prospects and gave out 75 applications: "If I get 5 to 10 good employees, it will be well worthwhile."

Dealing with the long-run problem of nursing shortages requires national planning. Consequently, a commission on nursing appointed by the US Department of Health and Human Services is studying the problem. In December it is to report its findings and recommendations to Otis Bowen, secretary of the department.

"I think that a major part of the problem that nurses have been paid relatively little and treated relatively badly," says William Roper. Therefore, many of those trained as nurses "aren't working as nurses," he says. As administrator of the Health Care Financing Administration, Dr. Roper is the federal government's top offi-

cial in charge of programs, like medicaid, which pay a little less than half the nation's nursing-home costs.

The Labor Department says that in 1986 the median salary of full-time registered nurses in the US was \$23,900. Those who worked in nursing homes were generally among the lower-paid half — in 1987 their median salary was \$19,900. As Robidoux of Waterman Heights says: "We're competing with the hospitals to get nurses, and the hospitals can pay higher salaries."

When former and current nurses discuss problems in their profession, almost inevitably they mention the lack of respect accorded them, especially in hospitals.

Experts and nurses themselves say higher salaries would help. But for nursing homes that would mean higher costs, which would be passed on to patients and their families in higher charges. Already Americans in nursing homes are paying an average of \$22,000 a year.

Administrators and other experts on long-term care say that, in an effort to hold down costs, medicaid often reimburses nursing homes for less than the cost of the actual care. The program is jointly funded by the federal government and individual states; the latter determine the amount that will be paid, which varies state to state.

"Some states are paying in the low \$30s for a day of nursing home care," says Willging. This doesn't cover the actual cost, he says. Who makes up the difference? It's the patient who pays privately. He frequently is charged more than the actual cost in what is a de facto subsidy of medicaid patients.

Beyond salary is training. To provide quality, Beverly Enterprise's Paxton says, nursing homes "must provide very skilled training to the unskilled."

Retaining nurse's aides is almost as difficult as recruiting them. "Being a nurse's aide is awfully tough," Willging says.

"Some parts of it can be very unappealing," such as aiding patients who have lost control of their bodily functions. "Turnover rates approach 200 percent in nursing homes," he says. "You'll have three people filling the position in some homes" in a year.

One way to help retain aides, experts say, is to build a career ladder for them. Besides providing higher pay and more respect, Paxton says, "we must also provide career options. . . ."

Finding the right employee in the first place is also essential. "The successful nursing-home employee," Paxton says, "has a strong piece of nurturing and caring in his personality. . . . I think we have to remember that a nursing home is a person's home."

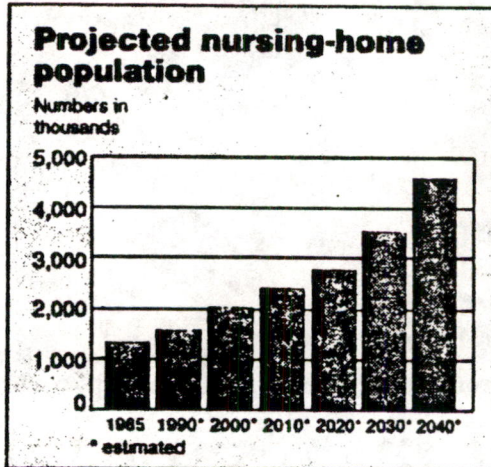
Despite the lower pay, some registered nurses cite advantages to working for nursing homes and home-care agencies: Nurses have more respect and greater responsibility for patients' care.

Hospitals, where three-fourths of America's nurses are employed, are what one nurse calls "doctor driven": Physicians make

the decisions. Nurses say they often feel they are rushing around carrying out physicians' orders without being able to fully use their own knowledge and abilities.

It's different in nursing homes and at-home care: Nurses do much of the planning to see that patients' needs are met.

"I like my work because I teach people," says Phydariel Jackson, a registered nurse with the Visiting Nurse Association of Washington, D.C. Ms. Jackson, who has a gift for gaining the trust even of recalcitrant people, visits patients in their homes and helps family members learn to care for them. "I like the independence of it," she says quietly, "and the people are so nice, too."



Source: US Administration on Aging

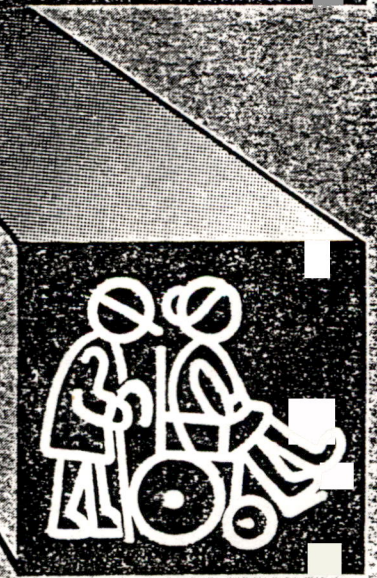
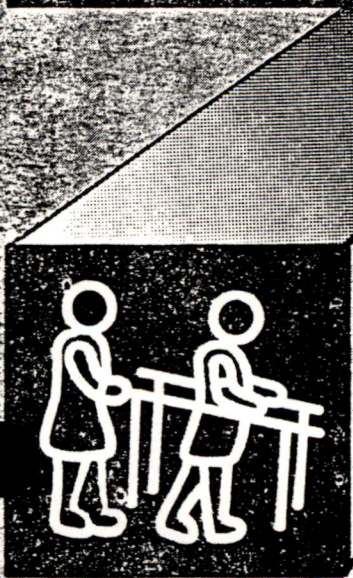
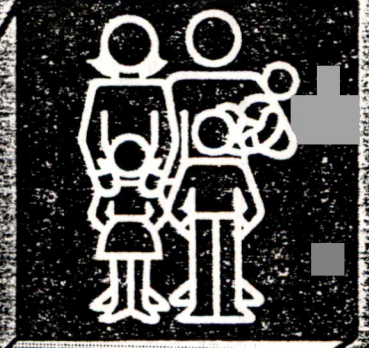
JOAN RAPAPORT - STAFF

# REPORT TO CONGRESS AND THE SECRETARY

[EXCERPT]

BY THE  
TASK FORCE  
ON

# LONG-TERM HEALTH CARE POLICIES



## EXECUTIVE SUMMARY

The challenge of meeting the needs of our disabled and aging population requires immediate attention. Few individuals can finance an extended nursing home stay or other long-term care services entirely out of their assets and incomes. Many people, however, may be able to provide for nursing home and other long-term care services through buying long-term care insurance.

At age 65 people are estimated to have more than a 43 percent risk of entering a nursing home some time during the rest of their lives. However, financing long-term care is not just a problem for older persons. In the year 2000, 40 percent of functionally dependent Americans will be less than 65 years old. Besides the high cost of financing institutional care, disabled and older persons living in the community will need long-term care services to remain at home.

The Task Force on Long-Term Health Care Policies strongly recommends that both public and private sectors take steps immediately to encourage expansion of private financing for long-term care services through long-term care insurance. Even during the Task Force's deliberations, and partly in response to its initiatives, the development of long-term care insurance has moved forward, but the pace of development needs to accelerate. The Task Force offers its recommendations as a blueprint for more rapidly developing and expanding a private system for financing long-term care.

Long-term care includes a wide range of medical and support services for people who suffer physical or mental disorders causing functional limitation or disability and therefore need assistance for an extended period to maintain or promote functional well-being. Long-term care ranges from informal in-home services to institutional skilled nursing.

Spending on long-term care has grown rapidly and will continue to grow as the population ages. Almost half the institutional

costs for long-term care are paid directly out-of-pocket, while less than 2 percent is paid through insurance.

The statute creating the Task Force requested recommendations for action in the areas of education, market development, and consumer protection to improve and foster the growth of long-term care insurance.

The Task Force accepted the definition of long-term care insurance adopted by the National Association of Insurance Commissioners (NAIC) in their Long-Term Care Insurance Model Act (Model Act). This definition requires insurance to offer benefits for not less than 12 consecutive months in a setting other than an acute care unit of a hospital. The Task Force added explanatory notes to the definition to clarify certain points: 1) services are covered in various settings—at home or in the community, as well as in institutions; 2) long-term care insurance does not duplicate Medicare coverage for those eligible; 3) covered services include personal care to maintain activities of daily living; 4) future policies may bring arrangements not yet envisioned; and 5) the Task Force encourages development of both the products covered by the definition and other forms of risk pooling.

Private long-term care insurance can protect people against large out-of-pocket expenses. It gives individuals the opportunity to retain choices and develop a flexible, planned response to a potentially ruinous event that will confront many people over 65 as well as many disabled people under 65. Insurance offers the most cost effective, collective approach to meeting financial risks that often devastate individuals.

The Task Force believes a broad market for long-term care insurance can and should be developed. While very few disabled and older persons have obtained long-term care insurance, no other private financing mechanism appears to offer a more cost effective and viable means of meeting long-term care costs.

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The Task Force acknowledges that private long-term care insurance cannot provide a total solution for financing long-term care. For the foreseeable future long-term care will continue to be provided by formal and informal caregivers, in institutional, home, and community settings, and financed by a mixture of public and private expenditures. When the Task Force reviewed integrated public/private approaches, especially those significantly expanding government financial support for catastrophic episodes of long-term care, it concluded that more information was needed to determine the viability of a joint public/private approach.

The Task Force identified and analyzed market factors that promise to stimulate an active private long-term care insurance market with attractive and affordable products and, at the same time, provide reasonable protection for consumers. In the judgment of the Task Force, the critical factors are these:

- **Public Awareness**--Consumers need to be more aware of several key topics: 1) the absence of long-term care coverage under Medicare, Medicare supplement insurance, and most acute care insurance and prepaid health programs; 2) the potential costs of long-term care over their lifetime; 3) the range, cost, and availability of long-term care insurance products; and 4) the advantages and limitations of various insurance features. In particular, the Federal government has a responsibility to inform Social Security beneficiaries that Medicare does not cover long-term care services.
- **Consumer Protection**—The Task Force found that the Long-Term Care Insurance Model Act developed by the National Association of Insurance Commissioners provides a sound basis for balancing the interests of product development with adequate protection for consumers. However, greater consumer protection can be provided through more stringent requirements for renewability of individual

long-term care insurance policies and through the regulation of the reserves for continuing care retirement communities.

- **Market Development**—The absence of basic data on the use of long-term care insurance by an insured population and the need to define benefit levels present problems for insurance companies in designing products that meet certain needs: 1) cover services in expanded settings like homes and communities; 2) prevent overuse of services (induced demand); and 3) avoid creating a risk pool weighted too heavily to those most likely to require long-term care (adverse selection). The Task Force generally concluded that insurance companies must be given latitude to experiment with benefit design and utilization controls if they are to develop products that will be affordable and attractive to consumers.

- **Expansion of the market through employer-sponsored long-term care insurance**—Offering long-term care insurance through employment has the greatest potential to cover large numbers of people, but penetrating this market will require overcoming impediments and providing incentives.
- **Tax incentives**—Existing rules must be clarified in several respects: the tax treatment of reserves for long-term care insurance and interest on those reserves and the tax treatment of long-term care insurance in general. Tax incentives are especially important to encourage development of long-term care insurance through employment-based plans and vested retirement funds. Compared to other approaches, employment-based plans would make more attractive and affordable products available and extend coverage to the largest number of people.

Efforts of the NAIC have significantly advanced the work of the Task Force in developing recommendations to assure responsible marketing practices and prevent sales abuses. In adopting the Model Act, the NAIC has established an appropriate vehicle for protecting consumers. The Task Force was able to

further NAIC efforts by developing an additional recommendation to give Insurance Commissioners greater authority over cancellation and renewability of long-term care insurance policies

The Congress charged the Task Force to recommend ways to assure a reasonable relationship between premiums and benefits, and this task presented marked difficulties. The NAIC draft regulations dated June 22, 1987, rely on loss ratio to test premium reasonableness, but the Task Force concluded that this test is of limited use at present. Further developing actuarial tables on frequency and duration of nursing home stay and utilization may prove to be more helpful in judging the real value of long-term care insurance.

The Task Force adopted 41 recommendations. Taken together, they provide practical directions for strengthening long-term care financing through private insurance. They vary in difficulty of implementation, effect on the issues, cost effectiveness, political acceptability, and budget impact. Particularly important recommendations cover seven areas, and their implementation should command the highest priority

1. **Inform Consumers that Medicare, Medigap, and acute health care insurance do not cover long-term care.** The Department of Health and Human Services should communicate directly to all current and new Social Security beneficiaries the exact nature and limitations of Medicare long-term care coverage, as well as available alternatives. Effective communication will require developing appropriate information and referral capabilities.
2. **Encourage States to adopt the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act.** A number of States have already adopted the Model Act, and all other States are strongly encouraged to do the same. The Task Force believes, however, that the cancellation provision should be more limited than permitted in the Model Act.

3. **Promote the availability of long-term care insurance through employment.** Offering long-term care insurance through employment is an effective way to make attractive, affordable coverage available to large groups of working-age people. A number of approaches promise to help accomplish this objective. Tax incentives and encouragement of employer cooperation will be essential to these efforts. At a minimum, the present restrictions on buying long-term care insurance through cafeteria plans and flexible spending accounts should be removed.
4. **Develop long-term care insurance financing through vested pension funds.** Both before and after retirement, individuals should be permitted to use vested pension and retirement savings (including IRAs, Keogh plans, and others) to purchase long-term care insurance. Transfers from such funds should not be taxed or subject to penalties.
5. **Use Federal and State tax codes to encourage the purchase of long-term care insurance.** Most desirable would be broad-based measures that effectively encourage purchase of long-term care insurance without unduly reducing government revenues. The most important incentive in lowering the cost of long-term care insurance depends on clarifying whether tax exempt status applies to long-term care insurance reserves held by insurers and to the investment earnings credited to them.
6. **Encourage new approaches to determine eligibility for long-term care insurance benefits.** The level-of-care and service definitions currently in use are unreliable in determining eligibility for long-term care insurance benefits. The Task Force believes that developing need assessment systems, based on ability to perform activities of daily living, offers a useful alternative in deciding eligibility for benefits.
7. **Encourage greater cooperation in the collection and sharing of long-term care data.**

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The Task Force, with the cooperation of the Department of Health and Human Services and the Veterans Administration, has taken steps to increase the sharing of Federal

data and recommends further Federal, State, and private efforts to improve the quality and availability of actuarial data.

## Chapter I

### RECOMMENDATIONS

The Task Force adopted recommendations to promote and develop a market for long-term care insurance and to assure consumer protection against possible market abuses. Not every member of the Task Force fully agrees with every recommendation, but all recommendations were supported by a substantial majority of Task Force members. These recommendations may vary in difficulty of implementation, effect, cost effectiveness, political acceptability and budget impact. Taken together, however, they provide a desirable direction for States, the Federal government, and the private sector to follow in strengthening private financing of long-term care.

The Task Force considers several recommendations particularly significant. These major recommendations affect both individual and group policies. Recommendations that would reduce costs do so for both types of policies. The consumer protection section focuses particularly on the individual policy, as group policies derive much of their consumer protection through negotiation at the time they are established. The Task Force emphasizes the following steps as its major recommendations:

- Communicating the information that Medicare, Medigap, and acute health care insurance do not cover most long-term care services.
- Encouraging States to adopt the National Association of Insurance Commissioners' (NAIC) Long-Term Care Insurance Model Act.
- Developing employer-sponsored long-term care insurance.
- Developing long-term care insurance financed through vested pension funds.
- Using Federal and State tax codes to encourage development of long-term care insurance.

- Encouraging innovative approaches to determining eligibility for long-term care insurance benefits.
- Encouraging greater cooperation between the public and private sectors to improve the quality and availability of actuarial data on long-term care.

Following are specific Task Force recommendations. They focus on elements of the Congressional mandate to the Task Force. They are listed by category, generally in the order the issues are discussed in Chapters III through VII.

### CREATING AWARENESS

1. When discussing the Medicare program, the Federal government, including the Congress, must be careful to communicate accurately the limited nature and extent of long-term care coverage.
2. Public information campaigns are needed to make people aware that Medicare, Medigap (Medicare Supplement Insurance), and existing health care policies provide little or no coverage for long-term care services.
3. The Department of Health and Human Services should:
  - a. Tell all current and new Social Security beneficiaries, through direct mailings and use of Social Security District Offices, that Medicare does not cover most long-term care services.
  - b. Publish a separate Medicare guide describing the limited Medicare skilled nursing facility benefit and home health benefit, which are oriented toward providing post-acute care.
  - c. Develop a long-term care insurance buyer's guide.
  - d. Develop a model public information program for use by States.
  - e. Provide assistance in implementing such programs at the request of States.
  - f. With the NAIC, create a clearinghouse for sharing knowledge of successful information programs.

- g. Assist businesses and unions in educating employees about long-term care insurance.
- 4. State Insurance Commissioners should:
  - a. Require Medigap policies to state the extent of, and limits on, long-term care coverage.
  - b. Develop and distribute long-term care insurance buyer's guides, individually or through the NAIC.
- 5. Insurers and their trade associations should:
  - a. Review their informational and promotional materials to ensure that they accurately describe long-term care needs and coverage.
  - b. Develop educational programs explaining long-term care needs and financing options.
- 6. Long-term care service providers, individually and through their organizations and associations, should develop and distribute public information programs dealing with long-term care needs and financing and delivery.
- 7. Consumer groups and organizations representing older people should develop materials that deal specifically with the need for long-term care services and the options for financing and delivery of this care.
- 8. Insurance companies, provider groups, consumer groups, and organizations representing older and disabled people should work with groups and associations of physicians, nurses, lawyers, estate planners, and others with whom people consult for advice and assistance on financing long-term care needs, to increase awareness and improve knowledge of long-term care insurance.

#### **AVAILABILITY AND SCOPE OF PUBLIC PROGRAMS**

- 9. The President should designate a lead agency to direct all Federal agencies providing health care benefit programs to inform beneficiaries clearly about the limited nature of any long-term care benefits provided under these programs.

- 10. Publications on Medicare, Medicaid, Medigap, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and Veterans Administration programs should more clearly explain the coverages and limitations of these benefits with respect to long-term care.

#### **STIMULATING DEMAND**

- 11. Federal, State, and private public information efforts should:
  - a. Target the messages to specific age groups, such as pre-40, 40-65, and post-65.
  - b. Focus on the need for people to plan early for financing long-term care.
  - c. Emphasize that long-term care includes non-institutional as well as institutional services.
- 12. Public information programs should work with organizations that represent or serve older people to increase the effectiveness, coordination, and penetration of educational efforts.
- 13. Federal and State governments should make long-term care insurance available to their own employees and retirees through existing group mechanisms.
- 14. States should consider how their Medicaid eligibility requirements might create incentives or remove disincentives to purchasing long-term care insurance.

#### **CONSUMER PROTECTION**

##### **Adoption of the NAIC Model Act**

- 15. State governments should adopt the National Association of Insurance Commissioners Long-Term Care Insurance Model Act. The NAIC Model Act was designed to protect consumers, promote product availability, and encourage benefit experimentation, and its provisions make appropriate distinctions between group and individual coverage. However, the Model Act should be amended as follows: Individual policies should be cancellable only for the most unusual and compelling reasons and therefore,

only with the permission of the State Insurance Commissioner. At the same time, the insurer should be entitled to adjust rates in the same manner as they are adjusted on guaranteed renewable policies.

16. The State Insurance Commissioner should have the authority to permit cancellation of a long-term care insurance policy by class, but only when it is determined to be in the best interest of the public to do so.

#### **Preventing Sales Abuses**

17. State governments should continue to be responsible for vigorously protecting consumers from fraudulent, unfair, or illegal sales or claims practices. The Federal government should not impose on States requirements for regulating long-term care insurance in the absence of a showing that the States are failing to meet their responsibilities for consumer protection.

18. As the NAIC Model Act recommends, States should require that disclosure materials in long-term care insurance policies:
  - a. Meet specific standards for readability, content, location, and layout.
  - b. Contain an "outline of coverage," including limitations on coverage and provisions for renewal.

19. Insurance organizations that provide training and/or continuing education for insurance agents, such as insurance companies, the Association of Health Underwriters, and the Association of Life Underwriters, should develop specific programs on long-term care insurance, long-term care financing, and the legal and ethical considerations of selling insurance.

#### **Portability**

20. Insurers should be encouraged to develop employment-based group insurance policies and other types of group-sponsored coverage for long-term care that enable policyholders to continue the coverage or convert to individual policies or make other acceptable arrangements if employ-

ment terminates, an insured group is disbanded, or the master long-term care policy in which the individual is participating is cancelled.

#### **Adequacy of Reserves for Continuing Care Retirement Communities (CCRC)**

21. States should enact legislation based on the standards for CCRCs established by the American Association of Homes for the Aging and by the American Academy of Actuaries to:

- a. Review the actuarial fitness and financial viability of the CCRCs as they begin operation.
- b. Assure appropriate actuarial and financial planning to cover long-term care health costs and residents' needs.
- c. Require CCRC developers and managers to disclose fully all services and care to be provided and method of financing, currently and in the future.

#### **Market Value Measures**

22. At this time, loss ratios are based on relatively crude projections and are not a good measure of market value. The Task Force therefore discourages undue reliance on such estimates. To the extent a regulator is committed to using a target loss ratio, however, the parameters recommended for long-term care insurance by the NAIC should be used.

23. As the NAIC Model Act recommends, State Insurance Commissioners should continue to review new long-term care insurance filings carefully to assure that such policies are not deceptive or misleading.

#### **Policy Design**

24. Long-term care insurance companies should offer purchasers the option of buying benefits that cover long-term care provided in the home or community, as well as in institutions.

25. Insurers and States, through the NAIC, should work together to develop stan-

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dard definitions for levels of care and services which could be used in long-term care insurance policies.

26. Insurance companies should be encouraged to determine eligibility for benefits using an "activities of daily living" need assessment scale. Insurers using level-of-care definitions to determine benefit eligibility should seek to avoid making coverage for institutional services depend on distinctions among skilled nursing services, intermediate care services, and custodial services.
27. Long-term care insurers are encouraged to use the case management approach to determine and coordinate the most appropriate level of care in the most cost effective manner.
28. Minimum eligibility and benefit standards should be limited to those set forth in the NAIC Model Act and regulations and such additional standards as may be necessary to protect against offering illusory benefits.
29. Consistent with the NAIC Model Act:
  - a. State legislatures and regulators should recognize the experimental nature of long-term care insurance and allow reasonable flexibility to insurers in developing eligibility criteria and benefit levels for long-term care insurance.
  - b. State laws and regulations should provide insurers reasonable latitude to develop new products designed to limit insurance-induced demand and adverse selection, situations in which the existence of the insurance creates a demand for it and attracts buyers who are more in need of its protection than the population at large.
30. As the NAIC Model Act recommends, State regulation of long-term care insurance should not universally prohibit making a prior hospital stay and/or prior nursing home stay prerequisite to eligibility for payment of benefits. However, insurance companies should be encouraged to develop alternatives that permit insured

persons with equal need for long-term care to have equal access to insurance benefits, regardless of prior hospitalization or nursing home stays.

## **TAX INCENTIVES AND EMPLOYMENT ISSUES**

31. The U.S. Department of the Treasury should formalize its position regarding the tax treatment of the long-term care insurance reserves held by insurers and the investment earnings credited to them. Such reserves should be treated in the same manner as similar reserves supporting traditional life insurance products, that is, additions to the reserves and earnings on them should be tax-deductible to the extent that reserves are required to support benefits under the contracts.
32. Premiums paid, including amounts paid by employers on behalf of employees, and benefits received under long-term care insurance policies and plans should be treated in at least the same manner as medical care benefits for tax purposes. The idea of treating premiums paid by individuals as partially tax-deductible, apart from the exemption for general medical expenses, should be considered.
33. Federal tax laws should be clarified or modified to remove impediments to employer sponsorship and to funding long-term care coverage as an employee benefit:
  - a. Long-term care insurance should be a permissible benefit under Internal Revenue Code Section 125 cafeteria plans.
  - b. Incentives for employers to pre-fund retiree health benefits, including long-term care benefits, that were eliminated in the Deficit Recovery Act of 1984 (DEFRA) should be restored. Specifically, deductible employer contributions to pre-fund retiree medical benefits plans should be allowed to take into account future medical inflation, and the earnings on funds set aside for such benefits should not be taxed if retained in fund.

