CHAPTER 1

PUBLIC POLICY

Historical Overview of Long-Term Care

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The U.S. and world population will continue to grow; the world population is currently growing at the rate of 1.14% per year. The number of older people in the population is also expected to increase both in number and in proportion. Between 2000 and 2010, the faster growth rates were seen at older ages (U.S. Census Bureau, 2011). Starting in 2011, approximately 10,000 Americans turn 65 every day. By 2050, when the last of the boomers reach age 85, about 20% of the U.S. population will be 65 or older, up from 13% today. As a result, the need for long-term care will also increase significantly. Of these 89 million people, about 27 million are expected to need some form of long-term care (SCAN Foundation, 2012). With this increasing need, it is important to ask whether there will be an adequate supply of services to meet our country's need and demand. The basic questions include the following: What is long-term care? Can we improve or maintain the quality of care provided? How should we prepare to finance those needs? Does the market respond adequately to the needs of its people? Should the government be involved in this matter to ensure that enough care of adequate quality is available? What policies are best to put in place and/or maintain the long-term care needs of our aging population?

LEARNING OBJECTIVES

- **Describe the U.S. demographic profile transition.**
- **Identify key demographic trends of older Americans.**
- **Describe rationales for public policy.**
- **Identify key historical long-term care (LTC) milestones and policies.**
- **Differentiate federal, state, and local LTC policies.**
- **Describe the role of Affordable Care Act (ACA) in strengthening LTC policies.**

This chapter will discuss briefly key demographic trends and impacts on long-term care continuum and what long-term care is, and review the key historical milestones and major policies in the U.S., the rationales for government policies, and cost/quality-related public control mechanisms. In addition, the chapter will discuss how public perceptions have shaped and influenced development of long-term care policies in the United States.

Key Demographic Trends of Older Americans

Some key demographic trends that will influence the long-term care service industry include rapidly increased retirement age group, lower acuity level of aging population, longevity and healthier lifestyle, socioeconomic status, gender imbalance, culture and ethnicity, and same-sex marriage and the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) communities.

Demographic Bulge

As aforementioned, the population of the United States is aging, rapidly. In 2011, the oldest baby boomers reached the retirement age, and in 2030, the youngest will join the group. The impacts of the increased retirement age population cannot be underestimated. California has the largest population of over 65-year-olds in the country, estimated at 4.4 million in 2011 (Administration on Aging, 2012). The age 65 to 74 population will grow at 300% of the overall rate of population growth over the next 50 years, and the age 75 years and older population will grow at 600% of the overall rate of population growth, making these the fastest-growing age groups in the state (California State Controller, 2014).

The dramatic increase in the older adult population will increase financial strains on government resources. Citizens aged 65 and older contribute proportionally less in taxes every year, with the share of federal income taxes paid by this group dropping from 14% in 2008 (U.S. Internal Revenue Service, 2008) to just 6% in 2012 (U.S. Internal Revenue Service, 2012). Despite their decreased contribution, the population over age 85 will accrue health expenses 3 times more than those who are between the ages of 65 and 74 (Davey, Takagi, & Wagner, 2013) due to the increased health challenges as one ages.

The combination of the increased size of the population of older Americans, their decreased contribution to government revenues and increased need for services, and the smaller size of the younger population all contribute to a situation in which the allocation of government resources will become an even greater challenge. This will have the hardest impact

on the Social Security system, which will need to draw resources from a shrinking population of working-age Americans to fund benefits for a rising population of older Americans.

Lower Acuity Among the Aging

Balanced against the impact of the sheer number of older Americans is the potential that baby boomers will experience lower acuity levels as they age than earlier generations. A 2006 study by the Robert Wood Johnson Foundation (2014) estimated that overall acuity levels for baby boomers will remain lower than the preceding generation until this group begins to reach their 80s. These lower acuity levels may be the result of better living conditions during the baby boomers' lifetimes, healthier lifestyle choices, and advances in the quality and availability of medical care. One effect of lower acuity levels is that a larger proportion of this generation may have the opportunity to utilize lower levels of the long-term care continuum, and avoid using skilled nursing facilities (SNFs).

Longevity and Healthier Lifestyles

The longevity of older adults in the United States, generally defined as those older than 65 years of age, has changed in many ways since the 1900s. This segment of the population has tripled in percentage compared to the general population. In 2012, 13.7% of the population was over 65 years of age in comparison to 4.1% in the early 1900s (Administration on Aging, 2012). In addition, the actual number of older adults has increased due to advances in medical technology, healthier diets, and improvements in general lifestyle. Thus, from the 1900 to 2012, those 65 years and older increased from 3.1 million to 43.1 million (Administration on Aging, 2013). In addition, the life expectancy of Americans has increased by 20 years for women and 17 years for men. It is now anticipated that a baby born in 2011 will live 30 years longer than a baby born in 1900 as a result of medical advances (Administration on Aging, 2013).

Socioeconomic Status of Older Adults

The majority of older adults report that their primary income is from Social Security. Although 86% of older adults rely on Social Security for their major source of income, assets, private pensions, government pensions, and employment do provide some financial support (Administration on Aging, 2013). Studies have indicated that baby boomers are not as prepared for retirement as their parents. This is a result of poor financial planning,

depressed market returns, and the opportunity to live to an older age. One in six older adults resides in poverty, equating to 9% to 15% in this age group. Poverty most greatly impacts older adults in African American communities (22% to 33%), followed by Asian Americans (11%), Latino Americans (22%), Native Americans (20% to 43%), and Euro-Americans (6%). A greater number of women than men experience poverty (U.S. Census Bureau, 2011).

Gender Imbalance