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- c. Employers should be allowed to transfer assets from over-funded pension plans to fund retiree welfare benefit plans without penalty or taxation.
34. Individuals should be allowed to make tax-free transfers from vehicles that finance retirement income to buy long-term care insurance. Such transfers should be permitted both before and after retirement and should include transfers from:
    - a. Pension funds.
    - b. Life insurance funds.
    - c. Individual Retirement Accounts (IRAs).
    - d. Keogh plans.
    - e. Annuities.
    - f. Stock bonus and employee stock ownership plans.
  35. Retirees should be allowed to transfer a portion of their post-retirement income tax-free to purchase long-term care insurance.
  36. The range of financing options should be expanded by allowing funding of long-term care as a contingent benefit under pension plans and life or disability insurance contracts.

37. States are encouraged to offer tax-favored treatment for long-term care insurance in the same manner recommended to the Federal government.

#### **DATA NEEDS**

38. Federal and State government agencies should share long-term care data in an expeditious and open manner with each other, with the insurance industry, and with other interested parties.
39. The Department of Health and Human Services should request input from States, the insurance industry, and other interested parties when planning new long-term care surveys.
40. Insurance companies, trade associations, the Veterans Administration, States, and the Department of Health and Human Services should cooperate with the Society of Actuaries in its efforts to collect long-term care data.
41. The Department of Health and Human Services should continue to sponsor periodic long-term care data conferences to provide information on recent Department surveys.

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## Chapter II

### CONCLUSIONS

#### FINANCING LONG-TERM CARE THROUGH PRIVATE INSURANCE

With the older population growing at a much faster rate than the population as a whole, the need for long-term care services to older people as well as the disabled is likely to grow proportionally faster than for younger age groups. Costs of services related to long-term care have risen rapidly over the past two decades and will continue to increase as the population ages. Clearly, then, the question is how shall we, as a society, finance long-term care services.

As discussed more fully in Chapter III, individuals pay for 51.4 percent of institutional long-term care directly out-of-pocket, and the Medicaid program pays for 41.8 percent. Services outside institutions are even more heavily financed from out-of-pocket funds, although most home and community-based care is provided by family and friends at no cost to the recipient. The Task Force believes that private long-term care insurance can offer individuals financial protection by substituting insurance benefits for significant amounts of direct out-of-pocket expenditures. It may also, to some extent, reduce Medicaid expenditures for some people who would otherwise exhaust their assets and income paying for long-term care services and then become dependent on Medicaid.

Private long-term care insurance would allow many individuals expanded options and choices without impoverishing themselves. Private long-term care insurance can provide flexibility, giving people choices about the policy bought, the type and level of care received, and the settings where care is received. Furthermore, long-term care insurance can be integrated into a financial plan that will pay for long-term care through insurance, assets, and income in a mix that suits the needs and desires of the individual, whether the goal is achieving financial in-

dependence, preventing spousal impoverishment, leaving an inheritance, or something else.

The Task Force believes that long-term care financing will continue to come from a mixture of sources for the foreseeable future. Some Task Force members, however, favor a greater public sector role in financing long-term care, including a social insurance approach to the problem. Some members of the Task Force support a public/private program structured to provide universal public coverage after a fixed level of private coverage. The majority of the Task Force, however, believed that greatly increased public spending for long-term care services is unlikely, especially in the short-term, and that privately sold long-term care insurance offers the best means at present for financing long-term care.

The Task Force acknowledges that private long-term care insurance cannot provide a total solution for financing long-term care services for everyone. Indeed, studies suggest that a significant number of people are not likely to be able to afford to purchase long-term care insurance, including some who now "spend down" to qualify for Medicaid. Others will find themselves uninsurable for health or age reasons. However, reorganizing and making the parts of the mixed financing system more efficient are a far better approach than waiting until the body politic can settle on one "right" solution.

Large segments of society can and should provide for their own future needs. Private insurance offers these individuals a reasonable alternative to spending their assets and impoverishing themselves to pay for long-term care. Public programs like Medicaid should continue to provide for those in need. Perhaps, with the expansion of private long-term care insurance coverage, public programs will better be able to finance care for the needy.

Pooling is the most economical and efficient private or public means of collectively funding a future risk. Americans have a his-

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tory of pooling risks, making circumstances that would otherwise be financially disastrous to an individual more manageable because the consequences are shared by a group. Insurance is an efficient and well accepted means of pooling risks like the potential need for long-term care. The Task Force, therefore, focused on developing recommendations it believes will open and maintain markets for quality private long-term care insurance.

The high cost of long-term care and the demographics of an aging population make "pay-as-you-go" financing far less desirable than funding the cost of these services in advance. There are several ways to accomplish this pre-funding. For example, if a small portion of each worker's total compensation were devoted to investment in future long-term care benefits throughout that worker's lifetime, sufficient funds would be available to fund long-term care needs.<sup>1</sup> Again, by spreading the risk, pooling through private insurance would reduce the amount of pre-funding needed from any one person.

The viability of long-term care insurance relates directly to 1) whether the premium is affordable, and 2) whether the product is designed to meet the needs and desires of consumers. Computer microsimulation modeling done for the Department of Health and Human Services shows that by the year 2018, 63 percent of those over age 65 could own some type of a long-term care insurance policy if premium costs for those under 65 did not exceed 1 percent of income and premium costs for those over 65 did not exceed 3 percent of income.<sup>2</sup>

The number of people able to purchase insurance would increase if the purchase were made earlier when premium costs are lower. For example, the cost of insurance could be reduced by taking advantage of a Task Force proposal to use a part of vested pension funds during one's working years to purchase long-term care insurance. Other methods might also encourage the offering and purchase of long-term care insurance in the workplace. Beneficial tax treatment

would reduce the cost of insurance, as well, and help make both individual and group policies more affordable at all ages.

The Task Force believes that the 422,000 long-term care insurance policies already in force demonstrate that there is a market for long-term care insurance and that the market can be more fully developed. The increase in the number of individual policies purchased during the term of the Task Force and the development of group long-term care insurance products is a clear sign of growing interest. Recent public discussion on the subject of long-term care coverage has undoubtedly contributed to increased demand and led to the development of group policies, policies with home-care options, and policies that no longer use hospitalization as a prerequisite for receiving long-term care benefits.

The fact that many insurance companies have entered or are planning to enter the long-term care insurance market suggests industry consensus on a potential market. The number of companies showing interest in marketing a long-term care insurance product has grown significantly, from fewer than 20 in 1984<sup>3</sup> to more than 70 in 1987.<sup>4</sup> The Task Force also noted that since Medicare began in 1965, a period of only 22 years, insurance companies have been able to cover about 70% of older people with Medigap insurance. With the increasing affluence of older people, it seems reasonable to expect rapid growth of long-term care insurance if market barriers discussed in this report can be overcome.

Private financing of long-term care through insurance will demonstrate its potential as marketing increases and people become as aware of their need for long-term care as of other retirement needs. Offering long-term care insurance through the workplace is critical to the successful development of this market. This approach will promote market growth and reduce the age of purchase. Ultimately, the success of this insurance will depend on the quality of products offered and the ability of insurers

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to experiment and serve market demands.

Achieving a fully developed market depends on how many of the issues discussed in this report are addressed. Activity in the market will occur more rapidly and fully if:

1. State Insurance Commissioners continue to support reasonable experimentation in this product line.
2. Insurers accept the need for regulatory requirements related to product performance and continuation of coverage.
3. The Congress adopts the modest tax changes proposed.
4. The U.S. Department of Treasury formalizes its position on the tax status of long-term care insurance reserves.
5. The Department of Health and Human Services and other organizations conduct public information campaigns.
6. Employers recognize a variety of ways to help employees meet long-term care needs.

### **ISSUES MERITING FURTHER ATTENTION**

Many other mechanisms for financing long-term care insurance could supplement or provide alternatives to the development of the long-term care insurance market. The Task Force was unable to review all possibilities in the detail necessary to make informed recommendations. Those discussed in this section need further study to determine their relative value, impact, and potential for financing long-term care. Some of these alternatives were studied in greater detail by the Department of Health and Human Services in the long-term care portion of the Catastrophic Illness Study.

#### **Public-Private Program**

The Task Force reviewed proposals for a structured public/private "stop-loss" program. Such programs could integrate public and private financing of long-term care services in a variety of ways, but they should do the following: pool risk; ensure appropriate types of care; provide incentives for ap-

propriate placement; and use socially optimal financing. Under these arrangements, individuals or the private sector generally would be responsible for the cost of the first 2 or 3 years of long-term care, and then a publicly funded program would assume responsibility for financing these services. Proponents contend that such a program could:

- Reduce premiums of private long-term care insurance by shortening the period of financial risk.
- Improve consumer demand by creating certainty that benefits of the combined program would not end while the need for care continued.
- Increase public awareness of long-term care needs and encourage purchase of long-term care insurance to fill the gap in the public program.
- Reduce Medicaid costs by preventing many people from transferring or "spending down" their assets on long-term care and then becoming eligible for Medicaid.
- Have a neutral influence on the Federal budget, by reducing Medicaid expenditures, or add relatively little new public expenditures.

Opponents of this structured public/private approach counter that:

- Insurance companies will not be interested in developing products for the small market left available to the private sector, particularly given the probable public pressure to fill more and more of that portion with public coverage.
- The program could be highly inequitable. Scarce public resources for the poor could end up subsidizing lengthy nursing home stays and other services for wealthy persons, since public monies would pay for all care beyond an initial period, regardless of income.
- There are better ways for insurers to limit their risk, through policy design and an active private re-insurance market.

- Public awareness campaigns are a less costly means of developing market demand.
- The Medicaid "spend down" population may not have sufficient discretionary income to purchase long-term care insurance.
- Budget neutrality or low public cost can only be achieved if current Medicaid users reduce Medicaid long-term care utilization enough to offset the costs of new public program eligibility for upper-income groups.

The Task Force was concerned about lack of actual data to substantiate either position. While expenditures of such a program would certainly be substantial, the Task Force noted savings would depend on generating correct assumptions about the characteristics of those who "spend down" to Medicaid eligibility and the likelihood that they would purchase certain amounts of long-term care insurance. Even if the "spend down" population did have sufficient discretionary income to purchase long-term care insurance, the program might produce an income transfer from lower income to higher income persons. Some econometric models suggest that increasing sales of long-term care insurance to younger age groups might achieve the same savings in the Medicaid program without creation of a new public program.<sup>5</sup> Finally, the reductions in premiums for long-term care insurance resulting from this proposal appear modest.

The Task Force concluded that a recommendation on this subject would require more extensive data than now exist on the characteristics of the Medicaid "spend down" population. Specifically, data need to be developed and collected on the following issues:

- Methods of implementing "stop-loss" programs through government reinsurance arrangements with private insurers and individuals.
- Savings in private insurance premium costs generated by a public/private program.
- Feasibility of subsidizing the purchase of private long-term care insurance by Medi-

caid or other public indigency programs.

The Task Force is pleased that the Department of Health and Human Services has requested applications for projects to research and analyze long-term care costs, including catastrophic long-term care costs, and the Medicaid "spend down" process.<sup>6</sup>

#### **Medicaid Initiatives in Support of Long-Term Care Insurance**

The State of Indiana passed legislation in 1987 to make a person eligible for Medicaid coverage of long-term care without meeting other resource and eligibility standards if the individual is: 1) enrolled in Medicare Parts A and B; 2) the beneficiary of a Medicare supplement policy or enrolled in a pre-paid health care delivery plan; and 3) the beneficiary of a long-term care insurance policy or pre-paid plan with long-term care benefits. This legislation requires appropriate Federal waivers to take effect. The Task Force felt that this program might encourage the development of the long-term care insurance market, could provide valuable data, and should be given further study.

#### **Social Health Maintenance Organizations (S/HMOs)**

The social/health maintenance organization (S/HMO) is a new concept in which a single provider organization, like an HMO, assumes responsibility for providing a full range of health and personal care services under a fixed, pre-paid premium. Although there are only four S/HMOs currently being tested, the Task Force believes that the case management approach they embody has the potential to coordinate and manage the use of acute and long-term care services cost effectively. The Task Force strongly supports the concept of managed care. While a S/HMO offers more than management of long-term care, certainly much can be learned about this approach from the S/HMO. The Department of Health and Human Services has recently extended a demonstration program involving four S/HMOs which should provide significant data for the private sector to review.

## Home Equity Conversion

Older home owners could be helped by financing that allows them to draw upon the equity in their home without having to move elsewhere. Home equity conversion is a way to secure a loan and defer repayment. More study and research needs to be undertaken to determine the circumstances under which home equity conversion would be a useful method of financing long-term care services. The Congress and some State legislatures are currently considering legislation that would establish a demonstration program in home equity conversion.

## ORGANIZATION OF TASK FORCE REPORT

The balance of the Task Force report is organized into five parts. Chapter III describes the demographic and economic aspects of long-term care. Chapter IV discusses the need for greater public awareness and makes recommendations for education to improve knowledge about long-term care financing and insurance. Chapter V reviews various consumer protection issues, describes the NAIC Model Act, and recommends more stringent tests for cancelling individual long-term care insurance. Chapter VI analyzes tax treatment of long-term care and explores the development of employment-based group insurance. Chapter VII examines barriers to market development and suggests several approaches to overcoming these barriers. The appendices include materials prepared by or at the request of the Task Force and selected materials directly related to this report.

## NOTES

<sup>1</sup> ICF Incorporated, "Policy Options For Long Term Care," Final Report Submitted to the American Health Care Association (Washington, DC, May 1987), p. 29.

<sup>2</sup> Department of Health and Human Services, Technical Work Group on the Private Financing of Long-Term Care for the Elderly, "Report to the Secretary for Private Financing of Long-Term Care for the Elderly" (Washington, DC, November 1986), p. 3-242.

<sup>3</sup> Mark R. Meiners, "The State of the Art in Long-Term Care Insurance," in *Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives. Conference Proceedings*, ed. P.H. Feinstein, M. Gornick, and J.N. Greenberg, Health Care Financing Administration Publication No. 03174 (Washington, DC: Government Printing Office, 1984).

<sup>4</sup> Task Force on Long-Term Health Care Policies, "Survey of Policies in Force," May 14, 1987. (See Appendix A-3.)

<sup>5</sup> Department of Health and Human Services, Technical Work Group on the Private Financing of Long-Term Care for the Elderly, pp. 3-241 to 3-243.

<sup>6</sup> *Federal Register*, 52, No. 99 (May 22, 1987), 19398-19401.

# CRS Report for Congress

## Financing and Delivery of Long-Term Care Services for the Elderly

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May 25, 1988



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## ABSTRACT

The projected growth of the elderly population, combined with large and increasing public and private out-of-pocket expenditures for long-term care services, and especially nursing home care, has generated a great deal of interest in altering the way long-term care services are financed and delivered. Recent congressional action on catastrophic health insurance for the elderly has brought new attention and focus to these issues and the uncovered liability most elderly persons face for long-term care costs. This report provides an overview of information on these two major issues in long-term care--(1) the potentially catastrophic expenses elderly persons can incur as the result of chronic illness or disability and (2) the need and demand for additional home and community-based care. It includes information on characteristics of the elderly and their utilization of long-term care services as well as their projected utilization of services in the future. It also reviews public sector programs that support long-term care and private sector approaches that have been suggested in the past few years as feasible alternatives for financing this care.

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## FINANCING AND DELIVERY OF LONG-TERM CARE SERVICES FOR THE ELDERLY

### Summary

Long-term care is an important policy issue for the Congress. In the future, the Nation will have significantly more elderly persons, both in absolute numbers and as a proportion of the population. By the year 2040, elderly persons will represent 22 percent of the Nation's population, as opposed to the 12 percent they currently represent. In addition, those 85 and over, who are at the greatest risk of needing long-term care, are one of the fastest growing age groups in the country.

Studies show major increases in the need for long-term care for the future. Today approximately 1.3 million elderly persons are residents of nursing homes. For every elderly person residing in a nursing home, there are at least twice as many persons living in the community requiring various kinds of care. Estimates for the future show that the nursing home population might be as high as 4.4 million persons by the year 2040, and the disabled elderly population living in the community might include up to 14.4 million persons by that time.

Expenditures for long-term care services, principally nursing home care, already strain the budgets of public programs, as well as private resources. In 1986, total national nursing home expenditures of \$38 billion were financed about equally by public programs, primarily the Medicaid program, and private sources of payment. Nearly all of private spending for nursing home care was paid directly by the consumer out-of-pocket. With nursing home care costing in the range of \$20,000 to \$25,000 per year, this out-of-pocket spending can represent a catastrophic expenditure for many elderly persons. In fact, many elderly persons deplete their assets and income to pay for nursing home care and thereby become eligible for Medicaid payment for their care.

Currently there is only relatively limited public sector funding available for home care services for the disabled elderly living in the community. Studies have estimated that between 60 and 80 percent of the care received by the impaired elderly living in the community is provided by relatives and friends who are not compensated for the care they provide.

Policymakers over the years have struggled with issues related to the potentially catastrophic expenses of nursing home care and the need and demand for additional home and community-based care. Currently a great deal of consideration is being given to private sector options, and especially private insurance, for financing these needs. Expanded public sector support might be needed for the large numbers of needy elderly who could not afford such alternatives.

## OVERVIEW

Congress has considered issues related to the financing and delivery of long-term care for nearly 15 years. The projected growth of the elderly population, combined with large and increasing public and private out-of-pocket expenditures for long-term care services, and especially nursing home care, has generated a great deal of interest in altering the way long-term care services are financed and delivered. In addition, policymakers have also sought ways to expand community-based services to correct what some perceive to be a bias in the current system for financing institutional long-term care. Recent congressional action on catastrophic health insurance for the elderly has brought new attention and focus to these issues and the uncovered liability most elderly persons face for long-term care costs. This report provides an overview of information on these two major issues in long-term care--(1) the potentially catastrophic expenses elderly persons can incur as the result of chronic illness or disability and (2) the need and demand for additional home and community-based care. This report includes information on characteristics of the elderly and their utilization of long-term care services as well as their projected utilization of services in the future. It also reviews public sector programs that support long-term care and private sector approaches that have been suggested in the past few years as feasible alternatives for financing this care.

The phrase "long-term care" refers to a wide array of medical, social, personal, supportive, and specialized housing services needed by individuals who have lost some capacity for self-care due to chronic illness or physical or mental conditions which result in both functional impairment and physical dependence on others for an extended period of time. Major subgroups of individuals needing long-term care include the elderly and non-elderly disabled, the developmentally disabled (primarily the mentally retarded), and the mentally ill. This report focuses on long-term care services required by the elderly, generally those persons 65 years and older. Elderly persons, by virtue of their high risk of chronic illness that results in disability and functional impairment, are the primary users of long-term care in this country.

The range of chronic illnesses and conditions resulting in the need for supportive long-term care services is extensive. Unlike acute illnesses, which occur suddenly and are usually resolved in a relatively short period of time, chronic conditions are of an extended duration and may be difficult to treat medically except to maintain the status quo of the patient. Although chronic conditions occur in individuals of all ages, their incidence, especially as they result in disability, increases with age. These conditions may include heart disease, strokes, arthritis, and vision and hearing impairments. Dementia, the chronic, often progressive loss of intellectual function, is also a major cause of disability in the elderly. At least half and perhaps as many as 70 percent of patients with dementia have Alzheimer's disease, a chronic, progressive, primary neurologic degeneration of unknown cause, which increases in prevalence with advancing age and for which there is currently no effective treatment.

Long-term care services include a wide variety of health and social services provided in an institution, in the community, or in the home. Services range from medical and therapeutic services for the treatment and management of chronic illness to assistance with basic activities and routines of daily living, such as bathing, dressing, cooking, and cleaning. These services are provided by skilled personnel, such as registered nurses, therapists, and social workers, as well as other personnel, such as homemakers and home health aides. Family members and friends also play a key role in providing long-term care services. By far, the majority of long-term care services are provided by family members. Studies have estimated that between 60 and 80 percent of the care received by the impaired elderly is provided by relatives and friends who are not compensated for the care they provide.

Based on the projected growth of the elderly population and current utilization patterns of institutional and community long-term care services, major increases in the demand for long-term care can be anticipated for the future. Today approximately 1.3 million elderly persons are residents of nursing homes. This is about 5 percent of the total elderly population. In addition, for every person 65 years of age and over residing in a nursing home, there are twice as many persons living in the community requiring the various kinds of care provided in an institution. Studies show significant increases in the number of disabled elderly residing in nursing homes and in the community for the future. The nursing home population might be as high as 4.4 million persons by the year 2040, and the disabled elderly population living in the community might include 14.4 million persons by that time.

Expenditures for long-term care services, and especially for nursing home care, strain the budgets of public programs, as well as private resources. In 1986, total national nursing home expenditures of \$38.1 billion were financed

about equally by public programs and private sources of payment. Public programs financed \$18.1 billion of the total, and private sources \$20.0 billion. Of total private spending for nursing home care in 1986, less than 2 percent was paid by private insurance coverage. Ninety-seven percent of the total private spending for nursing home care was paid directly by the consumer out-of-pocket. The average annual cost of nursing home care is in the range of \$20,000 to \$25,000 per year, representing a catastrophic expenditure beyond the financial reach of most elderly.

At least 80 Federal programs assist persons with long-term care problems, either directly or indirectly through cash assistance, in-kind transfers, or the provision of goods and services. Among these 80 programs, five are generally considered to be the major programs of Federal support for long-term care and these are discussed in detail in this report: Medicaid, Medicare, the Social Services Block Grant (SSBG), the Older Americans Act, and the Supplemental Security Income program (SSI). It should be noted that there are a large number of other Federal programs providing services such as specialized housing and transportation services to the functionally disabled elderly. In addition, numerous long-term care benefits are offered to veterans through the Veterans Administration (VA). No one program, however, has been designed to support a full range of long-term care services on a systematic basis.

The Medicare program is intended to address the acute medical care needs of the aged and disabled. The program was not designed to respond specifically to the chronic care needs of the elderly, for instance those with Alzheimer's disease, over a sustained period of time. For this reason, it offers only very limited protection against the costs of nursing home care and home care.

The Medicaid program, on the other hand, does support long-term services, principally nursing home care, but only for certain low-income people or for persons who have depleted their income and assets. The Medicaid program financed 41.5 percent, or \$15.8 billion, of the Nation's total expenditures for nursing home care in 1986. This total also represented nearly 90 percent of public spending for nursing home care.

Observers have noted that Medicaid's eligibility policies and benefit structure have actually created financial incentives to use nursing homes rather than community services. In general, Medicaid support for the chronically impaired elderly living in the community has been quite limited. In addition, certain elderly poor who are ineligible for Medicaid while living in the community may become eligible once they enter a nursing home, because the State has a higher income eligibility standard for nursing home residents. Others become eligible for Medicaid once they deplete their resources after entering the nursing home as privately paying patients.

While the Medicaid program is the predominant Federal program supporting long-term care services, two Federal social service programs provide community-based services which may prevent or delay institutionalization--the SSBG program and the Older Americans Act. However, their total resources are small in comparison with total Medicaid expenditures devoted to both institutional and community-based long-term care services. The SSBG program is generally limited to the provision of social services selected and defined by the State, and provides services not only to the elderly, but also to families and children. Funding under title III of the Older Americans Act is used for the development of a service delivery system for older persons, focusing on social and nutrition services, and in the 100th Congress, separate funding for in-home services for the frail elderly was authorized.

In addition to these programs, the SSI program provides cash assistance to needy aged, blind, disabled individuals, but can include, at the discretion of the States, supplemental payments to support selected community-based long-term care services.

While these various Federal programs supporting long-term care provide a measure of flexibility to target services on specific groups or needs, their differing eligibility requirements, service benefits, service definitions, and reimbursement policies have resulted in a fragmented and uncoordinated long-term care policy at the Federal level. In addition, this lack of coordination among Federal programs has also presented major implementation challenges to the States, especially where certain of these programs delegate administrative responsibility to State governments.

The following chart summarizes some of the major differences among Federal programs which support institutional and community-based care.

Major Federal Programs Supporting Long-Term Care Services:  
Services Covered, Eligibility, and Administering Agency

Program	Services covered	Eligibility	Administering agency	
			Federal	State
Medicaid/Title XIX of The Social Security Act	<p>Skilled nursing facility <u>a/</u> Intermediate care facility <u>b/</u> Home health <u>c/</u> Adult day care <u>b/</u> Personal care <u>b/</u></p> <p>Section 2176 waiver services, e.g., case management, homemaker, personal care, adult day care, habilitation, respite, and other services at State option <u>d/</u></p>	<p>Aged blind, disabled persons receiving cash assistance under SSI; others receiving cash assistance under AFDC. At State option, persons whose income exceeds standards for cash assistance under SSI/AFDC, i.e., the "medically needy."</p> <p>Aged, blind, disabled, or mentally ill Medicaid eligibles (including children) living in the community who would require nursing home level of care. At State option, persons living in the community with higher income than normally allowed under a State Medicaid plan.</p>	Health Care Financing Administration/HHS	State Medicaid agency
				In some cases, the 2176 "waiver" program may be administered by another agency, e.g., State agency on aging.

See footnotes at end of chart.

Major Federal Programs Supporting Long-Term Care Services:  
 Services Covered, Eligibility, and Administering Agency (cont'd)

Program	Services covered	Eligibility	Administering agency	
			Federal	State
Medicare/Title XVIII of the Social Security Act	100 days of skilled nursing care facility Home health Hospice	Generally Social Security status. Persons 65 years and over; persons under 65 years entitled to Federal disability benefits; and certain persons with end-stage renal disease.	Health Care Financing Administration/HHS	N/A
Social Services Block Grant/Title XX of the Social Security Act	Variety of social services as defined by the State, including homemaker, home health aide, personal care, home-delivered meals, and adult day care.	No Federal requirements. States may require means tests.	Office of Human Development Services/HHS	State social services/human resources agency. In some cases other State agencies may administer a portion of title XX funds for certain groups e.g., State agency on aging

See footnotes at end of chart.

Major Federal Programs Supporting Long-Term Care Services:  
 Services Covered, Eligibility, and Administering Agency (cont'd)

Program	Services covered	Eligibility	Administering agency	
			Federal	State
Older Americans Act/Title III	Variety of social services as determined by State and area agencies on aging with priority on in-home services. Also case management, day care, protective services. Separate appropriation for home-delivered meals/ and for in-home services for the frail elderly, including adult day care as a respite for families, and minor home modifications.	Persons 60 years and over. No means tests, but services are to be targeted on those with social or economic need.	Administration on Aging/Office of Human Development Services/HHS	State agency on aging

See footnotes at end of chart.

Major Federal Programs Supporting Long-Term Care Services:  
Services Covered, Eligibility, and Administering Agency (cont'd)

Program	Services covered	Eligibility	Administering agency	
			Federal	State
Supplemental Security Income/ Title XVI of the Social Security Act	Federal income support. Maximum Federal payment for persons with no income is \$354 per individual and \$532 per couple in 1988. Supplemental payment for non-medical housing and/or in-home services, at State option.	Aged, blind, disabled persons who meet federally established income and resources requirements. States may make payments to other State-defined eligibility groups.	Social Security Administration/ HHS	State supplemental payment program may be State or federally administered.

a/ Required for individuals over age 21.

b/ At option of State.

c/ Required for individuals entitled to skilled nursing home care.

d/ May be offered under a waiver of certain Medicaid State plan requirements, if requested by the State and approved by HHS.

Policymakers have also been concerned about striking the right balance between nursing home care services and home and community-based long-term care services. By far the largest portion of public expenditures for long-term care is for nursing home care, with the Medicaid program accounting for nearly 42 percent of total national spending for nursing home care. Other programs, such as the SSBC and the Older Americans Act, while providing a range of community-based long-term care services, have comparatively limited funding to provide a

balance to the enormous institutional support provided through the Medicaid program. Long-term care reform in the past, therefore, has included efforts to reduce inappropriate institutionalization of the chronically ill by creating programs to assure that those referred for institutional care actually need such care and by increasing the availability of community-based care services, such as home care and adult day care services.

Various Federal research and demonstration projects have attempted to test new ways of providing and coordinating long-term care services. Some of these projects have led to the National Long-Term Channeling Demonstration program by the Department of Health and Human Services (DHHS). With nursing home care representing a substantial portion of public and private expenditures for long-term care, these research and demonstration efforts have had the following objectives: (1) to reduce the cost of long-term care by reducing inappropriate institutionalization and the demand for institutional care by persons who could otherwise be served through community-based services at less cost; (2) to test whether a carefully managed system of care would create more efficient use of existing services and deter unnecessary institutionalization; and (3) to make available to clients a wider range of community-based services than previously existed. At best, the demonstrations have had mixed results in terms of overall costs savings, reductions in the use of institutional care, and effects on client functioning. Based on the weight of evidence emerging from the enormous amount of research which has been conducted on the effects of community-based care, many analysts have come to the conclusion that these services were oversold as a cost-effective alternative to institutional care. Analysts and service providers alike are increasingly recognizing that expanded community care services may in fact be needed by a broader group of elderly persons who need help to remain in their homes. These services may result in

additional expenditures for a functionally impaired population and this expansion may represent an appropriate response to the needs of a changing population.

Another major research and demonstration initiative of DHHS currently underway is the social/health maintenance organization (S/HMO). This project builds upon and extends the health maintenance organization model, where health care services are offered to a defined population on a pre-paid capitation basis. The S/HMO provides not only conventional health care services to a group of elderly persons but also provides a range of long-term care services including nursing home care, home health, and homemaker services. Among the questions to be addressed by this demonstration are whether a consolidated pre-paid system of acute and long-term care can produce greater savings than conventional HMOs already serving Medicare beneficiaries, and whether the long-term care services offered through the program will reduce nursing home admissions and the number of persons who become eligible for Medicaid's nursing home benefit.

Uncertainty about the potential costs of expanded community-based care, and intervening concern about budget deficits and increasing expenditures under entitlement programs which currently finance long-term care, have shifted the focus of the long-term care debate from concern almost exclusively with reform of Federal programs to consideration of private sector initiatives which might relieve fiscal pressures on public programs. In addition, these private sector alternatives are believed to offer potential protection against the private catastrophic expenses that can result from a need for long-term care. Some of the private sector options advanced as feasible alternatives for financing long-term care include private health insurance, life care communities, and home equity conversion. Not discussed in this report are

other options often suggested as alternative financing mechanisms for long-term care, including the various tax code amendments proposed to provide savings incentives for long-term care and others to assist families to continue providing long-term care services.

The private sector option receiving the most attention recently is private insurance for long-term care. The private long-term care insurance market has been a rapidly growing one, with over 70 companies writing policies covering over 420,000 persons. A number of barriers have been cited as impediments to the development of meaningful long-term care insurance policies, such as the potential for adverse selection (where only persons more likely to need long-term care buy insurance) and induced demand (where individuals decide to use more services because they have insurance and/or will shift from non-paid providers, such as family members, to paid providers of care). Despite these problems, insurance companies are writing more policies with broader coverage and benefits. Currently there is interest in increasing the affordability of premiums for long-term care insurance through employer-based group coverage and through mechanisms designed to limit liability of the insurance company for long-term nursing home costs.

Life care communities, also called continuing care retirement communities, are living arrangements available to a limited but potentially growing number of older persons. Such communities are established to provide housing, meals, housekeeping, and certain long-term care services, as necessary, to older persons for the duration of their lives. Older persons enter into a contractual agreement which sets forth the services to be received by the resident in exchange for financial payments, including an entrance fee and monthly payments. The precise number of existing life care communities is difficult to obtain due to issues in the definition for life care. However,

one source estimates about 683 communities and some estimates are higher. Various analysts indicate the number is expected to grow in the future. Supporters of this concept indicate that a life care contract provides financial protection against the future costs of long-term care and offers a protective living arrangement for persons whose needs will increase over time. However, because of the substantial fees required for entrance and on a monthly basis, some analysts believe this option may be available to only a limited proportion of the elderly population.

Home equity conversion contracts, in which older persons use the equity in their homes to finance certain expenses, have also been advanced as a means to finance certain long-term care services. While substantial numbers of elderly persons have accumulated equity in their homes, to date only a very limited number of home equity conversion contracts have been negotiated.

Observers have pointed out that the economic status of future generations of the elderly may improve to the extent that they will be able to finance, through risk pooling arrangements, at least a portion of their long-term care expenses themselves, without resorting to the impoverishment currently required under Medicaid to qualify for that program's nursing home benefit. In addition, others have noted that public programs will simply not be able to support expanded long-term care services in the future as the ratio of workers to retirees declines and as the number of the very oldest segment of the population increases. For the time being, however, these options appear to provide only limited opportunities for alternative financing schemes for long-term care. In addition, they seem to have only limited applicability for the large numbers of elderly who are poor or may be poor in the future.

## I. WHAT IS "LONG-TERM CARE?"

The phrase "long-term care" refers to a wide array of medical, social, personal, supportive, and specialized housing services needed by individuals who have lost some capacity for self-care due to chronic illness or physical or mental conditions which result in both functional impairment and physical dependence on others for an extended period of time. Major subgroups of individuals needing long-term care include the elderly and non-elderly disabled, the developmentally disabled (primarily the mentally retarded) and the mentally ill. This report focuses on long-term care services required by the elderly. Elderly persons, by virtue of their high risk of chronic illness that results in disability and functional impairment, are the primary recipients of long-term care in this country. <sup>1/</sup>

The range of chronic illnesses and conditions resulting in the need for supportive long-term care services is extensive. Unlike acute illnesses, which occur suddenly and are usually resolved in a relatively short period of time, chronic conditions are of an extended duration and may be difficult to treat medically except to maintain the status quo of the patient. Although chronic conditions occur in individuals of all ages, their incidence,

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<sup>1/</sup> Doty, Pamela, Korbin Liu and Joshua Wiener. An Overview of Long-Term Care. Health Care Financing Review, v. 6, no. 3, spring 1985. p. 69.

especially as they result in disability, increases with age. 2/ These conditions may include heart disease, strokes, arthritis, and vision and hearing impairments. Dementia, the chronic, often progressive loss of intellectual function, is also a major cause of disability in the elderly. 3/ At least half and perhaps as many as 70 percent of patients with dementia have Alzheimer's disease, a chronic, progressive primary neurologic degeneration of unknown cause, which increases in prevalence with advancing age and for which there is currently no effective treatment. 4/

The presence of a chronic illness or condition alone does not necessarily result in a need for long-term care. For many individuals, their illness or condition does not result in a functional impairment or dependence and they are able to go about their daily routines without major hindrance or need for assistance. 5/ It is when the illness or condition results in a functional or activity limitation that long-term care services may be required. Limitations can vary in severity and prevalence. For example, a chronic condition may result in dependence in certain basic self-care functions such as bathing, dressing, eating, toileting, and/or mobility from one place to another. These are referred to as limitations in "activities of daily living" (ADLs). A second set of measures reflecting lower levels of disability in the performance of a daily routine are often referred to as limitations in

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2/ Rice, Dorothy and Carroll Estes. Health of the Elderly: Policy Issues and Challenges. Health Affairs, v. 3, no. 4, winter 1984. p. 29.

3/ Rowe, John. Health Care of the Elderly. New England Journal of Medicine, v. 312, no. 13, Mar. 28, 1985. p. 831.

4/ Ibid.

5/ Long Term Care: Background and Future Directions. Health Care Financing Administration, Department of Health and Human Services, Jan. 1981, HCFA 81-20047. p. 4.

This report discusses the financing of long-term care services, and especially the extent to which various Federal programs cover and fund these services. It also describes various proposals that have been advanced as alternative private financing schemes for long-term care.

"instrumental activities of daily living" (IADLs). <sup>6/</sup> These include such functions as shopping, cooking, cleaning, managing money, and taking medicine. For example, certain individuals may not have limitations in basic self-care functions, but may not be able to clean or shop without some kind of assistance. Other individuals may suffer from a chronic condition or multiple conditions resulting in limitations in both ADLs and IADLs and therefore require a number of specific long-term care services.

Long-term care services include medical, therapeutic, and social services for the treatment and management of chronic illnesses and conditions, and often these are provided by skilled personnel such as registered nurses, therapists, and social workers. They also include assistance with bathing, grooming, housekeeping, cooking--the ADLs and IADLs mentioned above--and these services are often provided by other personnel, such as homemakers, home health aides, as well as volunteers, and family and friends.

Services can be provided in institutions (generally nursing homes), in the community, or in the home. Long-term care services can be provided formally through agencies or organizations that are paid for their services, or informally by family or friends who offer assistance without compensation of any kind. By far the great majority of long-term care services are provided by family or friends.

The projected growth of the elderly population, combined with large and increasing Federal and other public expenditures for long-term care services, especially nursing home services, has generated a great deal of legislative interest in altering the way in which long-term care services are financed.

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<sup>6/</sup> Liu, Korbin and Kenneth Manton. Disability and Long-Term Care. A paper presented at the Methodologies of Forecasting Life and Active Life Expectancy Workshop. Bethesda, Maryland, June 25-26, 1985.

family and friends meet all the needs of the elderly long-term care population and what their role will be in the future.

This section provides information about certain demographic and income characteristics of the elderly population. It also presents findings of studies that estimate potential future utilization of long-term care services.

A. Growth of the Elderly Population

The aging of the Nation's population has dramatic implications for projections of need for long-term care services. The elderly population has grown much more rapidly in this century than has the remainder of the population. As table 1 shows, from 1900 to 1950, the total population doubled in size while the population aged 65 and over increased by 4 times; from 1950 to 1980, when the total population increased by 50 percent, the aged population doubled in size, to 25.5 million. Between 1980 and the year 2020, the total population is projected to increase by slightly more than 30 percent, while the elderly population is projected to more than double again. By 2020, the projected elderly population will be 51.4 million, and by 2040, it will increase by 30 percent to almost 67 million.

## II. SELECTED CHARACTERISTICS OF THE ELDERLY AND MEASURING THEIR NEED FOR LONG-TERM CARE

The need for long-term care services in the future--and the role of public programs in financing these services--will depend on a number of factors. These include demographic changes in the Nation's population, levels of disability, medical advances in the prevention and treatment of chronic conditions, and economic conditions which affect an individual's ability to pay for services, to name a few. Estimating the dimension of the need for long-term care is a difficult but critical task for policymakers.

Large and increasing amounts of public dollars already finance long-term care services, and proposals to reform the way public programs pay for this care are certain to have significant budgetary impact. However, it is difficult to estimate the extent of this impact. One of the principal reasons for this difficulty is the problem in estimating utilization of long-term care services in the future. For example, medical advances may result in the prevention of certain chronic conditions, or simply in incremental improvements in their management. Medical and scientific advances could also lead to reductions in general mortality which would result in increases in the size of the potential long-term care population. In addition, family and friends provide the bulk of long-term care services used by chronically disabled elderly living in the community and do so without charge to any public or private program. It is difficult to assess whether services provided by

TABLE 1. Size of the Elderly Population, 1900 to 2020  
(in thousands)

Year	Total U.S. population	65+		85+		Aged support ratio*
		No.	%	No.	%	
1900	76,303	3,084	4.0	123	0.2	7.6
1950	150,697	12,270	8.1	577	0.4	13.7
1980	226,505	25,544	11.3	2,240	1.0	18.6
2000	267,955	34,921	13.0	4,926	1.8	21.6
2020	296,597	51,422	17.3	7,081	2.4	29.3
2040	308,559	66,988	21.7	12,834	4.2	38.7

\* Ratio of 65+ plus population to working age population, 19-64 years, multiplied by 100.

Source: U.S. Department of Commerce. Bureau of the Census. Decennial Censuses of Population 1900-1980 and Projections of the Population of the United States by Age, Sex, and Race: 1983 to 2080 (Advance Report). Current Population Reports, Series P-25. No. 952. May 1984. Projections are middle series.

As a result of the rapid increase in the elderly population, their proportion of the population increased from 4.0 percent in 1900 to 11.3 percent in 1980; this is expected to increase to 17.3 percent by 2020. At the same time, the number of elderly in comparison to the number of persons in the working age population (persons aged 19-64) has increased substantially. The aged support ratio (that is, the ratio of the 65+ population to the working age population 19-64 years) increased from 7.6 in 1900 to 18.6 in 1980 and is expected to increase to 29.3 by 2020, and to 38.7 by 2040. This means that there will be fewer workers to support an aged population.

Despite the overall growth in the 65-plus group, the most critical demographic factor with implications for the future of long-term care service utilization is the startling pace of increase in the oldest segment of society. The "old-old," persons 85 and over, are currently one of the fastest growing

age groups in the U.S. population and, among the elderly, are at greatest risk of needing and using long-term care services. This group represented only 0.2 percent of the total population in 1900, but increased to 1.0 percent in 1980; by 2020, it is projected to be 2.4 percent of the population, and nearly 14 percent of the elderly population (up from about 9 percent in 1980). By 2040, the old-old group is expected to be 4.2 percent of the population, 6 times as large as it was in 1980.

## B. Economic Characteristics of the Elderly

### 1. Income and Poverty Rates

In 1986, the median income of families headed by persons 65 or older was \$19,932; the median income of an unrelated individual in the same age group was \$7,731. This compares to \$29,458 for all families and \$12,116 for all unrelated individuals. <sup>7/</sup> Data from the 1980 Census of Population and Housing show that the cash income of the elderly is lower in each older age group. Married couples with a head aged 65-69 had a median income of \$18,400, compared to \$11,200 for those 85 and over. Men aged 65 to 69 and living alone had a median income of \$8,200, while those 85 and over had incomes of \$6,000; the comparable figures for women living alone were \$6,800 and \$5,200, respectively. <sup>8/</sup>

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<sup>7/</sup> U.S. Bureau of the Census. Current Population Reports. Series P-60, no. 157. Money Income and Poverty Status of Families and Persons in the United States: 1986 (Advance Data from the March 1987 Current Population Survey). U.S. Govt. Print. Off., Washington, D.C., 1987. p. 14.

<sup>8/</sup> U.S. Bureau of the Census. 1980 Census of Population and Housing. Public Use Microdata Sample. Special tabulations.

The poverty rates for the elderly have shown a dramatic decline over the last 25 years. In 1959, the poverty rate for the elderly was 35.2 percent and by 1984 the rate had fallen to 12.4 percent, the lowest rate ever recorded for that group. In addition, from 1982 to 1986, the poverty rates among the elderly population in general have been lower than those for the rest of the population. In 1986, 12.4 percent of those 65 and over were poor compared to 13.6 percent for the entire population. (In 1986, the estimated poverty threshold for persons 65 years and over living alone or in households with no other family members was \$5,255, and for two person families whose head was 65 years and over, it was \$6,630.)

The aggregate poverty rates, however, mask important differences within the remainder of the population and within the elderly population. For example, the rate for the entire population is inflated by the very high rates of poverty among children. While the overall rate for the total population was 13.6 percent, the poverty rate for children under 18 years was 20.5 percent as compared to 10.2 percent for the adult population aged 22-64 years. <sup>9/</sup>

With respect to elderly population, specific groups are at substantially greater risk of poverty, including the very old, female-headed households, and minority and ethnic groups. Poverty rates increase sharply with age; in 1986, the rate for persons aged 85 and over was 17.6 percent, nearly 2 times higher than the rate for those 65 to 74 years which was 10.3 percent. <sup>10/</sup> Households with female heads over 65 years had a poverty rate of 23.1 percent, almost twice as high as the overall elderly poverty rate. Older minority groups are particularly disadvantaged. For example, in 1986, the poverty rates for black

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<sup>9/</sup> Money Income and Poverty Status of Families and Persons in the United States: 1986. p. 30.

<sup>10/</sup> U.S. Senate. Special Committee on Aging. Aging America, Trends and Projections. 1987-88 ed. Washington, D.C. p. 44.

and Hispanic elderly were 31 percent and 26.5 percent, respectively. Older minority women have significantly higher rates of poverty than other groups. Households with black or Hispanic female heads over 65 years had poverty rates of 45 percent and 38.9 percent, respectively, in 1986. 11/

## 2. Net Worth

In 1984, the net worth of the elderly (including equity in their homes and automobiles as well as other financial assets and subtracting any debt) varied by age group. Households with heads aged 65 to 69 on average had greater net worth (\$66,600) than households with heads 70 to 74 (\$60,600), or households 75 and over (\$55,200). The age group that will become elderly in the next decade, those 55 to 64, had a higher level of net worth (\$73,700) than their immediate seniors, and also a higher level than younger age groups (\$56,800 for those 45 to 54 and \$35,600 for those 35 to 44). 12/ Beginning with those aged 55 to 64, an increasing share of net worth is in the form of home equity. This ranges from just over 50 percent of net worth among those aged 55 to 64 to 57 percent among those 75 and over.

## 3. Future Resources

A number of sources indicate that in the future, the new elderly will have increasingly higher incomes and assets. These predictions may have implications for the ability of the elderly to finance long-term care. Median income

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11/ Money Income and Poverty Status of Families and Persons in the United States: 1986. p. 24-26.

12/ U.S. Bureau of the Census. Current Population Reports. Series P-70, no. 7. Household Wealth and Asset Ownership: 1984 (Data from the Survey of Income and Program Participation). U.S. Govt. Print. Off., Washington, D.C., 1986. p. 19.

among the elderly as a whole has been projected to rise (controlling for inflation) from 10 to 20 percent from 1980 to 1995 (assuming 1.0 to 1.5 percent average annual growth in income among the general population). <sup>13/</sup> Under the same growth assumptions, income among persons aged 55 to 64 is projected to increase from between 15 and 20 percent in the same period. Asset levels are even more difficult to project, but because of the improved historical personal economic experiences of the future aged who have lived through the post-World War II prosperity, some anticipate that their levels of resources will be considerably greater than past generations of elderly. <sup>14/</sup> Other factors which will affect the economic status of the younger elderly as well as those who will become elderly in the coming decades have been cited as likely to have positive effects on future financial improvements for these groups as compared to their earlier counterparts. These include higher wage levels, broader pension coverage, and higher labor force participation among married women. <sup>15/</sup>

Although the relative well-being (measured with income and assets) of the future elderly may on average be greater than that of recent generations of elderly, there will also continue to be large differences among the various groups of the elderly. Some of the differences will be the same as those described above, based either on lifetime differences of individuals or on sudden or gradual changes in family status or available sources of income and assets. Even if poverty rates are substantially lower than they currently

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<sup>13/</sup> U.S. Bureau of the Census. Current Population Reports. Series P-60, no. 122. Illustrative Projections of Money Income Size Distributions for Households: 1980 to 1995. U.S. Govt. Print. Off., Washington, D.C., 1980. Series C. 1.0 and 1.5 percent growth in household income.

<sup>14/</sup> Etheredge, Lynn. An Aging Society and the Federal Deficit. Milbank Memorial Fund Quarterly/Health and Society, v. 62, no. 4, 1984. p. 527-528.

<sup>15/</sup> Ycas, Martynas and Susan Grad. Income of Retirement-Aged Persons in the United States. Social Security Bulletin, v. 50, no. 7, July 1987. p. 14.

are, there may be more poor elderly than there are now, because of the increasing numbers of elderly people. For example, if the poverty rate among the elderly drops 20 percent by the year 2000, to 10.0 percent (from the 1986 level of 12.4 percent), there would still be 3.5 million poor elderly--about the same number as there were in 1986. If poverty rates were to remain constant, there would be 4.3 million poor elderly in 2000. Thus, these demographic and income factors may continue to exert pressure on public sector long-term care programs.

C. Utilization of Institutional and Community-Based Long-Term Care Services

1. Utilization of Nursing Home Care

Based on the projected growth of the elderly population and current utilization patterns of institutional and community long-term care services, major increases in the demand for long-term care can be anticipated for the future. In 1985, the National Nursing Home Survey, conducted by the National Center for Health Statistics, found approximately 1.3 million elderly persons residing in nursing homes. <sup>16/</sup> Elderly nursing home residents accounted for 88 percent of total nursing home residents. They amounted to 5 percent of the Nation's total elderly population 65 years of age and over.

When the elderly nursing home population is examined by age category, residents aged 85 and over comprised the largest age group (45 percent), followed by those 54 years of age (39 percent) and those 65-74 (16 percent).

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<sup>16/</sup> Use of Nursing Homes by the Elderly: Preliminary Data from the 1985 National Nursing Home Survey by Esther Hing. Advance Data from Vital and Health Statistics. no. 135. DHHS Pub. No. (PHS) 87-1250. U.S. Department of Health and Human Services. Public Health Service. National Center for Health Statistics. Hyattsville, MD., May 14, 1987. p. 2.

See table 2. Elderly nursing home residents are also predominantly female. Almost 75 percent of elderly residents were female in 1985. The use of nursing homes increases with age for both males and females, but women used nursing homes at significantly higher rates than men regardless of age group and especially at the very oldest age category. This greater rate of utilization by elderly women reflects their longer life expectancy and the greater likelihood of persons without spouses and in poor health to enter nursing homes. 17/

TABLE 2. Number, Percent Distribution and Rate of Nursing Home Residents 65 Years of Age and Over By Age and Sex, United States 1985

Age, sex	Number of residents	Percent distribution	Number of residents per 1,000 population 65 years and over
<b>Total</b>	1,318,300	100.0%	46.2
<b>Age</b>			
65-74 years	212,100	16.1	12.5
75-84 years	509,000	38.6	57.7
85 years and over	597,300	45.3	220.3
<b>Sex</b>			
<b>Male--total</b>	334,400	25.4	29.0
65-74 years	80,600	6.1	10.8
75-84 years	141,300	10.7	43.0
85 years and over	112,600	8.5	145.7
<b>Female--total</b>	983,900	74.6	57.9
65-74 years	131,500	10.0	13.8
75-84 years	367,700	27.9	66.4
85 years and over	484,700	36.7	250.1

Source: Unpublished data from the 1985 National Nursing Home Survey. National Center for Health Statistics. Due to rounding, numbers may not add to totals.

The number of elderly residents in nursing homes increased 17 percent from 1977 (the time of the last National Nursing Home Survey) to 1985. Those 85 years of age and over accounted for 76 percent of the increase in elderly residents from 1977 to 1985. 18/ One study has estimated that the elderly nursing home population will grow to 2 million by the year 2000, to 2.8 million by the year 2020, and to nearly 4.4 million by the year 2040. 19/

The 1985 National Nursing Home Survey found that most elderly nursing home residents required assistance with basic ADLs. As discussed above, limitations in ADLs reflect dependence in such self-care functions as bathing, dressing, eating, etc. In 1985, 91 percent of elderly residents of nursing homes required assistance in bathing; 78 percent required assistance in dressing; 63 percent required assistance in using the toilet room; 63 percent required assistance in transferring from a bed or chair; 55 percent were incontinent; and 40 percent required assistance in eating. 20/

In general, elderly nursing home residents were more dependent in performing these ADLs in 1985 than in 1977. A larger proportion required assistance or had difficulty with bathing, using the toilet room, continence, and eating in 1985 than in 1977. This can be explained in part by the increasing number and proportion of very old persons (85 and over) residing in nursing homes in 1985. 21/ However, the proportion of residents functionally dependent in each ADL was generally higher in 1985 than in 1977 when age was held constant. 22/ This might be the result of various State screening

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18/ Ibid.

19/ Manton, Kenneth and Korbin Liu. The Future Growth of the Long-Term Care Population: Projections Based on the 1977 National Nursing Home Survey and the 1982 Long-Term Care Survey. Unpublished paper, 1984. p. 20.

20/ Use of Nursing Homes by the Elderly, p. 4.

21/ Ibid.

22/ Use of Nursing Homes by the Elderly, p. 5.

programs that have attempted to control expenditures for nursing home care by limiting placement in nursing homes to those with the greatest functional dependencies. See chapter III, Part C of this report for more information about these programs, generally referred to as preadmission screening programs.

Analysis of nursing home utilization for those persons actually entering a nursing home has found a high degree of variance in their lengths-of-stay. In general, analysis has found two broad categories of persons using nursing home care--those who have short lengths of stay and those with long stays. One model developed with data from two previous National Nursing Home Surveys found that long-stayers stay an average of 2.5 years, and short-stayers an average of 1.8 months. <sup>23/</sup> Other analysis has estimated that the great majority of persons entering a nursing home stay for relatively short periods of time. This analysis shows that 75 percent of persons entering a nursing home stay less than one year, and one-third to one-half of all entrants stay less than 3 months. Few persons entering a nursing home--14 to 17 percent--stay more than 3 years. <sup>24/</sup>

## 2. Utilization of Home and Community-Based Care

For every person 65 years of age and over residing in a nursing home, there are at least twice as many persons living in the community requiring assistance with limitations in various ADLs and IADLs. The 1984 National Health Interview Survey, conducted by the National Center for Health

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<sup>23/</sup> Keeler, Emmett, Robert Kane, and David Solomon. Short- and Long-Term Residents of Nursing Homes. *Medical Care*, Mar. 1981, v. XIX, no. 3. p. 365.

<sup>24/</sup> Cohen, Marc, Eileen Tell, and Stanley Wallack. The Lifetime Risks and Costs of Nursing Home Use among the Elderly. *Medical Care*, v. 24, no. 12, Dec. 1986. p. 1169.

Statistics, provides information about this functionally dependent elderly population living in the community. Specifically, the survey included a special questionnaire, the Supplement on Aging (SoA), to provide information on the physical limitations, chronic conditions, use of community services, and living arrangements of elderly persons residing in the community.

The SoA sought to measure functional limitations in two ways. First, it asked persons if they had difficulty performing ADLs, as well as other home management activities that reflect lower levels of disability if a limitation is present. These home management activities, referred to as IADLs, include such functions as cleaning, cooking, and shopping. As noted above, the presence of a functional limitation does not necessarily result in the need for a long-term care service. For this reason, the SoA asked a second set of questions to determine whether persons received help with their limitations. Persons receiving help with their functional limitations are a subset of those persons who have difficulty with an activity, and, according to SoA, might be a better measure of functionally-limited persons living in the community. <sup>25/</sup>

The SoA found that about 6 million elderly noninstitutionalized persons had difficulty performing ADLs. These individuals amounted to 23 percent of the elderly population living in the community. Of these persons, about 2.5 million, or 10 percent of all noninstitutionalized elderly persons, received help with their limitations. By the SoA standard, these persons might be considered the ADL functionally-limited population living in the community.

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<sup>25/</sup> Dawson, D., G. Hendershot, and J. Fulton, Aging in the Eighties: Functional Limitations of Individuals Age 65 years and Over. Advance Data from Vital and Health Statistics, no. 133. DHHS Pub. No. (PHS) 87-1250. Public Health Service. National Center for Health Statistics. Hyattsville, MD. June 10, 1987. p. 5.

The SoA also found that about 7 million, or 27 percent, of the noninstitutionalized elderly had difficulty performing home management IADLs. About 22 percent of these persons received help with these activities. 26/

Another survey, the National Long-Term Care Survey, also provides information about the functionally impaired elderly population living in the community, the assistance they receive for their limitations, as well as who pays for this assistance and how much it costs. The National Long-Term Care Survey, administered in 1982 and 1984, identified elderly Medicare enrollees who were living in the community and who were functionally impaired in ADLs or IADLs for at least 3 months. The SoA, by way of contrast, did not limit its sample to persons who experienced a functional limitation for a given period of time.

Analysis of 1982 survey data shows that an estimated 4.6 million elderly persons were living in the community with limitations in ADLs and IADLs of at least 3 months' duration. 27/ These persons represented 18 percent of the elderly population. Of this total, approximately 1.4 million persons had IADL limitations only. The remaining 3 million had limitations in ADLs, with 1.5 million persons having limitations in 1 to 2 ADLs, 683,000 having limitations in 3 to 4 ADLs, and 849,000 having limitations in 5 to 6 ADLs. 28/ Based on the 1982 survey findings, the same authors estimate that the population with these ADL and IADL limitations will increase to nearly 7.3 million by the year 2000, to 10.1 million by the year 2020, and to 14.4 million by the year 2040.

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26/ Dawson, et. al., Aging in the Eighties. p. 5-6.

27/ Liu, Korbin, Kenneth Manton, and Barbara Liu. Home Care Expenses for the Disabled Elderly. Health Care Financing Review, v. 8, no. 2, winter 1985. p. 52.

28/ Ibid. These numbers do not add to the total because of the existence of unknowns in the survey.

Results of the 1982 survey also show that most of the disabled elderly living in the community received assistance for ADL and IADL problems from spouses, children, or other informal sources of support. <sup>29/</sup> Of the 4.6 million functionally limited elderly, more than 70 percent (3.2 million) relied exclusively on nonpaid sources of assistance. This finding corresponds to other research that has estimated that between 60 to 80 percent of the care received by the impaired elderly is provided by relatives and friends who are not compensated for the care they provide. <sup>30/</sup>

There is evidence that informal care giving is one of the key factors in delaying or preventing institutionalization of the frail elderly. However, the aging of the Nation's population has important implications for the availability of informal family sources of support for long-term care. Estimates from the 1982 National Long-Term Care Survey show that the average age of caregivers of the impaired elderly was 57 years. More striking is the finding that one-quarter of caregivers was aged 65-74, and 10 percent was 75 years or older. These data support the view that informal services are largely provided by the "young-old" to the "old-old." <sup>31/</sup> As the population ages, very old chronically ill parents with children who themselves are retired or chronically impaired will become more common. <sup>32/</sup> Researchers have noted that the probability of young elderly (aged 65-69) women having at least one surviving parent aged 85 or older will more than double over the next 60

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<sup>29/</sup> Ibid.

<sup>30/</sup> Long-Term Care: Background and Future Directions. Health Care Financing Administration, Department of Health and Human Services. Jan. 1981, HCFA 81-20047.

<sup>31/</sup> U.S. Congress. House. Select Committee on Aging. Exploring the Myths: Caregiving in America. Pub. no. 99-611, Jan. 1987, Washington, D.C.

<sup>32/</sup> Long-Term Care: Background and Future Directions, p. 12.

years. 33/ This factor has tended to underline the need for a range of formal services which can support caregivers.

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33/ Soldo, Beth and Kenneth Manton. Health Status and Service Needs of the Oldest Old: Current Patterns and Future Trends. Milbank Memorial Fund Quarterly/Health and Society, v. 63, no. 2, spring 1985. p. 310.

### III. PUBLIC SECTOR PROGRAMS FOR FINANCING AND DELIVERY OF LONG-TERM CARE SERVICES

Implicit in any discussion of long-term care policy is the fact that large amounts of public dollars currently finance long-term care services, and that even greater amounts will be spent in the future as the elderly population, especially the very old, increases. It is not easy to aggregate spending data for the various Federal, State, and local programs that support nursing home and non-institutional long-term care services. At least 80 Federal programs alone assist persons with long-term care problems, either directly or indirectly through cash assistance, in-kind transfers, or the provision of goods and services. In addition, differences in definitions of services to be included in long-term care and inconsistent reporting across programs make aggregation of expenditure data very difficult, if not impossible.

However, it is generally agreed that most of the public sector's support for long-term care services is for nursing home or other institutional care. In 1986, the Nation spent \$38.1 billion for nursing home care, accounting for 9.4 percent of total personal health care expenditures. Approximately 47 percent of the Nation's expenditures for nursing home care, or \$18.1 billion, was financed by Federal, State, and local governments.

By far the largest portion of public expenditures for nursing home care is financed by the Medicaid program for the poor and medically indigent. In

1986, Federal, State, and local Medicaid expenditures for nursing home care amounted to \$15.8 billion. This represented 41.5 percent of total national spending on nursing home care and 87 percent of public spending for nursing home care in 1986. 34/

Medicaid's expenditures for nursing home care also represented a significant portion of total program spending. Medicaid program data show that payments for nursing home care (excluding nursing homes for the mentally retarded) amounted to 30 percent of total program spending for services in FY 1986. In addition, the aged accounted for the great majority of nursing home payments in the Medicaid program. Eighty percent of Medicaid's payments for nursing home care were for elderly beneficiaries in FY 1986. Furthermore, these payments for nursing home care for the elderly represented two-thirds of all program payments made on behalf of the elderly. Nursing home payments accounted for more than 75 percent of total program payments for the elderly in 27 States in FY 1986.

It should be noted that the share of nursing home care financed by public programs has been declining since 1979, from 56 percent to 47 percent in 1985. In part, this can be explained by vigorous State efforts to control

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34/ The source for the above information is the Health Care Financing Administration's (HCFA) annual report on national health care expenditures. This report provides a useful analysis of expenditures for major categories of health services, sources of payment (out-of-pocket, private insurance, Medicare, Medicaid, and other Federal, State, and local programs) for these services, and the relative share each of these sources' payments represents of total national spending. With regard specifically to nursing home care, the HCFA analysis includes spending for all persons using this service. In the HCFA analysis, these persons include the elderly, the mentally retarded, and others. Expenditures attributable solely to the elderly cannot be isolated from the total for nursing home care. Medicaid program data, on the other hand, allows spending for Medicaid's nursing home benefit for the mentally retarded to be excluded from total nursing home spending.

expenditures for nursing home care under their Medicaid programs. <sup>35/</sup> These efforts have included limitations on the construction of nursing home beds, either through requirements to certify the need for more beds before construction can begin, or through the prohibition of construction or addition of beds altogether (often referred to as moratoriums). States have also used various forms of utilization review and pre-admission screening mechanisms to limit inappropriate use, as well as reimbursement policies to control costs per day of care provided.

By way of contrast, the Medicare program for the aged and disabled accounts for only a small portion of the Nation's expenditures for nursing home care. Medicare's expenditures amounted to \$600 million and represented less than 1.6 percent of national spending and 3.3 percent of public spending for nursing home care in 1986.

Expenditures for non-institutional community-based services are relatively small compared to spending for nursing home services. Whereas nursing home care represented a sizeable portion of total Medicaid spending for health care services in 1986, home health care accounted for only 3.3 percent of total Medicaid spending in that year and amounted to approximately \$1.35 billion. One State (New York) alone accounted for 57 percent of total Medicaid home health expenditures.

Medicare's spending for home health care benefits is also a small proportion of total program expenditures. In 1986, Medicare payments for home health care amounted to 3 percent of total program payments for covered services.

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<sup>35/</sup> Nursing Home Reimbursement under Medicaid. Intergovernmental Health Policy Project. Washington, D.C., Feb. 1986. p. 2.

While its share remains small, home health care has been one of the fastest growing components of both the Medicare and Medicaid budgets. Between 1974 and 1986, home health care expenditures under Medicare increased from \$139 million to \$2.27 billion. This represented a 26 percent average annual compound rate of growth. (It should be noted that this rate of growth has slowed considerably, recently. Between 1984 and 1985, Medicare home health care expenditures increased by 14.1 percent. Between 1985 and 1986, they increased by 4.7 percent.) Medicaid expenditures for home health have also increased rapidly--from \$31 million in 1974 to \$1.35 billion in 1986, a 37 percent average annual compound rate of growth.

While the Medicaid program is the predominant Federal program supporting long-term care services, a variety of social service programs provide community-based services which may prevent or delay institutionalization. Chief among these are the SSBG program and the Older Americans Act. While their total resources are small in comparison with total Medicaid expenditures devoted to both institutional and community-based long-term care services, in many communities these two programs represent an important source of support for services for the frail elderly and often fill gaps in service needs not met by either the Medicare or Medicaid programs.

All States provide a number of home and community-based long-term care services for diverse client groups, including children, disabled, and the elderly, through the SSBG program under title XX of the Social Security Act. Such services may include homemaker, home health aide, chore, adult day care services, and adult foster care. Due to the lack of Federal reporting requirements, very little national data are available on recipients of services and expenditures under the program. However, home-care type services for needy groups is the one service provided by almost all States.

Home care, including homemaker, chore, and personal care services, is one of the major service categories under title III of the Older Americans Act. For FY 1987, it was estimated that the program provided homemaker services to 686,000 older persons and home health aide services to 151,000 older persons. The Older Americans Act also authorizes a home-delivered meals program for homebound elderly. An estimated 86 million home-delivered meals were served to 729,000 persons under auspices of the program during FY 1987.

**A. Major Federal Programs and Activities Supporting Long-Term Care Services**

As noted above, at least 80 Federal programs assist persons with long-term care problems, either directly or indirectly through cash assistance, in-kind transfers, or provision of goods and services. These programs often respond in a manner that is problem-specific, categorical in nature, or targeted at specific client groups. For example, certain programs provide health services while excluding social services; others are oriented to the elderly to the exclusion of the younger disabled. Some programs carry income eligibility requirements, others do not.

This section describes selected Federal programs--Medicaid, Medicare, the SSBG, Older Americans Act, and SSI programs--which address the health and social services needs of the elderly. Taken together, these programs constitute the major focus of Federal financial support presently available for both community-based and institutional long-term care services. The differing characteristics of these programs reflect what some observers point out to be the uncoordinated nature of Federal support for long-term care services.

Not discussed here are a host of other Federal programs dealing with such components of the long-term care spectrum as housing, transportation, tax policy, as well as services provided through the VA. It should be noted,

however, that numerous long-term care benefits are offered to veterans through the VA, including nursing home care, domiciliary care, outpatient clinics, and adult day health services, as well as cash payments for aid and attendance for certain severely disabled veterans. Services are offered directly by the VA and are also provided on a contract basis in non-VA hospitals and community nursing homes, and on a grant basis in State veterans' home facilities. Issues surrounding the financing and delivery of long-term care services to the veteran population are of increasing concern to the VA because of the growing number of older veterans. By the year 2000, approximately 2 out of every 3 males age 65 or older will be veterans and the VA is predicting dramatic increases in the need for and utilization of various long-term care services by the veteran population.

The discussion immediately below summarizes some of the major differences of the Medicaid, Medicare, SSBG, Older Americans Act, and SSI programs in their approach to health and social services in general and long-term care in specific. This discussion is followed by a more detailed description of each of these programs.

- o PROGRAM GOALS. Medicaid is the major Federal program financing health care services for certain low income persons. While it provides health care benefits, and to a limited degree, medically-related social services, to certain eligible persons with chronic care needs, it is not designed to support the full array of long-term care services on a systematic basis. Its principal form of support for long-term care services is for nursing home care. Medicare, on the other hand, is a nationwide health insurance program for the aged and disabled and is intended primarily to address acute medical care needs. To the extent that it provides coverage for certain long-term care services, it does so with the intent of reducing the need for more intensive and expensive acute care services; the program was not designed to respond specifically to chronic care needs of the elderly over a sustained period of time. The SSBG program is designed to assist families and individuals in maintaining self-sufficiency and independence; however, the program is generally limited to the provision of community-based social services selected and defined by each State and does not support institutional care. The Older Americans Act is intended to foster the development of a broadly

defined, comprehensive and coordinated service system for the aged; however, it is limited in its ability to have a significant impact on long-term care due to its small level of resources as compared to other programs. The SSI program's purpose is to provide an income floor for needy aged, blind, and disabled individuals; it provides cash payments but not services.

- o ADMINISTRATIVE AUTHORITY AND FINANCING MECHANISMS. The Medicare program is administered and financed at the Federal level with uniform national standards. The Medicaid, SSBG, and Older Americans Act programs are shared Federal-State programs with States responsible for implementation of Federal legislation and regulations. The SSI program is administered at the Federal level but allows States to augment the Federal SSI payment and this portion of the program may be federally or State-administered. The Medicaid and Older Americans Act programs carry specific requirements for States to match Federal funds, whereas the SSBG does not. By virtue of their statutory obligations to beneficiaries, Medicare, Medicaid, and SSI represent uncontrollable expenditures in the Federal budget. In contrast, the total funding available for programs under the Older Americans Act is subject to an annual limit imposed through the appropriations process. Although the SSBG is considered an entitlement program to States, it carries a statutorily imposed Federal expenditure ceiling.
- o SERVICE BENEFITS, DEFINITIONS, AND STANDARDS. As a general rule, Medicare and Medicaid provide reimbursement primarily for medical and health care services; however, in certain instances Medicaid reimbursement is available for social service components of health care services, e.g., under State options for personal care or adult day care services and under "section 2176" home and community-based waiver provisions. The SSBG program provides reimbursement for social services only but will provide coverage for medical care when such care is "integral but subordinate" to the provision of a social service. Funding under title III of the Older Americans Act is to be used for the development of a service delivery system for older persons, focusing on supportive and nutritional services. Recipients of SSI receive a cash payment which is federally determined but States may decide how much and for what purpose to supplement the Federal payment. Definitions for similar or complementary services vary among programs and sometimes among programs within a single State. Certain service definitions are established at the State level, or at the local level by individual service providers. Similarly, standards for services may be established upon legislative specifications.
- o ELIGIBILITY. Entitlement for Medicare is generally based on Social Security status. Eligibility for Medicaid is linked to actual or potential receipt of cash assistance under the federally-assisted Aid to Families with Dependent Children program and the SSI program for the aged, blind, and disabled. The SSBG does not require that applicants or recipients meet income eligibility guidelines, although States may set standards. The

Older Americans Act program prohibits income testing for services; however, funds under the program must be directed toward those with the greatest social or economic need. Eligibility for the Federal payment portion of SSI is based on federally established income and asset rules.

### 1. Medicaid--Title XIX of the Social Security Act

The Medicaid program is a Federal-State matching program providing medical assistance for certain low-income persons. Each State administers its own program and, subject to Federal guidelines, determines eligibility and scope of benefits. In general, each State also determines the payment rate for services provided to Medicaid recipients. The Federal Government's share of medical expenses is tied to a formula based upon the per capita income of the State. At a minimum, the Federal Government will pay 50 percent of the costs of medical care; this amount ranges up to 79.65 percent in the lower per capita income States.

The States vary greatly with regard to services they include in their plans and groups eligible to receive these services. For example, major long-term care services provided under Medicaid include intermediate care facility (ICF) services, skilled nursing facility (SNF) services, and home health services. 36/ Other Medicaid services sometimes associated with the

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36/ Medicaid law defines SNF services as services which are required to be given to an individual who needs, on a daily basis, skilled nursing care (provided directly by, or requiring the supervision of, skilled nursing personnel) or other skilled rehabilitation services which, as a practical matter, can only be provided in a SNF on an inpatient basis. Medicaid law defines an ICF as an institution that is licensed under State law to provide on a regular basis health-related care and services to individuals who do not require the degree of care and treatment which a hospital or SNF is designed to provide but who because of their mental or physical condition require care and services (above the level of room and board) which can be provided only through institutional facilities. Effective Oct. 1, 1990, P.L. 100-203, the Omnibus Budget Reconciliation Act of 1987, will eliminate Medicaid's distinction between SNFs and ICFs, and will create in their place a "nursing facility" benefit.

needs of long-term care patients include: private nursing services, clinic services, personal care services at home, adult day health services, physical therapy and related services, and inpatient care for patients 65 years of age or older in institutions for mental diseases. However, not all States cover these services equally. In addition, States may cover certain other home- and community-based services under special waiver programs reviewed and approved by the Secretary of the DHHS.

Medicaid law requires that States cover under their programs the "categorically needy"--all persons receiving assistance under the Aid to Families with Dependent Children (AFDC) program and most persons receiving assistance under the SSI program. States may also cover additional persons as categorically needy. These might include persons who do not receive cash welfare assistance, but become eligible for Medicaid according to special income rules used by certain States for persons residing in nursing homes. By Federal law, this special level can be no more than three times the basic SSI payment level, and is often referred to as the "300 percent rule."

In addition to the categorically needy, States may at their option cover the "medically needy," persons whose income and resources are large enough to cover daily living expenses, according to income levels set by the State, but not large enough to pay for medical care. If the income and resources of the "medically needy" individual are above a State-prescribed level, the individual must first incur a certain amount of medical expense which lowers the income to the medically needy levels (the so-called "spend-down" requirement). Thirty-seven States and jurisdictions have medically needy programs that can cover the elderly. As a result of State variations such as these, persons with identical circumstances may be eligible to receive Medicaid benefits in one State but

not in another; even individuals in the same State with similar incomes may not be equally eligible for benefits due to welfare rules.

a. Medicaid's coverage of nursing home care. Over the years, observers have noted that Medicaid's eligibility policies and benefit structure have actually created financial incentives to use nursing homes rather than community services. Until fairly recently, Medicaid support for chronically impaired elderly persons living in the community has been quite limited. Many of the non-skilled personal care and supportive services needed by chronically impaired elderly persons to remain in the community were simply not covered under Medicaid. These services, however, are typically covered as part of Medicaid's nursing home benefit. In addition, certain lower income elderly who were ineligible for Medicaid while living in the community could become eligible for nursing home care, if they resided in a State using a higher income eligibility standard for nursing home residents (the 300 percent rule).

Others become eligible for Medicaid once they deplete their resources after entering the nursing home as privately paying patients. With nursing home care costing in the range of \$20,000 to \$25,000 a year, many elderly persons in nursing homes can quickly meet the resources and income requirements for Medicaid coverage of their care by spending down. A 1983 General Accounting Office (GAO) report, Medicaid and Nursing Home Care, reviewed case studies and did other analysis that showed that one-quarter to two-thirds of Medicaid patients in nursing homes in certain areas initially entered as private paying patients and subsequently converted to Medicaid. <sup>37/</sup> GAO also

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<sup>37/</sup> Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly. U.S. General Accounting Office, GAO/IPE-84-1. Oct. 21, 1983, p. 25-26.

found that higher proportions of residents with longer nursing home stays were supported by Medicaid than those with shorter stays.

The 1985 National Nursing Home Survey provides limited information about persons shifting to Medicaid payment for their nursing home care. At the time of the survey, 605,800 residents (41 percent) reported that Medicaid was their primary source of payment at admission, and 885,700 residents (59 percent) reported that other non-Medicaid sources (such as own income or family support, Medicare, other government programs, etc.) were the primary source of payment at admission. <sup>38/</sup> For those not using Medicaid as the primary source of payment for their care at admission, 20.5 percent reported shifting to Medicaid at some point prior to the last month before the Nursing Home Survey interview. However, data about the precise point when Medicaid became the primary source of payment--and the length of the spend-down process--was not collected by the survey. The National Nursing Home Survey also shows that the percentage of persons shifting to Medicaid increased as duration of stay in the nursing home increased.

Another analysis published by the House Select Committee on Aging provides estimates of the length of time of spend-down and the risk of impoverishment for elderly persons needing long-term care services. This study uses a micro-simulation model of income and assets developed by the Urban Institute, together with data from the Medicare and Medicaid programs on the cost of long-term care services, to estimate the length of time elderly persons using long-term care services would find their income and assets spent down to the Federal poverty level. The study estimates that 70 percent of elderly persons living alone find their income spent down to the Federal poverty level after 13

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<sup>38/</sup> Unpublished data from the 1985 National Nursing Home Survey, National Center for Health Statistics, Department of Health and Human Services.

weeks in a nursing home, and over 90 percent are impoverished within 1 year of admission. <sup>39/</sup> When both income and financial assets were considered, nearly one-half of the elderly living alone are impoverished after 13 weeks in a nursing home and approximately two-thirds are impoverished within 1 year. For couples, 34 percent are impoverished after one spouse has spent 13 weeks in a nursing home and almost 80 percent are impoverished when income alone is considered. When both income and assets are taken into account, almost one-half of couples are impoverished after 1 year in a nursing home.

b. Medicaid "2176 waivers" for home and community-based care. In order to allow States to broaden coverage for a range of community-based long-term care services and to receive Federal reimbursement for these services, Congress in 1981 passed legislation authorizing the Secretary of DHHS to approve special State applications to provide such services under their Medicaid programs. These services are often referred to as "2176 waiver services" after the section in the Omnibus Budget Reconciliation Act of 1981 which originally authorized them.

Under a 2176 waiver program, States may cover home and community-based services in only a portion of the State, rather than in all geographic jurisdictions as would be required absent a waiver. In addition, they may limit coverage of selected services to certain State-defined individuals eligible for assistance, rather than offering these services to all persons in particular eligibility groups. States may also determine eligibility for 2176 waiver services using the same more liberal income criteria used for determining eligibility for nursing home care, rather than the lower income limits usually

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<sup>39/</sup> U.S. Congress. House. Select Committee on Aging. Long-Term Care and Personal Impoverishment: Seven in Ten Elderly Living Alone Are at Risk. Pub. No. 100-631. Oct. 1987, Washington, D.C.

applied to people living in their homes. Most States with 2176 waiver programs use these more liberal income standards. 40/ States must limit coverage of these services to persons who would otherwise require and have paid for by Medicaid, the level of care provided in institutions.

Prior to the 2176 waiver program, Medicaid services available to frail elderly persons living in the community were generally restricted to medical and medical-related services. The waiver authority acknowledges that a wide variety of other non-medical services may be needed in order prevent or postpone institutionalization. For this reason, services traditionally considered to be social services are covered by the waiver authority. These include case management (commonly understood to be a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or organization), homemaker/home health aide services, personal care services, adult day care, respite care, and other services that can contribute to the health and well-being of individuals and their ability to reside in a community-based setting. States have used this "other" category to provide home modifications and transportation services, among others. A National Governors' Association (NGA) survey in July 1987 found 37 States with operational waiver programs that serve elderly persons in at least some part of the State. 41/ About 59,000 elderly persons were being served in these programs.

The Omnibus Budget Reconciliation Act of 1987 (OBRA87) established a new waiver authority for the elderly, separate from the 2176 waiver authority.

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40/ U.S. Congress. Congressional Research Service. Medicaid Eligibility for the Elderly in Need of Long-Term Care. CRS Report for Congress no. 87-986, by Edward Neuschler. Prepared under Contract no. 86-26. Center for Policy Research. National Governors' Association, Sept. 1987. p. 34.

41/ Ibid.

With this new authority, Congress was responding to an issue that had arisen in connection with HCFA's implementation of the 2176 authority. To meet the law's requirement that the average per capita expenditures under 2176 waiver programs not exceed average per capita expenditures that would be incurred in the absence of the waiver, HCFA required States to use a formula demonstrating budget neutrality. This formula required States to estimate the number of individuals who would otherwise be served in a Medicaid nursing home bed. HCFA used this estimate as a ceiling on the number of persons who could be served under the waiver. States that had restricted their supply of nursing home beds through certificate-of-need programs or construction moratoria were therefore limited in the number of persons they could serve under the waiver.

Congress, therefore, established in OBRA87 a new waiver authority to allow States to provide, according to a new definition of budget neutrality, home and community-based services to elderly persons at risk of nursing home care. The budget neutrality formula limits States electing the waiver to a maximum percent rate of growth in their institutional and noninstitutional long-term care outlays under Medicaid, compounded annually. The Secretary is required to promulgate, by October 1, 1989, indices for projecting increases in institutional and non-institutional long-term care costs, as well as State-specific projections of increases in the number of residents over age 75. Upon promulgation of these indices, the test for budget neutrality will be the greater of: (1) the sum of the percentages yielded by these indices, and (2) 7 percent, compounded annually.

## 2. Medicare--Title XVIII of the Social Security Act

Medicare is a Federal health insurance program with a uniform eligibility and benefit structure throughout the United States. The program covers most individuals entitled to Social Security benefits, persons under 65 entitled to Federal disability benefits, and certain individuals with end-stage renal disease. Coverage is available to persons without regard to their income or assets.

Medicare's coverage is focused primarily on acute health care, particularly hospital and physician care and accompanying periods of recovery. It was never envisioned to provide protection for long-term care, and for this reason, it offers only very limited protection against the costs of long-term care types of services. Program coverage of nursing home care, for instance, is limited to short-term stays in certain kinds of nursing homes, referred to as SNFs, and only for those persons who can demonstrate a need for daily skilled nursing care for a condition related to a prior hospitalization. Many persons who require long-term nursing home care do not need daily skilled nursing care, and, therefore, do not qualify for Medicare's benefit. As a result of these restrictions, Medicare covered, for those persons receiving SNF benefits, an average of 27 days of care in 1984. <sup>42/</sup> In addition, the program paid for less than 2 percent of the Nation's nursing home expenditures in 1986.

For similar reasons, Medicare pays for limited amounts of community-based long-term care services, primarily through the program's home health benefit. To qualify for home health services, the Medicare beneficiary must be confined to his or her home and under the care of a physician. In addition, the person

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<sup>42/</sup> Medicare: Use of Skilled Nursing Facilities, 1984. Health Care Financing Administration. Office of Research and Demonstrations. Research Brief no. 86-4. p. 2.

must be in need of skilled nursing care on an intermittent basis, or physical or speech therapy. Services must be provided by a home health agency certified to participate under Medicare, according to a plan of treatment prescribed and reviewed by a physician. Most chronically impaired persons do not need skilled care to remain in their homes, but rather supportive care and assistance with basic self-care functions and daily routines that do not require skilled personnel. Although there is no statutory limit on the number of home health visits covered under the program, persons receiving home health services under Medicare used an average of 27 visits in 1984. <sup>43/</sup> Medicare's skilled care requirements for home health limit utilization of the benefit.

In addition to these SNF and home health care benefits, Medicare covers a range of long-term care services, and especially home care services, for terminally ill beneficiaries. These services, authorized in 1982 and referred to as Medicare's hospice benefit, are available to beneficiaries with a life expectancy of 6 months or less. Hospice care benefits include nursing care, medical social services, physicians' services, counseling, therapy services, home health aide and homemaker services, medical supplies, including drugs and biologicals, and short-term inpatient care. Medicare expenditures for hospice care amounted to \$35 million for FY 1986 and \$63 million for FY 1987.

The introduction in FY 1984 of a prospective payment reimbursement system (PPS) for inpatient hospital care under Medicare has raised a number of questions about its impact on the quality of care received by the elderly, including care available in long-term care settings covered by the

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<sup>43/</sup> Kirby, Will, Vikki Latta, and Charles Helbing. Medicare Use and Cost of Home Health Services, 1983-84. Health Care Financing Review, v. 8, no. 1, fall 1986. p. 93.

program--SNFs, home health, and hospice. <sup>44/</sup> Moreover, concern has been raised about the effects of PPS on the ability of community-based social service agencies, partially supported by the Older Americans Act and the SSBG, to adjust their programs to meet the growing needs of hospital discharged patients for certain social services, such as home-delivered meals and a variety of other in-home services not covered by Medicare or Medicaid.

Medicare's PPS sets predetermined fixed payment rates for each hospital inpatient admission, based on the diagnosis-related group (DRG) into which that admission falls. This fixed payment provides hospitals with incentives to limit costs incurred for each Medicare patient admission, generally either by reducing lengths of stay and/or intensity of care provided.

Since the introduction of PPS, average lengths of stay in hospitals have decreased markedly for Medicare beneficiaries. In 1982, the last full year before PPS, average hospital length of stay for persons 65 and over was 10.1 days. By 1985 it had declined to 8.8 days and in the last 2 years has risen slightly to 8.9 days. <sup>45/</sup> To the extent that this decrease in length of stay represents a reduction in unnecessary acute care, one objective of PPS reform is being met. However, concern has been expressed about the availability and quality of care for those beneficiaries who may be discharged sooner from hospitals and who may need additional services that may or may not be covered by Medicare as SNF or home health care. GAO has identified a number of issues which must be evaluated in any assessment of the impact of PPS on

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<sup>44/</sup> U.S. General Accounting Office. Post-Hospital Care: Efforts to Evaluate Medicare Prospective Payments Effects Are Insufficient. GAO/PEMD-86-10. June 1986. p. 10.

<sup>45/</sup> American Hospital Association National Panel Survey as reported in Technical Appendixes to the Report and Recommendations to the Secretary, U.S. Department of Health and Human Services. Prospective Payment Assessment Commission, Mar. 1988. p. 26.

post-hospital care: Have patients' post-hospital care needs changed since implementation of PPS? How are patients' needs being met? Are patients having access problems? How have long-term care costs been affected? 46/ Currently little information exists to provide conclusive answers to these questions, although HCFA has sponsored a number of studies that are intended to address these issues.

In addition, limited studies have noted that earlier hospital discharges are having a marked effect in some areas of the country on the demand for community-based social services. An early study, which attempted to measure the changes in the service delivery patterns and priorities of community-based long-term care services provided through the Older Americans Act since implementation of PPS, found increases in the length of service and varieties of in-home services required by the elderly. 47/ Other observers have pointed to growing pressures to use limited social services funding to respond to the needs of patients discharged sooner from hospitals under PPS, resulting in a reduction of services for other chronically ill or functionally impaired elderly living in the community who have not been discharged from a hospital and who require services to remain independent.

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46/ Post-Hospital Care: Efforts to Evaluate Medicare Prospective Payment Effects Are Insufficient, p. 12.

47/ U.S. Congress. House. Committee on Education and Labor. DRGs and the Community-Based Long Term Care System. Testimony presented by the Southwest Long-Term Care Gerontology Center, University of Texas Health Science Center, Dallas. July 30, 1985.

3. Social Services Block Grant Program--Title XX of the Social Security Act

Title XX of the Social Security Act authorizes block grants to States for a wide range of social services to diverse population groups, including the aged, disabled, and children. States are allowed considerable discretion in their support of social services as long as the services are structured to meet the following goals of the program: achieving or maintaining economic self-support and self-sufficiency; preventing or remedying neglect, abuse, or exploitation; preventing or reducing inappropriate institutional care by providing for community-based care; and securing referral or admission for institutional care when other forms of care are not appropriate, or providing certain services, such as counseling or discharge planning, to individuals in institutions (excluding room and board). The SSBG provides reimbursement for social services only, but will provide coverage for medical care when such care is "integral but subordinate" to the provision of a social service.

States receive allotments of SSBG funds on the basis of the State's population, within a Federal expenditure ceiling. There are no requirements for use of title XX funds--States are provided relative freedom to spend Federal social service block grant funds on State-identified service needs. Legislation in the 100th Congress authorized \$2.75 billion for FY 1988; for FY 1985 through FY 1988, the appropriation level has been \$2.7 billion.

The title XX program was significantly changed by provisions of P.L. 97-35, the Omnibus Budget Reconciliation Act of 1981, effective in FY 1982. Through FY 1981, the program contained requirements regarding the population to be served and the kinds of services to be provided to families and individuals. Under provisions of P.L. 97-35, States were given much more discretion in determining the service population and services to be offered. The law

eliminated requirements that States expend a portion of funds for welfare recipients, that services be limited to families with incomes below 115 percent of the State median income, and that fees be charged to persons with specified income levels. While previous State planning requirements were lessened, the law continues to require States to develop and make public a report on how funds are to be used prior to the State plan period, including information on the types of activities to be funded and the characteristics of individuals to be served.

The 1981 law also eliminated State reporting requirements; therefore, only very scant data are available as to the extent to which title XX supports long-term care services. Two sources of data provide only limited information as to States' efforts in community-based long-term care services. The first is a DHHS analysis of the States' pre-expenditure reports under title XX (a report on States' intended use of funds); the second is an analysis of a limited number of States' use of funds by the American Public Welfare Association (APWA). According to the DHHS analysis of States' SSBG FY 1987 pre-expenditure reports, home-based services (including homemaker, chore, home health, companionship, and home maintenance services) were to be provided by 49 States (to adults and children); adult day care by 24 States; and adult foster care by 15 States. According to SSBG data compiled by the APWA for a limited number of States, in 1985 homemaker, home management, and chore services were provided to 5.7 percent of total title XX recipients, or about 110,020 persons of all ages. Home-based services accounted for about 8.9 percent of total expenditures, or \$171 million (out of a total estimated amount of Federal, State, and local funds of \$2.8 billion). Adult day care services were provided to less than 1 percent of total title XX recipients, or about 5,181 persons for the States included in the survey. They accounted for \$28.9 million, or 1.5 percent of

total expenditures. <sup>48/</sup> It should be noted that these data are for total title XX recipients. National data specific to the elderly and disabled population and by service are limited. A recent telephone survey of States by the American Association of Retired Persons (AARP) showed that for 44 States, the proportion of SSBG funds used for the elderly ranged from 1 to 50 percent, with the average amount at 18 percent. The survey also found that the services most frequently provided to the elderly were home-based services (41 States); adult protective services (29 States); adult day care (18 States); transportation (17 States); and nutrition services (17 States). <sup>49/</sup>

Although the SSBG represents the major social service program supported by the Federal Government, its ability to significantly support the long-term care population is relatively limited. Because it provides a variety of social services to a diverse population, the program has competing demands. For example, the program is one of the major Federal programs supporting child day care and protective services for children and as well as a variety of other services to children and disabled. The APWA data on social services provided in 20 States in FY 1985 points out the diversity of services available. A total of 5 services accounted for over one-half of all services provided to recipients as follows: information and referral services (19.4 percent); protective services for children (13.6 percent); family planning services (7.1

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<sup>48/</sup> American Public Welfare Association (APWA). A Statistical Summary of the Voluntary Cooperative Information System (VCIS) Social Services Block Grant (SSBG). Data for FY85. Jan. 1988. Data were compiled by the APWA under its VCIS where States voluntarily report data on their social service programs. Data for recipients are for 20 States and expenditures are for 29 States. Total expenditures including a combination of State and local funds, Federal title XX funds, and other funds for 29 States, were an estimated \$2.8 billion in 1985.

<sup>49/</sup> Gaberlavage, George. American Association of Retired Persons. Social Services to Older Persons Under the Social Services Block Grant. Apr. 1987. p. 6.

percent); child day care services (7 percent); and counseling services (6.4 percent). <sup>50/</sup> Moreover, community care programs such as those supported by title XX are minimal when compared to Federal programs which support institutional care. For example, Federal funds available for all title XX activities in 1986 (\$2.7 billion) were approximately 27 percent of total Federal nursing home expenditures in that year (\$10.1 billion).

#### 4. The Older Americans Act

The Older Americans Act carries a broad mandate to improve the lives of older persons in the areas of income, emotional and physical well-being, housing, employment, social services, civic, cultural, and recreational opportunities.

The purpose of title III of the Act, which authorizes formula grants to States for services to older persons, is to foster the development of a comprehensive and coordinated service system for older persons in order to (a) secure and maintain maximum independence and dignity in a home environment for older persons capable of self-care; (b) remove individual and social barriers to economic and personal independence for older persons; and (c) provide a continuum of care for the vulnerable elderly. Of the Act's total funding in FY 1988, the major share--70 percent--is devoted to the title III program. Under title III, grants are made to State agencies on aging, which in turn award funds to 670 area agencies on aging, to plan, coordinate, and advocate for, a comprehensive service system for older persons.

Title III supports a wide range of supportive services, as well as congregate and home-delivered nutrition services. Certain supportive services

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<sup>50/</sup> Ibid., APWA, p. 13.

have been given priority by Congress, including in-home services, such as homemaker and home health aide, visiting and telephone reassurance, and chore services. Each area agency is required to spend a portion of its supportive services allotment on these services. Other community-based long-term care services which may be provided under title III include case management, assessment, adult day care, and respite care, among others.

Services under the title III program are to be provided to older persons without regard to income, although concentrated on those with the greatest social or economic need. Older persons are to be given the opportunity to contribute to the cost of services, but failure to do so cannot be a basis for denial of service.

Unlike the title XX program in which States receive a block of funds for unspecified social services, Congress makes separate appropriations of title III funds for supportive services, for congregate nutrition services (in which older persons receive meals and other services in a group setting), and for home-delivered nutrition services. States receive allotments of these funds according to the number of older persons in the State as compared to all States. The law gives States and area agencies flexibility to define the supportive services to be provided and to transfer funds among the three service categories. Although a wide range of social services, including community-based long-term care services, may be supported by title III, the major share of funding is devoted to the nutrition services programs. Total FY 1988 appropriations for title III are \$834.4 million, with 67 percent of this amount appropriated for nutrition services. Only about one-third of title III funds is specifically appropriated for the entire range of social services authorized by the Act.

In-home services clearly represent an expenditure priority for the title III program. According to a National Data Base on Aging survey of 121 area agencies, in 1984, about one-quarter of funds controlled by area agencies (including Older Americans Act funds as well as non-Older Americans Act funds) was directed at in-home services. While a substantial portion of these funds was spent on the home delivered meals component, which receives a separate appropriation under the Act, almost an equal proportion of the total spent on in-home services was devoted to housekeeping, personal care, and chore services. 51/

In recognition of the demand for community-based long-term care services, Congress amended the title III program in 1987 to create a separate authorization of funds for non-medical in-home services for the frail elderly as part of the Act's reauthorization legislation (P.L. 100-175). Although support for home care services has been a priority under the title III program for some time, under prior law there was no separate authorization of funds for this purpose. In-home services, therefore, had to compete with other social service funding priorities of State and area agencies. The following services are authorized under the new program: homemaker and home health aide; visiting and telephone reassurance; chore maintenance; in-home respite care, and adult day care as a respite for families; and minor home modification not to exceed \$150 per client. State agencies on aging receive allotments for in-home services on the basis of the current title III formula (that is, based on the State's share of the population 60 years or over as compared to all States). States are required to develop eligibility criteria for the use of in-home services,

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51/ Data are from a random sample survey of 121 area agencies on aging in 1984. Supplied by the National Data Base on Aging, a service of the National Association of State Units on Aging and the National Association of Area Agencies on Aging.

taking into account factors such as age, and other factors related to frailty. For FY 1988 \$25 million was authorized and \$4.8 million was appropriated.

The ability of the Older Americans Act to have a significant impact on the long-term care system is limited, due to its relatively small level of funding as compared to other programs. However, many State and area agencies have made strides to improve long-term care services through coordination activities with health and other social service agencies, and through the development of a social service infrastructure for the elderly at the local level. Some State agencies on aging have also acted as catalysts to reorganize community-based health and social services systems at the State and local levels so as to serve more effectively the long-term care population. For example, State agencies have developed case management and assessment systems through area agencies on aging and have supported services otherwise unavailable to the frail population. In other cases, State agencies on aging have been given responsibility for the administration of the section 2176 home and community-based waiver program under Medicaid. Although the amount of funding which title III devotes to community-based long-term care services may represent a small fraction of the amount spent for these services under Medicare and Medicaid, the title III program has the flexibility to fill gaps in services for persons otherwise unserved. Since Older Americans Act services may be provided without the restrictions required under Medicare and without certain income tests specified by Medicaid, in some cases title III may be used to serve persons whose Medicare and Medicaid benefits have been exhausted or who are ineligible for Medicaid.

Although the congregate nutrition program receives the major share of title III funding, in recent years States have increasingly shifted funds from this program to other title III services, including the home-delivered meals

and supportive services components. In FY 1987, States shifted about \$49 million from the congregate nutrition appropriation to the other service components. This represented about a 14 percent decrease from the appropriated amount of \$348 million. Reasons cited for this trend include the increasing age of the older population and increased demand for home-based services by a frailer and older population. An evaluation of the Older Americans Act nutrition program performed for the Administration on Aging showed that recipients of home-delivered nutrition services tended to be older, poorer, and in worse health than congregate nutrition participants.

Another Older Americans Act long-term care activity, which may receive increased attention in the future as the number of nursing home residents grows, is the long-term care ombudsman program. Under this program, each State agency on aging is required to establish an Office of the State Long-Term Care Ombudsman whose responsibility is to investigate and resolve complaints made by, or on behalf of, older individuals who are residents of long-term care facilities. Complaints may relate to action or inaction of long-term care providers or other agencies which may adversely affect the health, safety, welfare, or rights of residents. Ombudsmen are required to exercise oversight of SNFs, ICFs, board and care homes, and other adult care homes. Each State is required to assure that program representatives will have access to facilities, residents, and their medical and social records. Although the operation of the ombudsman program has been a required activity under the title III program since 1978, Congress recently amended the law to create a separate authorization of funds to support the program.

Total funding to support the ombudsman program in FY 1986 was \$19.1 million, including Federal, State, and local funds. About 10,900 persons were working at the State and local levels to implement the program, the majority of

whom were volunteers. Complaints frequently received by the program are those related to inadequate hygiene, physical abuse, personal items lost, stolen or used by others, and understaffing of facilities.

5. Supplemental Security Income Program--Title XVI of the Social Security Act

The SSI program is a federally-administered income assistance program authorized by title XVI of the Social Security Act. Enacted by the 1972 Social Security Amendments and implemented in 1974, it replaced previous programs of State income assistance for the aged, blind and disabled. The SSI program provides a minimum income level for aged, blind, and disabled persons whose countable income does not exceed the Federal maximum monthly SSI benefit. In 1988 the monthly Federal SSI benefit is \$354 for an individual and \$532 for a couple with no other income. SSI payments are made to individuals under uniform, nationwide rules with respect to income and assets, and definitions of blindness and disability. In 1987 an estimated 4.4 million individuals received Federal SSI payments (1.5 million aged persons and 2.9 million blind or disabled persons). <sup>52/</sup>

The SSI program also allows States to supplement the Federal SSI payment through optional supplemental payments to individuals. All but eight States and jurisdictions provide some form of optional State payments. (These are Arkansas, Georgia, Kansas, Mississippi, the Northern Mariana Islands, Tennessee, Texas, and West Virginia.) Each State determines whether it will make a supplemental payment, to whom, and in what amount. These State supplemental payments, also paid on a regular monthly basis, are intended to

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<sup>52/</sup> This number includes persons receiving Federal SSI payments and/or federally-administered State supplementation. Data as of Sept. 1987.

supplement the basic Federal SSI payment for food, shelter, clothing, utilities, and other necessities. Some States provide optional State supplemental payments to all persons qualifying for SSI benefits, while others may limit payments to certain State-defined SSI recipients, or may extend payments to persons who would be eligible for SSI except for excess income.

A significant number of States provide supplemental payments to the basic SSI payment to support selected community-based long-term care services for certain eligible persons, including the frail elderly, the mentally retarded, or the chronically mentally ill. This is because the Federal SSI payment may be insufficient to pay for services which extend beyond room and board, such as non-medical supervision in group living arrangements or personal care services.

A recent analysis of State supplemental payment programs by the Center for the Study of Social Policy found that 43 States supported a diverse range of long-term services through their optional State supplemental payment program in 1987. All 43 States offered supplemental payments for certain State-defined out-of-home care, and 6 of the 43 States also supplemented the income of persons requiring long-term care assistance in their homes. Payments are made to individuals to support residence in a variety of supported housing arrangements, such as domiciliary care homes, adult foster care homes, congregate care facilities, adult residential care homes as well as for in-home services, such as homemaker or personal care services. The report indicated that although most States offer specialized payments to meet certain long-term care needs, most of the programs are relatively small. It was estimated that there may be

about 320,000 SSI recipients nationwide, who receive supplemental payments because of their need for long-term care services. <sup>53/</sup>

**B. Federal Research and Demonstration Initiatives**

Over the last decade, the Federal Government has made a substantial investment in research and demonstration activities in community-based care by supporting a wide range of projects designed to test new ways of providing and coordinating long-term care services as well as to achieve costs savings in the provision of care. Federally funded demonstrations have been sponsored principally by DHHS, and within DHHS, by HCFA and the Administration on Aging (AoA). In some cases, HCFA has waived Medicare or Medicaid service or eligibility requirements so that a fuller range of services may be provided to persons who would not ordinarily benefit under the existing programs. With nursing home care representing a substantial portion of public and private expenditures for long-term care, most Federal research and demonstration efforts have had the following objectives: (1) to reduce the cost of long-term care by reducing inappropriate institutionalization and the demand for institutional care by persons who could otherwise be served through community-based services at less cost; (2) to test whether a carefully managed system of care would create more efficient use of existing services and deter unnecessary institutionalization; and (3) to make available to clients a wider range of community-based services than previously existed. In order to accomplish these objectives, the projects developed case management systems to screen and assess persons judged "at risk" of institutional care in order to divert, where

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<sup>53/</sup> The Center for the Study of Social Policy, *Completing the Long-Term Care Continuum: An Income Supplement Strategy*, Washington, D.C., Mar. 1988. p. 27-46.

appropriate, persons to community-based care. In addition, case management systems were designed to improve the delivery of care to chronically ill persons with complex needs. Multidisciplinary teams (generally composed of medical, health, and social service professionals) were established to carry out the case management responsibilities.

Because the success of Federal demonstration projects was premised on findings of cost savings to the Medicare and Medicaid programs, effective client targeting strategies were of paramount importance. Projects used various methods to select prospective clients for demonstrations. Such methods ranged from the selection of persons whose needs, based on results of assessments of functional capacity, indicated a likelihood of nursing home entry, to acceptance of only those persons who had already been determined eligible for nursing home placement based on specified nursing home pre-admission screening procedures. It was believed that the demonstration projects could achieve cost savings only by serving those persons who could meet, or actually met, SNF or ICF level of care requirements, but who could be equally well cared for in the community by lower cost services.

Most of the projects have terminated as Federal demonstrations, but most have been viewed as precursors to the DHHS National Long-Term Care Channeling Demonstration Program begun in 1980 and completed in 1985. <sup>54/</sup> Because this demonstration was the most ambitious and extensive community-based long-term care effort to date, its results will be discussed separately below. However, some general remarks can be made about the themes which have emerged from these earlier demonstration initiatives.

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<sup>54/</sup> It should also be pointed out that these demonstration initiatives also served as a model for the creation of the Medicaid Section 2176 home and community-based waiver program discussed earlier in this paper.

At best, the demonstrations have shown mixed results in terms of overall costs savings, reductions in the use of institutional care, and effects on client functioning. Various reviews of the demonstrations conducted over the past decade have attempted to compare their respective findings and make general statements about their results. <sup>55/</sup> In general, many of these reviews have indicated that the demonstration findings do not support the view that cost savings can be achieved through the substitution of community-based long-term care services for institutional care. In some cases, the community-based services offered to clients were found to be "add on" services, that is, additional benefits whose costs were not offset by reduced nursing home costs. In addition, there is some evidence that any costs savings that were achieved by diverting nursing home-bound clients to community care were offset by the additional costs incurred as a result of the case management and assessment process.

One of the principal reasons for these findings has been difficulty in developing effective strategies for targeting community-based services on those persons who would actually have entered a nursing home without such services. Many of the projects served persons who were functionally disabled but who, in the long run, would not have entered a nursing home for a variety of reasons.

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<sup>55/</sup> Among the many reviews of these projects are the following: Stassen, Margaret and John Holahan, Long-Term Care Demonstration Projects: A Review of Recent Evaluations. Working Paper: 1227-2. The Urban Institute. Washington, D.C. Feb. 1981; Berkeley Planning Associates, Evaluation of Coordinated Community-Oriented Long-Term Care Demonstration Projects. Prepared for the Health Care Financing Administration. Berkeley, California. May 1985; Burwell, Brian. Home and Community-Based Care Options under Medicaid. Affording Access to Quality Care: Strategies for Medicaid Cost Management. National Governors' Association Center for Policy Research. Washington, D.C. July 1986; Doty, Pamela. Can Home and Community-Based Services Provide Lower Cost Alternatives to Nursing Homes? Working Paper. Health Care Financing Administration. Washington, D.C., Dec. 1984. Kemper, Peter, Robert Applebaum, and Margaret Harrigan, A Systematic Comparison of Community Care Demonstrations. Institute for Research on Poverty, Special Report. June 1987.

Thus, the projects were not found to have had any significant impact on reducing nursing home utilization. One exception to this has been a program in South Carolina which showed a substantial reduction in nursing home utilization though the implementation of a managed care system. This reduction has been attributed to the fact that the project accepted for community-based services only those clients who had already been determined to be in need of nursing home care through a State mandatory nursing home preadmission screening program. Although the demonstration was able to reduce nursing home utilization by successfully targeting a client group at high risk of institutionalization, it was able only to break even in terms of total costs. Consistent with the results of some of the other demonstrations, the South Carolina demonstration showed new costs generated by the case management process and additional community-based services. 56/

In the area of the effects of the community care projects on client functioning, there are also mixed results. Some of the projects were able to demonstrate reduced mortality, and improved client outcomes in terms of functional or cognitive abilities. However, other projects were not able to support totally the view that a wider range of community care options would have overall positive benefits on the health and well-being of clients. In some cases, this may be attributed to the fact that the projects were serving almost exclusively a very frail and disabled group whose functional status could not be easily improved by an expanded range of community-based service. These findings may point up the dilemma of providing services to a chronically disabled group--because the needs of this group are so complex and of such a

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56/ Burwell, p. 83; and Mathematica Policy Research, Inc. The Evaluation of the National Long-Term Care Channeling Demonstration: Final Report. Prepared for the Department of Health and Human Services, May 1986. p. xix, 14.

chronic nature, real improvement in client outcome may not in fact be an attainable goal.

Based on the weight of evidence emerging from the enormous amount of research which has been conducted on the effects of community-based care, many analysts have come to the conclusion that these services were oversold as a cost-effective "alternative" to institutional care. 57/ Demonstrations have shown that most persons who use expanded community care are not at risk of institutionalization, and of those who are, few become long-stayers. That is not to say, though, that these persons are not in need of such care. Analysts and service providers alike are increasingly recognizing that a broader group of disabled elderly persons, and their family caretakers, need and prefer expanded community care services. Expanded community care and the additional costs of such services may, therefore, simply represent an appropriate response to the needs of a changing population. 58/

1. National Long-Term Care Channeling Demonstration

In 1980, three units within DHHS--HCFA, AoA, and the Office of the Assistant Secretary for Planning and Evaluation--initiated the National Long-Term Channeling Demonstration. This project was designed to test whether a carefully managed approach to the provision of community-based long-term care services to a frail elderly population living outside institutions could help control overall long-term care costs while maintaining or improving the well-being of its clients. This project has been the largest, and the most

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57/ Weissert, William G. Seven Reasons Why It Is So Difficult to Make Community-Based Long-Term Care Cost Effective, Health Services Research, v. 20, no. 4., Oct. 1985. p. 432.

58/ Ibid.

rigorously designed, demonstration undertaken to test the effectiveness of a case-managed approach to long-term care service provision. The program comprised 10 States and local sites, with about 6,326 frail elderly clients, and was designed with experimental and control groups.

The term "channeling" refers to organizational structures and systems which coordinate available long-term care resources and manage them effectively on behalf of functionally-impaired clients. Channeling was expected to achieve its effects principally by providing clients with case management services, and by substituting less costly community or informal services for more expensive institutional care. Services included a range of community care options such as home health aide, homemaker, nursing, and respite care. Service expenditures were subject to pre-established controls.

The program was devised to answer questions which previous Federal demonstrations had not totally answered, such as how much do case management systems cost and how best to target community-based services on those who would otherwise be institutionalized. Other questions to be answered by the demonstration included: Does channeling reduce institutionalization and hospitalization? Is use of formal health and social services in the community increased? Do formal services substitute for services of families and friends? What impact does channeling have on public and private costs of long-term care, on longevity, improved health status, and overall client well-being?

The final results of the channeling demonstration do not support the argument for case-managed community-based services solely on the basis that they substitute for institutional care or that they can reduce the total costs of long-term care. However, the project did identify a range of unmet needs on the part of very frail older persons living in the community. Channeling clients were of advanced age (average age, 80 years), poor (average income of

clients and spouses was \$570 per month), and had major limitations in ability to conduct activities of daily living.

Major findings of the demonstration include the following:

- o The increased costs of case management and expanded community services offered by the demonstration were not offset by reduced nursing home costs. As a result, costs increased overall for those persons receiving expanded services;
- o Despite the frailty of the population, channeling did not identify a population who, without the services, would have entered a nursing home. Channeling did not substantially reduce nursing home utilization;
- o Channeling did not affect longevity, hospital use, or use of physicians and other medical services;
- o Channeling increased formal community service use. Service expenditures were highest for home health aide and homemaker/personal care services. Almost three-quarters of services dollars were spent for these services. This finding supports the prevalent view among social and health services providers that assistance with personal care and housekeeping represent the largest service need of the functionally impaired elderly and the one area which is inadequately supported by existing programs;
- o Channeling did not have any major impact on the amount of care-giving already provided to clients by families and friends. (This finding is consistent with a wide body of gerontological literature indicating that initiation of formal services for impaired persons does not supplant the informal service provided by family and friends.); and
- o Channeling did not affect measures of client functioning, but did reduce unmet need for services, increased clients' confidence in receipt of care, and increased life satisfaction. 59/

While it is difficult to generalize about the application of the findings of the demonstration to other situations, the overall implications of the demonstration led to the following statement included by the evaluators in the final report:

Expansion of the case management and community services beyond what already exists, then, must be justified on the basis not of cost savings but of benefits--increased in-home care, reduced unmet needs,

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59/ Mathematica Policy Research, Inc., p. 76-77 and 169-176.

and improved satisfaction with life among clients and the informal care-givers who bear most of the care burden. 60/

## 2. Social/Health Maintenance Organization Demonstration (S/HMOs)

In 1980, HCFA, DHHS, and private foundations began funding the development, planning, and operation of the S/HMO concept for financing acute and long-term care services for an elderly population eligible for Medicare and/or Medicaid. The S/HMO concept builds upon and extends the health maintenance organization (HMO) model for financing acute, medical care services. Specifically, an HMO offers health insurance coverage for specific health care services on a pre-paid, capitation basis (the premium charge for enrollment) and either provides directly, or arranges to have provided, the health services covered under the insurance contract. The HMO is at risk for the costs of the services it covers; that is, it will experience some level of profit or loss on the basis of its ability to estimate in advance its revenues and the utilization and costs of services it provides.

The success of conventional HMOs in managing acute medical care services and costs suggested the possibility of expanding the concept to include long-term care services to allow the elderly to begin to pool their risk for chronic care. Under the 3-year HCFA S/HMO demonstration, four test sites across the country have assumed responsibility for financing and providing a full range of medical and long-term care services under a fixed budget which is determined in advance. The four S/HMO sites are the Kaiser Permanente Medical Program in Portland, Oregon; Metropolitan Jewish Geriatric Center in Brooklyn, New York; Ebenezer Society in Minneapolis, Minnesota; and Senior Care Action Network in Long-Beach, California. These four sites serve an elderly population eligible

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60/ Ibid., p. 185.

for Medicare and/or Medicaid. Enrollees are to be a representative mix of people--from well to significantly impaired. Medicare, Medicaid, and private premiums will finance the services.

Long-term care services covered by S/HMOs include nursing home services, home health services, homemaker/home health aide services, personal care, adult day care, respite care, and home-delivered meals. Each S/HMO site has its own defined long-term care benefit. Because of limited experience with long-term care insurance and utilization, long-term care services are covered up to a maximum dollar amount per year and require a copayment. The limits range from \$6,500 per year to \$12,000. In addition, S/HMOs share with the Federal Government risks for plan losses in excess of certain dollar limits during the first 30 months of the demonstration and eventually assume full risk for the utilization and costs of covered services.

The four demonstration sites began providing services in 1985 and will continue to do so through September 1992. An independent contractor will evaluate all four sites. In general, the S/HMO demonstration is intended to provide information about the cost effectiveness of providing services in an integrated and managed system of care, its impact on the utilization of health and long-term care services by the elderly, and its effect on the quality of care available to the eligible population. Among the specific questions DHHS expects this demonstration to address are the following:

- o Whether comprehensive long-term care insurance can be marketed to a significant number of elderly;
- o What combination of benefits, eligibility criteria, premium and marketing techniques produce a viable long-term care insurance plan;
- o Whether a consolidated, pre-paid system of acute and long-term care services can produce greater system savings than HMOs serving Medicare beneficiaries with acute care services only;

- o Whether the new privately financed long-term care benefits will significantly reduce nursing home admissions and Medicaid "spend-down;"
- o Whether quality of care, service continuity and access can be improved by consolidating acute and long-term care in a single managed system; and
- o Whether informal support (i.e., care provided by family members, friends and community volunteers) of chronically impaired elderly is enhanced in a pre-paid, risk-based, case-managed health care system offering both acute and long-term care services.

Prior to the S/HMOs actual operation, the Office of Management and Budget (OMB) opposed Medicare waivers required to initiate the demonstration. Citing the Medicare program's acute medical care orientation, OMB opposed in principle the use of Medicare funds for long-term care. <sup>61/</sup> OMB feared that the demonstration, by covering additional chronic care and social services, would increase consumer demand and pressure for support of long-term care through Medicare and other Federal programs. In addition, OMB argued that, if the consolidated prepaid system for acute and long-term care envisioned in the S/HMO demonstration did produce savings in acute hospital costs, Medicare would not save money, given the great demand for long-term care as reflected in high occupancy rates in nursing homes and the large amount of community-based care provided informally by family and friends. Medicare would simply end up paying for long-term care through the capitated Medicare payment paid to S/HMOs, which is higher than the rate paid to other HMOs providing services to Medicare beneficiaries. Thus, Medicare funds would replace Federal/State funds used under the Medicaid program for long-term care, State/local funds supporting community programs, private out-of-pocket expenditures by individuals, and

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<sup>61/</sup> Social Health Maintenance Organization Demonstrations: First Returns, National Health Policy Forum. Issue Brief 454, Washington, D.C. p. 6.

informal care. The result would be cost shifting, rather than savings to the Medicare program.

In the end, Congress overrode OMB objections and mandated the S/HMO demonstrations in the Deficit Reduction Act of 1984. The four S/HMO sites have been in operation since 1985. Recently the Congress extended the operation of the demonstration through September 1992. Marketing the S/HMO concept proved more difficult than anticipated and sites could not reach their enrollment goals, for the purposes of the demonstration evaluation, in the time scheduled. HCFA has contracted with the Institute for Health Policy Studies of the University of California/San Francisco to evaluate the S/HMO demonstration. An interim report on the first 2 years' experience with enrollment, marketing, service utilization, and expenditures is expected to be delivered to Congress sometime in 1988.

### C. State Level Initiatives

The fragmentation and lack of coordination among major Federal programs which support long-term care services have provided the States with major implementation challenges. The Medicaid, Social Services Block Grant, and Older Americans Act programs all delegate administration and implementation responsibility to the States, and, in so doing, require the States to deal with problems inherent in the different goals of these programs, as well as their varying eligibility requirements, service benefits, and reimbursement policies. These implementation problems have also resulted from the fact that fragmentation at the Federal level has been mirrored in State administration, with major long-term care programs being administered by different State agencies.

Many States have responded to these challenges by enacting legislation and/or creating initiatives to reorganize and restructure benefits offered through the Federal programs, and to consolidate the administration of various long-term care programs in a single State agency.

State initiatives to alter and coordinate their long-term care policies were inspired, in part, by federally sponsored demonstration projects begun in the 1970s. Despite the mixed and rather negative results of the federally-sponsored demonstration efforts with respect to the impact of expanded community-based care on the costs of care, the directions established by the demonstrations have had widespread influence on State program development. For example, demonstrations funded under Medicaid and Medicare waiver authorities and the Older Americans Act research and demonstration authorities have served as models for State-mandated case management systems and nursing home preadmission screening programs. Some States have, through the creative use of Medicaid, SSBG, and Older Americans Act funds, created major system-wide changes in the way in which community care is organized and delivered. In addition, demonstration initiatives have also served as a testing ground for new community-based service models. For example, adult day care demonstrations which took place during the 1970s encouraged State and local agencies to merge existing health and social service funds available under Medicaid, SSBG, and the Older Americans Act to create the now more than 1200 adult day care programs in existence.

Although Federal direction and funding may have served as the impetus for improving and expanding community care services, certain parallel activities have been initiated by States without the benefit of Federal demonstration funds and without any changes in Federal legislation. Some States have developed statewide community care programs, and as one author points out,

where such systems exist, frequently State revenues are the dominant source of funding. <sup>62/</sup> Reliance on State funding has the advantage of allowing States to design programs without the restrictions that accompany Federal funding. Other States have addressed community-based long-term care needs by redirecting existing Federal program funds or by using existing Federal and complementary State funds in new ways. For example, the Virginia State Medicaid agency operates a nursing home pre-admission screening program through local public health departments for persons likely to be admitted to a nursing home but whose needs could be addressed through community-based services. The Massachusetts State agency on aging has established community-based organizations to manage certain key home care services for older persons through creative use of title III Older Americans Act funds and State funds. The Utah State agency on aging has established a program to identify persons at risk of being institutionalized and has developed alternative community-based service plans using personnel of the State's area agencies on aging network.

The objective of reducing institutional care costs and diverting potential users to other forms of care may have been the original impetus behind much of State efforts to alter long-term care systems. However, as evidence from demonstrations has proven to be increasingly less optimistic about cost-savings, long-term care systems development has become a priority of State legislatures for other reasons, such as the growth and aging of the elderly population and the necessity to plan for the future, and the desire of State legislators and planners to be responsive to the preferences of the elderly for community-based care over care in institutional settings.

There are several themes evidenced in State level initiatives.

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<sup>62/</sup> Justice, Diane. State Initiatives in Reforming Long-Term Care. Business and Health, Dec. 1986. p. 18.

- o Control of institutional access through screening/assessment procedures. Many States have initiated screening and comprehensive medical and social assessment procedures of those "at risk" of long-term care services in order to ascertain the most effective and least costly care option, given the client's needs. Such screening and assessment procedures are generally applied to persons about to enter a long-term care facility. A 1985 national survey found that 30 States had in operation pre-admission screening programs designed to determine the need and appropriateness of nursing home placement. 63/
- o Reorganizing access to community services. Some States have devised projects aimed at reorganizing access to community services by providing case management services or "gateway" procedures for clients. This concept has been developed to overcome problems associated with multiple providers and duplication of services that result in client confusion as to source of care and unnecessary administrative costs among agencies. The availability of Medicaid funds under the 2176 home and community-based service waiver program has spurred the development of many more case management systems but perhaps not on a statewide basis.
- o Consolidation of State administrative and funding responsibilities. Some States have combined authority for the administration and funding for all, or most, long-term care services under one State agency. Such action is designed to improve coordination and management of care, and to overcome fragmentation resulting from diverse requirements under various Federal programs.
- o Cost control mechanisms. Some States have eliminated the uncertainty of whether community care will exceed institutional care costs by pre-establishing upper cost limits on such care; for example, community care may be provided only when such care does not cost more than a certain percentage of institutional care. An example of this concept is contained in New York's Nursing Home Without Walls program. This cost control concept was incorporated into the National Long-Term Care Channeling Demonstration program and has been a basic element of certain Medicaid 2176 home and community-based service waiver programs.
- o Tax incentives for dependent care. Many States permit favorable tax treatment for families or other caretakers who care for dependent older persons. According to a survey of the National Association of State Units on Aging, 27 States and the District of Columbia have adopted some form of dependent care tax credits, generally designed to assist in the care of dependents by adults who are working or seeking work. Of these 27 States, five have

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63/ Iverson, Laura Hines. A Description and Analysis of State Pre-admission Screening Programs. Interstudy Center for Aging and Long-Term Care. Excelsior, MN. Mar. 1986.

enacted tax provisions specifically designed to assist caregivers with the expenses of caring for older persons. These States are Arizona, Idaho, Iowa, North Carolina, and Oregon. 64/

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64/ National Association of State Units on Aging. State Tax Policy Options for the Elderly: A Guide for Aging Advocates. Washington, D.C., May 1985. p. 46-47.

IV. PRIVATE SECTOR APPROACHES TO FINANCING AND DELIVERY OF  
LONG-TERM CARE

During the past several years, the focus of the long-term care debate has shifted from concern solely with reform of the way Federal programs support long-term care to consideration of private sector initiatives which might improve the elderly's ability to finance long-term care. This shift in focus has occurred for several reasons.

Expenditures under entitlement programs which already finance health and long-term care services, Medicare and Medicaid, have increased substantially over the years and continue to increase, despite reconciliation legislation which has slowed the rate of growth of these expenditures. There have also been large budget deficits which make the establishment of any new program difficult for some policymakers, especially one that might result in large additional and unpredictable Federal expenditures that could contribute to the deficit.

In addition, observers have noted that the decline in the ratio of workers to retirees and the growth in numbers of the very oldest segment of the population may have a marked impact on the ability of public programs to support long-term care in the future. Others also point out that the economic status of future generations of the elderly may improve significantly and that they may therefore be able to pay for a larger portion of the cost of certain long-term care services.

A number of private sector approaches have been suggested as potentially feasible alternatives for financing long-term care services. These range from ways to pool risks associated with the need for long-term care, through private insurance and life care communities for example, to conversion of an elderly homeowner's equity into a source of funds to pay for care. A discussion of each of these options and their feasibility for financing long-term care follows. Another method of risk pooling, the S/HMO, was discussed above in the section on Federal demonstrations. This report does not discuss still other options suggested for enhancing the elderly's ability to finance long-term care expenses, including various savings incentives such as individual retirement accounts (IRAs), and other tax code modifications to assist families providing long-term care services.

What role private sector options will play in the future in financing long-term care is unclear at the current time. The improvement in the economic status of certain groups of elderly may lead policymakers to create incentives for relatively better off persons to use these options to finance at least a portion of the costs of their care. Public sector support might be reserved for the most needy income categories of elderly and/or for those with large and prolonged long-term care costs. At the current time, however, most elderly do not have the resources to pay for the catastrophic expenditures associated with long-term care services over an extended period of time. For many, depletion of assets and income on the cost of care and subsequent Medicaid eligibility is the only option.

#### **A. Private Health Insurance Coverage for Long-Term Care**

Among the private sector approaches receiving the most attention recently as a potential alternative for financing long-term care services is private

health insurance. This alternative has been suggested not only because of growing fiscal constraints on public program expenditures, but more basically because private insurance coverage is currently available for a wide variety of health care services and catastrophic illness. Private insurance, however, has only recently been available for long-term care services or the catastrophic costs associated with long-term care.

Expenditures for long-term services, and especially for nursing home care, not only strain the budgets of public programs; they are also a burden on private resources. In 1986, total national nursing home expenditures of \$38 billion were financed about equally by public programs and private sources of payment. Public programs financed \$18 billion of the total, and private sources \$20 billion. Of total private spending for nursing home care in 1986, only 1.5 percent was paid by private insurance coverage. Ninety-seven percent of the total private spending for nursing home care was paid directly by the consumer out-of-pocket. The average annual cost of nursing home care is in the range of \$20,000 to \$25,000 per year, representing a catastrophic expenditure beyond the financial reach of most elderly. <sup>65/</sup> In fact, one study found nursing home cost to be the primary catastrophic expense of elderly persons with out-of-pocket expenses over \$2,000 a year. For these individuals with high out-of-pocket costs, nursing home care accounted for over 80 percent of these costs. <sup>66/</sup>

In addition, private insurance coverage has been viewed by many as a promising alternative because of general interest among the elderly population in purchasing private insurance to supplement their Medicare benefits.

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<sup>65/</sup> Doty, Liu, and Wiener, p. 74.

<sup>66/</sup> Rice, Thomas, and Jon Gabel. Protecting the Elderly Against High Health Care Costs. Health Affairs, v. 5, no. 3, fall 1986. p. 17.

Approximately 70 percent of the elderly purchase such policies. While these policies generally pay only certain deductible and coinsurance amounts for which Medicare beneficiaries are liable and do not cover long-term care, the widespread interest of the elderly in this broader coverage suggests to some observers that a market for long-term care coverage can and does exist.

Furthermore, advocates of this approach argue that nursing home utilization is an insurable event. They point to the studies, mentioned earlier in this report, showing that 75 percent of persons entering a nursing home stay less than 1 year, and relatively few stay for long periods of 3 years or more.

Although there is a good deal of activity today in the private long-term care insurance market, with more policies being offered and older policies being revised to provide more liberal coverage to the consumer, the private insurance industry has approached this potential market with caution. They have pointed out a number of problems. First, insurers have been concerned about the potential for adverse selection in long-term care insurance, where only those persons more likely to need care actually buy insurance. In addition, they point to the problem of the induced demand for services that can be expected to be generated by the availability of new long-term care insurance. With induced demand, sometimes also referred to as moral hazard, individuals decide to use more services because they have insurance and/or will shift from non-paid to paid providers for their care. This is especially critical in long-term care with about 60 to 80 percent of long-term community-based services being provided by family or friends who are not currently compensated.

There is the additional problem that many long-term care services that are felt to be critical in enabling frail elderly persons to remain in their homes are custodial, non-medical services. Traditionally these services, such as

personal care and homemaker services are considered noninsurable because of difficulty in confining eligibility to a limited number of people. In addition, given the nature of many chronic conditions, many people who need long-term care will need it for the remainder of their lives, resulting in an open-ended liability for the insurance company.

The insurance industry has pointed to one other barrier to the development of private insurance policies: that being the major role played by Medicaid in financing long-term care and especially nursing home care. According to this view, Medicaid is already viewed by many as a national coverage program for long-term nursing home care and does not have attached to it any stigma of a welfare benefit for the poor. Although Medicaid requires individuals to spend down their resources and income on the cost of their care before they can become eligible for Medicaid, the insurance industry and others have also observed that the ability of individuals to plan for the transfer of assets in advance of using nursing home care expands the number of persons who can receive this Medicaid benefit.

Despite these problems, the insurance industry has indicated increasing interest in the long-term care market. Surveys of long-term care insurance policies in 1986 found approximately 30 policies. <sup>67/</sup> In 1987 the DHHS Task Force on Long-Term Care Insurance Policies found 73 companies writing long-term care insurance policies covering 423,000 persons. <sup>68/</sup>

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<sup>67/</sup> Wiener, Joshua, Deborah Ehrenworth, and Denise Spence. Private Long-Term Care Insurance: Cost, Coverage and Restrictions. Unpublished paper. The Brookings Institution. Washington, D.C., Dec. 1987. Long-Term Care Insurance: Coverage Varies Widely in a Developing Market. U.S. General Accounting Office. May 1987. GAO/HRD-87-80.

<sup>68/</sup> U.S. Dept. of Health and Human Services. Report to Congress and the Secretary by the Task Force on Long-Term Health Care Policies. Sept, 1987. p. 72.

Available long-term care insurance policies vary greatly by benefits covered and length of time benefits are covered. Initially coverage of most plans focused on nursing home care. More recently developed policies seem to be offering more home care benefits. A GAO survey of 33 policies in 1986 found that nursing home benefits ranged from 3 months to 6 years, and home health benefits ranged from 10 days to 6 years. 69/

Most plans provide indemnity benefits that pay only a fixed amount for each day of covered service, thereby limiting the insurers' liability. Generally these payment amounts are not indexed to increases for inflation. Almost all long-term care policies contain restrictive clauses to limit further an insurer's liability and to control utilization of services. For example, policies frequently require that covered care be medically necessary or follow a hospitalization before benefits are paid. This may be particularly restrictive for persons needing certain home care and personal care assistance. In addition, policies often exclude from coverage certain pre-existing conditions and will deny claims for services needed in connection with such conditions.

Premiums for these diverse policies vary a great deal. Premiums are generally set by age at purchase, and the initial premium remains constant as a person ages, unless all premiums are raised for all age groups. A Brookings Institution survey of available policies in 1986 found that a low option policy paying \$40 per day for skilled nursing care and meeting certain other criteria had an average annual premium of \$318 for persons purchasing at the age of 65 and \$728 for persons age 79-80. A high option policy paying \$60 a day for skilled nursing services had an average annual premium of \$684 for persons age 65 and \$1,496 for individuals 79-80. 70/ Brookings points out that these

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69/ U.S. General Accounting Office, Long-Term Care Insurance, p. 21.

70/ Wiener, Private Long-Term Care Insurance, p. 5.

premiums are much higher than premiums for insurance policies that many elderly purchase to supplement their Medicare coverage. A 1985 survey found that the majority of persons buying these supplemental policies paid \$250-350 a year. 71/

Many agree that one of the keys to the future development and growth of the long-term care insurance market is increasing the affordability of premiums. One of the ways to accomplish this is to expand the pool of persons to whom policies are sold. Employer-based group coverage, some argue, offers significant potential for expanding the long-term care insurance pool and reducing premium cost. Premiums should be lower in employer-based group coverage because younger age groups with lower levels of risk of needing long-term care would be included, allowing reserves to be built up. In addition, group coverage has lower administrative expenses. Currently a significant portion of long-term care insurance premiums is associated with the expense of marketing and underwriting individual policies, where sales are made one at a time. 72/ Group coverage for long-term care has not been available until fairly recently. Some of these plans cover active and retired employees and their spouses, as well as the parents of active employees. At the end of 1986, one insurance company announced its intention of offering group coverage for long-term care. As of December 1987, three insurance companies sold coverage to 6 different groups, with a total of 15,000 persons enrolled. 73/

In addition, the Office of Personnel Management announced in January 1987, the intention of adding a new long-term care option to the life insurance

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71/ Ibid.

72/ Rivlin, Alice, and Joshua Wiener. Caring for the Disabled Elderly: Who Will Pay? The Brookings Institution. Washington, D.C. 1988. p. 69.

73/ Health Insurance Association of America. Employer-Sponsored Group Long-Term Care Plans as of Dec. 1987.

program currently available to Federal employees. Under the proposal, Federal employees who have been covered under the life insurance program for at least 10 years and who are at least 50 years old could convert a portion of their basic insurance to long-term care protection. As presently conceived, Federal employees could voluntarily elect to pay an additional long-term care premium that would entitle the employee up to 3 years of nursing home care or home health benefits paid at a fixed amount.

But just how broad-based employer interest is in a new employee benefit, let alone a long-term care benefit, is unclear at the present. Many employers currently face large unfunded liabilities for retiree pension and health benefits. Many employers also experienced this year fairly substantial increases in premiums for their current health benefits plans. In addition, employers offering coverage for long-term care have required their employees to assume the full premium cost of the plans.

One other suggestion has been offered for increasing the affordability of long-term care insurance. This would involve limiting the exposure of the insurance company to long-term nursing home costs by guaranteeing Federal or other government payment beyond a certain length of stay. Under this proposal, which is often referred to as stop/loss, persons who use long-term care would be responsible for the first 2 or 3 years of costs of care and would presumably buy an insurance policy to provide that protection. After that exposure, a government program would pick up the costs, without requiring persons to deplete their income and assets for the cost of care as is currently required under Medicaid. One of the assumptions behind this proposal is that insurance companies would be able to reduce premium costs since they would no longer have to worry about the costs of long-stay nursing home patients.

There is interest at both the Federal and State levels in this idea. One State, Indiana, has passed legislation providing to those persons purchasing a qualifying long-term care policy (i.e., a policy that meets certain criteria) the protection of Medicaid without requiring a person to spend down income and assets. This program will not be implemented until July 1989. It should be noted that the private insurance industry has expressed reservations about this approach and has suggested that premium costs may not be significantly reduced when a government program begins to pick up the costs for long-stay nursing home patients. The insurance industry suggests that initial age of purchase has more of an impact on premium cost than duration of coverage.

The DHHS Task Force on Long-Term Health Care Policies included in its September 1987 report to Congress a number of other recommendations for expanding the market for long-term care insurance. These include (1) informing consumers that Medicare and other health insurance policies do not cover long-term care; (2) encouraging the purchase of long-term care insurance through the preferential tax treatment of pension and other retirement funds used for this purpose; (3) creating other tax incentives that would encourage the development and purchase of policies; and (4) assuring consumer protection by encouraging States to adopt standards for policies that meet those developed by the National Association of Insurance Commissioners in its Long-Term Care Insurance Model Act.

What role private insurance will play in the financing of long-term care in the future is unclear at this time. Certainly its role is very limited for the poor and near-poor elderly. In addition, concern has been expressed about the extent to which existing policies will cover long-term care expenses in the future.

The Brookings Institution has been looking at various private sector options for financing long-term care, and especially the private insurance option. In a recently published book, Caring for the Disabled Elderly: Who Will Pay, the Brookings authors argue that long-term care insurance will finance only a modest proportion of total nursing home expenditures by the years 2016-2020. <sup>74/</sup> They point out that one of the major problems with private long-term care insurance policies is the lack of an indexed benefit. A policy that pays \$60 a day for care when a person purchases the policy at the age of 65 will not buy much care 20 years later when that person is most likely to use the benefit, if that benefit is not indexed to inflation or medical care inflation.

However, as noted above, the private insurance market for long-term care is a rapidly changing one. Three Blue Cross/Blue Shield plans have introduced service benefit long-term care insurance policies, which cover a certain number of nursing home days and home health visits, without regard to cost of a day of care. These policies are implicitly indexed. In addition, other indemnity policies have recently come on the market with indexed benefits.

The large number of changes in long-term care insurance policies in the past few years indicate that this market is in the early stages of development. Whether private insurance will play a significant role in financing long-term care in the future will depend in part on the nature of changes in this market over time. Policymakers will be watching to see if the insurance industry will create products that provide meaningful protection for the expenses associated with long-term care and whether these products will be affordable by large numbers of persons.

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<sup>74/</sup> Rivlin and Wiener, Caring for the Disabled Elderly, p. 22-23.

B. Life Care or Continuing Care Retirement Communities 75/

One long-term care living arrangement available for financing long-term care services for a limited but potentially growing number of elderly persons is the life care community. Life care communities, also called continuing care retirement communities, are organizations, usually situated in a campus-like setting, established to provide housing, meals, housekeeping, and social activities, to older persons for the duration of their lives. In addition to these basic services, life care communities provide long-term care services offered on the grounds of the facility.

The distinguishing characteristic about life care communities is the guarantee that residents will be provided with a range of services as long as they are residents of the community. Rights and obligations of the resident and the community are defined under the terms of a life care contract. The life care contract sets forth the services to be received by the resident in exchange for financial payments, including an entrance fee and monthly charges. Because the life care contract is intended to provide financial protection against the future cost of long-term care services for each resident, it is viewed in part as a form of insurance.

Long-term care services provided in a life care community may include skilled and intermediate nursing home care, personal care, and other health care services such as home nursing, and physical, occupational, or speech therapy. Life care communities may differ in the amount of pre-paid nursing care offered under the terms of the contract. Acute care and hospital care are not provided, and some communities may require the resident to share in the

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<sup>75/</sup> Portions of this section were drawn from CRS Report 85-1127 EPW, Life Care Communities: Description and Current Issues, by Evelyn Howard, Dec. 23, 1985.

cost of health/long-term care services they receive from the community. Residents continue to use Medicare and/or private insurance plans to cover the costs of acute and long-term care services.

Generally residents who enter life care communities are relatively healthy but as their health/long-term care needs increase, they are provided with increased services as stipulated under the terms of the life care contract.

The number of life care communities and residents is relatively small. Estimating the exact number of facilities and residents is difficult due to variations in the definitions used to characterize communities. A 1987 study by the American Association of Homes for the Aging (AAHA) and Ernst and Whinney found about 683 communities. <sup>76/</sup> Another report estimated that in 1986 there were about 850 communities serving about 150,000 households. <sup>77/</sup> Analysts predict growth in the number of facilities in the future, yet sources of information differ as to how much growth has actually occurred and will occur in coming years. One source indicated that in the last decade, the total number of communities has remained relatively constant, with smaller facilities being replaced by larger communities. <sup>78/</sup> According to an AARP study, the number doubled in the past 10 years and is expected to more than double in this

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<sup>76/</sup> American Association of Homes for the Aging and Ernst and Whinney. Continuing Care Retirement Communities, An Industry in Action. 1987. p. 5. A 1984 study, Continuing Care Retirement Communities: An Empirical, Financial and Legal Analysis [by] Howard E. Winklevoss and Alwyn V. Powell estimated that there were about 275 life care communities serving about 90,000 elderly persons. Another survey of the life care industry in 1984 by Laventhol and Horwath, estimated about 600 communities.

<sup>77/</sup> These numbers were cited in a 1986 Wall Street Journal article cited in Netting, F. Ellen and Cindy Wilson. Current Legislation Concerning Life Care and Continuing Care Contracts. The Gerontologist, v. 27, no. 5, 1987. p. 647.

<sup>78/</sup> Ibid.

decade. <sup>79/</sup> Although most of the life care facilities in existence are operated by private, non-profit organizations, and some are affiliated with religious organizations (primarily Protestant), there has been increasing interest on the part of corporations, including major hotel, hospital and nursing home chains, insurers, and banks, in developing such facilities. <sup>80/</sup>

In order to gain access to a life care community, a resident is required to pay a lump sum entrance fee with monthly payments thereafter which are usually adjusted for inflation. Fees are generally based on the size and type of living unit (e.g., studio, one-, two-, or three-bedroom apartment). In addition, fees are based on some actuarial assumptions, such as life expectancy rates and projected future health care needs.

Some analysts have observed that the entrance and monthly fees may make the life care or retirement community option inaccessible to large numbers of elderly. The AAHA-Ernst and Whinney study found that the median entrance fee was \$45,300 for a 1-bedroom unit in 1986, with entrance fees ranging from \$19,500 to \$107,450, depending on the size of the living unit. Average monthly fees in 1986 ranged from \$570 to over \$1,100, depending on the type of facility and size of living unit. <sup>81/</sup> Others, however, dispute the claim that life care is only for the relatively well-off elderly.

The life care concept is a form of long-term care insurance in that residents pool their resources and share the risk of future costs of long-term care services. A portion of the entrance fees and monthly fees paid by all residents is used by the community to pay for the health and long-term care

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<sup>79/</sup> American Association of Retired Persons. National Continuing Care Directory, edited by Ann Trueblood Raper. Washington, D.C., 1984. p. 5.

<sup>80/</sup> Netting and Wilson, Current Legislation Concerning Life Care, p. 645.

<sup>81/</sup> American Association of Homes for the Aging and Ernst and Whinney, p. 17, 19-24.

costs of a small number of residents needing more extensive care at any given time. Because only a small number of residents would be expected to need intensive services at a given time, the fees could be considered like insurance premiums paid by the entire group but used by only a small group at a given time. In some cases, participation in a life care community may be viewed as a form of income redistribution when some portion of the fees paid by all residents are used to subsidize the costs of residents who can no longer afford to pay for their own care. 82/

Supporters of life care communities indicate that there are a number of advantages in this mode of long-term care. Life care communities offer continuous, and in large part, pre-paid health and supportive care in a protected setting with personal and financial protection against the costs of future health long-term care needs. Residence in such a community may offer increased opportunities for residents to maintain their relatively healthy status upon entry since professional oversight is available on a regular basis, as compared to completely independent living in the community where older persons may not actively seek health promotion opportunities. Residence in a protective community which offers a range of care may allay the fears that many elderly face of making a sharp transition from their homes to permanent residence in a nursing home when they become suddenly disabled. The pooling of health and long-term care risks may reduce the uncertainties of future costs of care, and the care provided under the terms of the life care contract can supplement coverage of acute care provided by Medicare and private health insurance.

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82/ Winklevoss and Powell, Continuing Care Retirement Communities, p. 13.

While life care communities may offer an option to some elderly, and even increasing numbers in the decades to come, they may not be able to serve a large proportion of the elderly population in general. Life care is not an option for the poor elderly or those with relatively intense pre-existing health/long-term care needs. Moreover, the idea of signing over a large portion of accumulated assets in one lump sum to an organization in return for protection against future costs may not be acceptable to large numbers of elderly persons. Turning over assets in such a way may eliminate inheritances for children which some elderly may wish to protect.

While some elderly may not be able to afford the relatively hefty entrance fees, analysts have pointed out that the equity older persons have in their homes may be employed for this purpose. The proportion of elderly persons owning their homes is large and they have substantial equity as a result. Of the 18.9 million households headed by older persons in 1985, 73 percent were owners. <sup>83/</sup> The median value of equity in homes held by the elderly in 1984 was \$46,000. <sup>84/</sup> More than 80 percent of the elderly have paid-off mortgages. <sup>85/</sup> One study points out that the high level of net home equity held by the elderly is not held only by those with higher income. About 65 percent of all elderly poor are homeowners, with 22 percent of the poor having more than

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<sup>83/</sup> Unpublished data from the Department of Housing and Urban Development.

<sup>84/</sup> U.S. Bureau of the Census. Current Population Reports. Series P-70, no. 7. Household Wealth and Asset Ownership: 1984. U.S. Govt Print. Off., Washington, D.C., July 1986. The mean value of home equity in 1984 was \$55,000.

<sup>85/</sup> Jacobs, Bruce. The National Potential of Home Equity Conversion. The Gerontologist, v. 26, no. 5, 1986. p. 496.

\$50,000 in net home equity. 86/ Other analysts indicate that because future generations of elderly will be better off than those of the past, they may be in a more advantageous position to afford payments for life care communities in the future. Inflation-adjusted retirement income under Social Security combined with private pensions and with IRA income may make the inflation adjusted monthly fees associated with life care communities payable by increased numbers of future generations of elderly.

Experience with life care communities is limited as are data about their effect on costs of organizing an integrated, pre-paid approach to long-term care service delivery. While it has offered an attractive option to a small number of elderly persons in the past, there have been problems. Some communities have experienced financial problems due in part to poor actuarial assumptions about the projected longevity of residents and their future health care needs, resulting in depletion of funds to cover costs. In view of these considerations, there has been interest on the part of Federal and State officials in more oversight and regulation over the development of these facilities in the interest of consumer protection. 87/ According to a 1986 national survey, 20 States had enacted legislation to regulate the life care industry and 7 States had such legislation under development. 88/

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86/ Jacobs, Bruce and William Weissert. Home Equity Financing of Long-Term Care for the Elderly. Long Term Care Financing and Delivery Systems: Exploring Some Alternatives. Conference Proceedings. Health Care Financing Administration, Department of Health and Human Services. Washington, D.C. Jan. 1984. p. 83.

87/ See U.S. Senate Special Committee on Aging, Life Care Communities: Promises and Problems. S. Hrg. 98-276. Washington, D.C. May 25, 1983. In 1978, the Federal Trade Commission began investigating management and marketing practices of some life care communities.

88/ Netting and Wilson, Current Legislation Concerning Life Care, p. 645.

### C. Home Equity Conversion

The search for alternative approaches to financing long-term care services has led some researchers to analyze the feasibility of using the single largest asset most older persons have--the equity in their home. As pointed out in the previous section, about 73 percent of elderly headed households are homeowners. The overall homeownership equity held by elderly is substantial. The total equity held by elderly homeowners is estimated to be between \$548 billion and \$700 billion. <sup>89/</sup> Some observers believe that, if converted into a source of cash, homeowner equity could be a tangible means of financing long-term care services for some elderly who are "house rich, but cash poor."

There are two major types of mortgage instruments which may be used to convert equity into income: reverse mortgages, and sale/leaseback contracts. <sup>90/</sup>

- o The reverse mortgage is the reverse of the traditional mortgage in the sense that the homeowner receives monthly payments from the lender instead of making such payments to the lender. The homeowner enters into a loan agreement under which the lender becomes committed to making a stream of monthly payments to the borrower and the payments are to be repaid at some future date. The monthly payments (and interest on those payments) accumulate as a debt against the home. Usually the payments are calculated to accrue to some predetermined value over some predetermined time period. An elderly homeowner, for example, may obtain a reverse

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<sup>89/</sup> U.S. Department of Health and Human Services. Catastrophic Illness Expenses. Report to the President, Nov. 1986. p. 80-81. See U.S. Congress. Senate. Special Committee on Aging. House Select Committee on Aging. Home Equity Conversion. Issues and Options for the Elderly Homeowner. Statement of Bruce Jacobs, University of Rochester. p. 14; and testimony of Kenneth Beirne, General Deputy Assistant Secretary for Policy Development and Research, Department of Housing and Urban Development. Briefing Document. House Pub. 99-513. Washington, D.C., Jan. 28, 1985. p. 58.

<sup>90/</sup> Reverse mortgages are also sometimes described as reverse annuity mortgages or loan plans. For further information, see Converting Home Equity Into Income for the Elderly: Issues and Options, by B. Ellington Foote, CRS Report No. 84-42. Apr. 5, 1984.

mortgage under which the monthly payments will accumulate a debt of \$60,000 in 10 years. At the end of the loan term the homeowner may have the option of obtaining a new reverse mortgage, or paying the debt by selling the home or converting to a regular first or second mortgage. The term for reverse mortgages typically ranges from 7 to 10 years. Under the Individual Retirement Mortgage Account, which is offered in about 7 States, the reverse mortgage runs for the remainder of the individual's lifetime.

- o Under the sale/leaseback contract, the homeowner sells the equity in the home but retains the right to reside there, usually for life. The buyer of the equity provides the elderly homeowner with a down payment and pays the balance in regular monthly installments. The seller, then, in effect becomes a renter of the home which he/she formerly owned.

In one extensive analysis of the potential for application of homeowner equity toward payment of long-term care expenses, researchers concluded that there is evidence that a large proportion of older persons could use some of their home equity to finance long-term care needs. This analysis showed that about one-third to one-half of all elderly homeowners at high risk of need for home care could finance a portion of home care needs out of homeowner equity. The analysis also found that homeowner equity could be used to pay for long-term care insurance premiums as well as for nursing home care. <sup>91/</sup> Another analysis which reviewed the potential for use of homeowner equity to purchase private long-term care insurance showed that home equity conversion could increase the ability of some elderly homeowners to pay for long-term care insurance, but concluded that reverse annuity mortgages and sale/leaseback arrangements do not easily provide for long-term care financing. Since these arrangements provide payments to individuals for longer periods of time than

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<sup>91/</sup> Jacobs, Bruce and William Weissert. Home Equity Financing of Long-Term Care for the Elderly. Long Term Care Financing and Delivery Systems: Exploring Some Alternatives, Conference Proceedings, Health Care Financing Administration, Department of Health and Human Services. Washington, D.C., Jan. 24, 1984. It should be noted that these findings were based on a model of probability of using home equity for this purpose, not on actual experience as to application of equity toward long-term care expenses.

usually needed to finance certain long-term care expenses, they may not have wide application for certain expenses requiring lump sums of cash over a short period of time. This report suggested that home equity conversion could be more useful if financial institutions permitted owners to use their homes as lines of credit, as necessary, to pay for long-term care expenses. 92/

While the idea of using home equity for payments of on-going expenses of the elderly has appeared in the literature for a number of years, the actual number of home equity conversion contracts is very limited. Lenders in only a handful of States have offered home equity loans and these loans may not be made on a regular basis. 93/ Therefore, the actual experience is relatively meager and its specific application to long-term care may be tentative. Recent changes in the Federal tax code may encourage the development of the use of home equity for purposes defined by elderly homeowners.

Thus far, there appears to be a lack of consumer demand. Moreover, some have indicated that it is not possible to accurately estimate demand until a variety of products are available and experience with various programs is accumulated by individuals and organizations to serve as examples for other potential users. 94/ A number of obstacles have been cited as barriers to the future development of these arrangements. Many of the elderly may be reluctant to enter into these agreements because they wish to pass on some

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92/ ICF Incorporated. Private Financing of Long-Term Care: Current Methods and Resources. Phase II. Submitted to the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Jan. 1985. p. 25-26.

93/ According to an information paper of the U.S. Senate Special Committee on Aging, lenders in the following States have offered loans: Arizona, California, Maine, Minnesota, New Jersey, Ohio, Pennsylvania, and Wisconsin. See U.S. Congress. Senate. Special Committee on Aging. Turning Home Equity into Income for Older Homeowners: An Information Paper. S. Rept. 98-216. July 1984. p. 12.

94/ Jacobs, The National Potential of Home Equity Conversion, p. 502.

inheritance to their heirs. Also, even if this strategy were more widely available, some question whether the elderly would actually use the funds to pay for long-term care services. Other elderly may not participate because they may feel that services available from public sources will be decreased if they use their home equity. Also, they may feel that if they outlive their equity, they may be forced to move. A number of other issues have been raised, including possible depreciation of homes, and concern that the elderly would not receive fair market value for their homes or that the lenders may default on the loans. These issues would require consumer protection measures.

There has been reluctance on the part of financial institutions to offer these instruments, particularly due to the current lack of mortgage insurance on the loans. Also, if the elderly homeowner lives beyond his/her equity, lending institutions may lose money because they may be reluctant to evict an elderly homeowner when the equity is exhausted. Finally, institutions may not want to enter into agreements in cases where the home is not expected to appreciate.

Other issues with respect to the tax implications of home equity conversions remain to be resolved. According to the Department of Housing and Urban Development (HUD), the status of sale/leaseback arrangements under the Internal Revenue Services (IRS) code is unclear. Questions in need of resolution include the right of the seller-lessee to take advantage of the one-time homeowner capital gains exclusion, and the ability of the purchaser-lessor to depreciate the rental property like other rental property. 95/

While home equity conversion is not extensively available, such arrangements may be attractive to some elderly for targeted long-term care expenses

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95/ U.S. Congress. Senate Special Committee on Aging and House Select Committee on Aging. Home Equity Conversion: Issues and Options for the Elderly Homeowner. Testimony of Kenneth Beirne, p. 59.

if the market became sufficiently developed and loans were devised to be responsive to individual needs. Conversion of home equity into cash to be applied toward the down payment for life care facilities was discussed above. Conversion of home equity to remain in one's own home may be more attractive in the long run than using equity to finance a life care facility down-payment. Because this option allows "house rich, but cash poor" elderly to remain in their own homes by drawing upon a ready flow of funds, it may ultimately appeal to many more persons than life care. It may particularly appeal to those without heirs. Advocates of this concept indicate that this strategy could generate a significant amount of funds which, if directed toward payment of long-term care services currently paid for by public sector programs, could reduce pressure on these programs.

V. ISSUES TO BE CONSIDERED IN FUTURE PROSPECTS FOR LONG-TERM CARE

In the past, debate on Federal long-term care policy has focused on a number of issues which policymakers still seek to resolve: how to offer more consistent and adequate protection for long-term care expenses; how to strike a balance between institutional and community-based care; and how best to target services on those most in need. Whereas in the past these issues were discussed principally in the context of proposals to reform Federal programs of support, more recent attention has been given to the role private sector alternatives, such as private insurance, life care communities, and home equity conversion mechanisms, can play in protecting the elderly from the catastrophic costs of long-term care. However, analysts have pointed out that alternatives such as these may not reach a large proportion of the elderly in need of long-term care and may only cover a portion of the costs of care they require. Some analysts, therefore, believe that both public and private sector strategies must be employed to accomplish goals of assuring adequate access to care and protection against the costs of this care. Recognizing that public financing is limited, policymakers have focused their concern with reform of public sector programs on strategies to define what portion of the elderly population in need of long-term care should be covered, what portion of expenses should be covered, and what financing alternatives can be identified. Reform of the way current Federal programs finance long-term care will be an area of continued interest due to the large Federal investment in long-term

care as well as the large numbers of elderly who depend on these programs for assistance.

Some of the questions to be addressed in the future may include the following:

- o What are appropriate roles for public programs and private sector options to play in the financing of long-term care? How should the public and private sectors respond to the needs of a diverse population? What alternatives can be developed to assure that public and private sector options will complement each other?
- o Assuming that some expansion of public programs will be necessary, how should the eligible population be defined? Should eligibility be based on levels of disability? If so, what levels? Should the presence of a family caregiver determine the level of benefits received? To what extent should the cost of an expanded public approach be borne by families and individuals? Should financial responsibility be related to ability to pay? What measures should be employed for controlling the costs of care?
- o To what extent should an expanded Federal role represent a modification of the Medicare program whose focus is on acute care? To what extent are the characteristics of long-term care services sufficiently different from acute care to require other approaches to reform?
- o What are appropriate roles for both the Federal and State governments in an expanded public sector approach? Given the substantial investment by some States in developing statewide systems for community-based long-term care over the past decade, what role should States play in the future?
- o Can private sector alternatives begin to improve the ability of the elderly to finance their own long-term care expenses without reform of Federal programs of support? Can comprehensive long-term care coverage be provided without public mandate and/or subsidy? What measures are necessary to obtain an adequate population base for long-term care insurance that is affordable? What tax incentives would be most effective in stimulating the development of an adequate private market for insurance?
- o Public programs and limited private insurance currently provide more support for institutional forms of long-term care than for community-based care. While uncertainty about the costs of expanded community-based care has inhibited the broadening of coverage, community care is the option of choice among many elderly persons. There is also substantial evidence that family members would prefer to continue providing support services to their disabled members if assistance were more fully available to ease the burden of caregiving. What are the most efficient means of assisting families while at the same time assuring cost

controls and efficient use of both public and private sector support?

- o What other viable options exist for enhancing the elderly's ability to finance long-term care expenses without impoverishment? Some have encouraged Federal and State tax modifications, and cash accumulations plans such as Individual Retirement Accounts for long-term care. Others have pointed to the need to expand incentives for special housing arrangements for the elderly.

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## **Catastrophic Health Insurance IP 370C**

President Reagan signed the Medicare Catastrophic Protection Act of 1988 (Public Law 100-360) into law on July 1, 1988. The law provided insurance to Medicare beneficiaries against the catastrophic expenses of serious illness or injury. The expanded benefits were financed through increases in Medicare premiums. On December 13, 1989, President Bush signed the Medicare Catastrophic Coverage Repeal Act of 1989 (Public Law 101-234) which repealed the catastrophic coverage provisions of Public Law 100-360. The material in this Info Pack discusses both laws and the problem of catastrophic health insurance.

Members of Congress who want further information on this topic may contact CRS at 707-5700. Additional CRS Reports may be identified by looking in the current *Guide to CRS Products* (for congressional use only) under "Health Insurance" and in the latest *Update* under "Health."

Additional information on this subject, primarily in periodicals and newspapers, may be found at a local library through the use of indexes such as the *Readers' Guide to Periodical Literature*, Public Affairs Information Service *Bulletin* (PAIS), and various newspaper indexes.

We hope this information will be helpful.

Congressional Reference  
Division

# Lawmakers Tell the Elderly: 'Next Year' on Health Care

By MARTIN TOLCHIN

Special to The New York Times

WASHINGTON, Nov. 22 — Hours after Congress voted to repeal the Medicare act covering the high costs of extended illness, House and Senate leaders pledged today to address health care for the elderly next year. But they acknowledged that many political obstacles remained.

The repeal of the Medicare Catastrophic Coverage Act was among the final acts of Congress before it adjourned for 1989 before dawn today. In the closing hours Congress also approved a \$14.7 deficit-reduction package that includes several minor tax increases and retains across-the-board spending cuts that automatically took effect Oct. 1 to meet the requirements of the budget-balancing law.

But the issue that dominated most of

## The contentious fight over Medicare quietly ends at 2 A.M.

Congress's final days was the contentious fight over repealing the expansion of Medicare to help the beneficiaries avoid financial ruin because of illness. Despite several last-minute efforts by the Senate to salvage part of the program, it finally fell. Tens of thousands of older Americans have protested having to pay a surtax to help finance the program, which provided health benefits that many received as retirees.

They also protested the program's failure to provide the protection many older Americans seek: insurance for the costs of long-term nursing home care. Such expenses have forced many families into bankruptcy.

### Final Vote in Early Hours

"Understandably, there is a reluctance on the part of members of Congress to get into the whole area, having just been burned on catastrophic," said Senator George J. Mitchell, of Maine, the majority Leader.

The final vote to kill the entire program of extended care came shortly before 2 A.M. after Senator Mitchell advised his colleagues that the Senate had but two choices: repeal the program or continue the current law, in-

cluding the politically unpopular surtax. Repeal came on a voice vote, with less than a handful of senators in the chamber. The Senate had tried to save parts of the program, but these efforts were rejected by the House.

"It's a quiet end to a long and loud controversy," Mr. Mitchell said.

### About 40% Paid the Surtax

The measure was intended to protect 33 million older and disabled Americans from the high costs of extended illness. It placed a ceiling on a Medicare patient's payments for hospitals, doctors and prescription drugs. The program also provided money for skilled nursing home care, mammography and hospice care and contained a provision intended to prevent the impoverishment of those with spouses in nursing homes.

But about 40 percent of the Medicare beneficiaries had incomes high enough to pay the surtax, which could be as much as \$800 a year for an individual. The surtax took effect this year, along with the hospital benefits, while payments for doctors under the plan was to take effect in January and the prescription drug benefits in January 1991. The plan is also financed by a flat premium of \$4 a month that is deducted from Social Security checks.

The Senate had sought to retain the hospital benefits, along with the flat premium, while eliminating the surtax.

But the Senate vote to repeal came this morning came after the House voted, 346 to 55, to reject the Senate effort to retain the ceiling on hospital payments.

"The seniors want and need protection against catastrophic illness," said Senator John McCain, Republican of Arizona, the sponsor of the Senate proposal.

The House voted 352 to 63 Tuesday to repeal the program, it third overwhelming vote to end the program.

### Monthly Deductions to End

The program will end when the President signs the bill and the deductions from the Social Security checks will stop.

Some lawmakers lamented the reluctance of the elderly to pay for health benefits and questioned whether Congress would approve legislation that would require all taxpayers to pay for the health care of the elderly, rather than address the health needs of the young and the 37 million people with no health insurance.

House Speaker Thomas S. Foley of Washington said, "I think there is a

concern on the part of the members that when we next undertake to address the problems of health care for the elderly, we will have the support of the constituency."

Senator Bob Dole, the Republican leader, also predicted that Congress would revisit the issue next year, but said that the lawmakers' inability to revise the Medicare program suggested that Congressional action would be long and difficult.

Representative Dan Rostenkowski, Democrat of Illinois, the chairman of the House Ways and Means Committee, said that he was dismayed that those who received new health benefits were reluctant to pay for them. The Congressman noted in a speech last week in Chicago that the elderly have often won the battle with the young over scarce Federal resources.

### 'The Old Have Gotten More'

"One of the most unhappy results of our ongoing budget gridlock has been an uneven contest between the very young and the very old," Mr. Rostenkowski said in the speech. "The young have lost nearly every time. That's partly because the old, however frail they may be, are sophisticated enough to use the political process to press their demands."

He said that "the sad story of the 1980's" was that "the old have gotten more while the young have gotten less."

Others insisted, however, that the Medicare expansion act helped an entire family by freeing adult children from the financial burdens of a sick parent, and thereby providing more spending money for the entire family.

# Health Law Surtax Defeated

## Senate Votes to Lower Catastrophic Benefits But Rejects Repeal

By Spencer Rich  
Washington Post Staff Writer

The Senate last night voted 99 to 0 to eliminate a controversial surtax and sharply reduce benefits in the 1988 law that protects elderly Americans from catastrophic health costs.

But the Senate refused to repeal the program altogether, as the House voted to do Wednesday, 360 to 66. The differences between the versions will have to be settled in a House-Senate conference.

The unanimous Senate vote adopted revisions proposed by Sen. John McCain (R-Ariz.), an arch-foe of the surtax that was resented by elderly Americans because the most affluent would have to pay up to \$800 this year to help finance the program.

"The surtax is the object of the ire and the anger of the senior citizens of America," McCain said. Sen. Phil Gramm (R-Tex.) said, "They hate it."

Under the McCain plan approved by the Senate, the program would retain the substantial improvement in Medicare hospital benefits voted in 1988, three improvements in Medicaid health care for the poor and several smaller Medicare benefits involving mammography, home health services, respite benefits for those caring for disabled relatives and hospice care.

But the Senate bill would eliminate two of the three biggest benefits in the 1988 law—the limits on out-of-pocket costs for doctor bills and prescription drugs.

While the bill would kill the surtax, it would leave in effect a non-controversial \$4 a month premium that will

rise gradually each year. It is paid by all Medicare beneficiaries, and McCain said the flat fee would fund all the benefits that his bill retains.

The proposal to repeal the law, proposed by Sens. John C. Danforth (R-Mo.) and William V. Roth Jr. (R-Del.), was defeated, 73 to 26. A plan sponsored by Sen. Dave Durenberger (R-Minn.) to retain the surtax, but limited to \$200 and save more benefits than the McCain plan, lost 52 to 37.

During the 11-hour debate, Senate opponents of repeal—many of whom also thought that McCain was cutting back benefits too much—expressed dismay at the intense opposition of elderly Americans over the surtax.

Some noted that only 5.6 percent of 33 million Medicare beneficiaries would have to pay the \$800 maximum premium this year.

"We've been hearing from some of the wealthiest citizens, said Minority Leader Robert J. Dole (R-Kan.). "The poor, the elderly and the sick are probably not going to contact us."

"The whole U.S. has been swung around on their tails by the 5.6 percent who don't want to pay for these benefits," Sen. Alan K. Simpson (R-Wyo.) said. "We're not confused; we're terrorized . . . Yeah, it's a social experiment; it's called pay for what you get."

"If we repeal this bill," Sen. Bill Bradley (D-N.J.) said, "people will die or go bankrupt . . . If we manage to salvage this program, next year they will thank us."

Durenberger expressed anger that President Bush had not taken an active role in defending the program. "If he'd work half as hard on catastrophic as he did on capital gains, we'd still have a bill."

But Sen. Orrin L. Hatch (R-Utah) said, "Most of the benefits will continue at a modest cost and we get rid of the surtax."

Sen. John D. Rockefeller IV (D-W.Va.) said that while he backed Durenberger's plan as more generous to the elderly, McCain's plan "is better than nothing."

When signed by President Ronald Reagan last year, the catastrophic illness law was lauded as the most significant advance in health care for

the elderly since Medicare passed in 1965. But opposition to the law surfaced when Congress convened in January and has increased ever since, fed by the resentment over the surtax.

Repeal or major retrenchment on a broad social benefits law of this type is unprecedented in modern times. In the case of the catastrophic law, resentment was spurred by its unique financing scheme under which the beneficiaries bore the entire cost of the program through premiums. All other social benefits of this type have been financed in whole or in part by taxes on the general population or the working population.

Durenberger argued that despite resentment over the surtax, the larger problem was "the doctor bills and medical bills" for 20 million older Americans with inadequate health insurance coverage or income to pay for medical care.

Senate Majority Leader George J. Mitchell (D-Maine) warned, "We must not lose sight of those who have no other recourse, who need that catastrophic protection and have no other way to get it."

In the key, early vote, the Durenberger plan lost decisively despite the support of Mitchell, Dole and Senate Finance Committee Chairman Lloyd Bentsen (D-Tex.) and the endorsement of Health and Human Services Secretary Louis W. Sullivan.

The White House, however, had said the Cabinet secretary was speaking for himself and not the administration. Sources said Sullivan protested to the White House against its refusal to endorse the Durenberger plan, which he considered the closest measure that met the administration's professed desire to preserve the 1988 law.

Besides cutting the maximum surtax to \$200 per person this year, the Durenberger plan would have elim-

# House Votes To Repeal Health Plan

## Action Follows Drive By Elderly Against 'Catastrophic' Surtax

By Spencer Rich  
Washington Post Staff Writer

The House voted 360 to 66 yesterday to repeal the 1988 law designed to protect the elderly from the costs of catastrophic illness.

After the vote to kill a program once hailed as the Reagan administration's major achievement in social policy, its supporters proposed a compromise that would have retained some benefits, but eliminated its most controversial component—a special income-based surtax. The House, however, was in no mood to compromise, and defeated that plan by a vote of 269 to 156.

The dramatic turnaround in the House—which approved the program overwhelmingly last year—followed an intense lobbying campaign by elderly Americans who bitterly opposed the surtax, which could cost the most affluent up to \$1,050 a year by 1993.

If the Senate follows the House's lead, it will mark the first time since the rise of the welfare state that Congress has acted to retract a major entitlement program. Supporters of the repeal yesterday said they were responding to the wishes of the elderly, while opponents warned that the House was making a mistake that would haunt it.

The 1988 law "has no support among the people we purport to help," said Rep. Brian J. Donnelly (D-Mass.), cosponsor of the repeal move along with Reps. Bill Archer (R-Texas) and Marty Russo (D-Ill.).

But Fortney H. "Pete" Stark (D-Calif.) said, "You allow the most well-to-do and highly organized of the seniors to turn you away from 20 million" who have no catastrophic protection of their own. "We are being stampeded by a small group . . . the wealthiest, to deny benefits to everyone else."

The catastrophic law increased three major Medicare benefits. It extended from 60 to 365 the number of days each year of hospitalization that would be paid for by Medicare; imposed a limit of \$1,370 a year on a person's out-of-pocket costs for Medicare-eligible doctor

See CATASTROPHIC, A28, Col. 1

### CATASTROPHIC, From A1

bills, and created a new prescription drug benefit under which the government would pay for the bulk of outpatient prescription costs once out-of-pocket payments reached \$600 a year.

All three improvements, along with some lesser ones, would be eliminated if the House bill passes the Senate. Three major Medicaid health benefits for low-income people would be retained.

Opposition to the catastrophic law first surfaced when Congress convened last January and has increased in intensity ever since. Objections from the elderly centered on an income-based premium, or surtax, required to be paid by the 40 percent of the elderly with the highest incomes to help finance benefits.

The amount rises along with income and could reach \$800 a person this year for the better-off elderly. Although only 5.6 percent of the elderly would pay the \$800 maximum this year, and three-fifths would pay no surtax because their incomes are too low, the provision prompted an avalanche of protests that even caught groups such as the American Association of Retired Persons, which supported the bill, by surprise.

Archer, the prime Republican sponsor of the repeal, called the special premium "an unfair tax" that subjects everyone who must pay it to "the highest tax rates of any group" in the country in order to finance benefits for fellow seniors who pay nothing and for the disabled who receive Medicare, including a growing AIDS population.

Policy analysts yesterday could not recall a similar instance where Congress repealed a major benefit and predicted that the controversy will dampen any enthusiasm for future legislation to benefit the nation's growing elderly population.

"This is without precedent," said Robert M. Ball, who served as Social Security commissioner under three presidents and is a Washington consultant. Congress has trimmed entitlement benefits, but usually adds or improves benefits for others in the process, Ball said.

Hugh Hecló, a political science professor at George Mason University and an authority on the federal bureaucracy, said he could recall only two similar instances of Congress wiping out benefit programs. The most recent occurred in the 1930s when Congress, furious at the Agriculture Department, abolished programs designed to help tenant farms. The other was in the 1870s when it disbanded the Freedman's Bureau, which was created to help former slaves.

Yesterday's vote, Hecló said, "lays the seeds for more inter-generational conflict," with younger people questioning why "we have been too generous to that portion of the population . . . They're taking it all and we're having to pay for it. They're not grateful for what we're trying to do."

Among the explanations given by members of Congress for the severity of the protests:

■ The benefit is the first to be funded entirely from premiums on beneficiaries, whereas benefits for the elderly traditionally have been paid for in whole or in part by general taxes on the whole population.

■ An estimated 5 million elderly already have roughly equivalent benefits financed in whole or in part by their former employers. For them, the high premiums are seen, in the words of one critic, as "a dead loss."

■ The mistaken belief by many elderly who will pay little or nothing because their incomes are too low that they must pay the \$800.

■ The belief by many elderly that long-term nursing-home care or custodial home care is preferable to additional hospital and doctor bill protections.

Calling for repeal, Donnelly said, "We didn't see a year ago . . . the fatal flaws. Over half the beneficiaries already had this coverage. We forced them to take it and pay an added fee" and did not give them "the right to choose their health coverage."

Rep. Willis D. Gradison Jr. (R-Ohio) said a better course than repeal would be to "refine" and correct the act's flaws. He said at least 15 million to 20 million elderly "will be much worse off" because of benefit loss from repeal.

"We in the Congress can't take the heat from a wealthy few," said House Ways and Means Committee Chairman Dan Rostenkowski (D-Ill.). "All principles are abandoned . . . Five million senior citizens may be complaining about the supplemental," but many millions more of the 33 million on Medicare, he said, are being hurt by repeal.

Like the Donnelly-Archer proposal, the substitute introduced by Stark, Gradison and Henry A. Waxman (D-Calif.) proposed to kill the premium and wipe out most of the major catastrophic-illness benefits of the 1988 law. But it would have retained the 1988 law's new prescription-drug benefit, several other Medicare benefits, including routine mammography screenings, and the Medicaid provisions.

The substitute was drafted last week in a last-ditch effort to stave off the repeal move. Archer, Donnelly and other advocates of repeal said the best course would be to repeal the whole law and start over again to construct some form of program that contained the benefits the elderly want with what they viewed as a fairer financing mechanism.

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*Staff writer Bill McAllister  
contributed to this report.*

## WHAT WAS VOTED DOWN

**T**he catastrophic-illness insurance program that the House voted to repeal yesterday was signed into law by President Ronald Reagan 15 months ago. The following key provisions would be eliminated from the law if the Senate concurs:

- Unlimited hospitalization coverage.
- A cap on out-of-pocket payments for doctors' bills.
- Help in paying for prescription drugs.
- Mammogram coverage.
- Improved coverage for nursing home care.
- Improved benefits for care in the home.
- Improved hospice benefits.
- A special premium or surtax of up to \$800 per person this year that would have helped finance the benefits.
- A flat monthly fee (\$4 in 1989).

SOURCES: The Washington Post, Democratic Study Group, Congressional Quarterly Almanac

inated the drug benefit. It would have retained not only hospital improvements but the new limit on out-of-pocket costs for doctor bills.

The 1988 law provided three major benefits designed to protect families from the costs of catastrophic illness that can wipe out a lifetime of savings overnight.

One increased the number of days of hospitalization that Medicare would pay for from 60 days a year to 365. A second guaranteed that no Medicare patient need pay more than \$1,370 a year out of pocket for Medicare-eligible doctor bills. The third provided that Medicare would pay the bulk of an individual's costs for non-hospital prescription drugs once out-of-pocket outlays reached \$600 a year. Of these three, only the hospital benefit would be preserved in the new Senate measure.

In addition, the 1988 law provided three major new Medicaid health benefits for low-income persons that would be preserved in both the House and Senate bills. They would prevent the impoverishment of a person whose spouse must go to a nursing home, provide Medicaid care for all poor pregnant women and infants and make the state pay Medicare fees for low-income elderly.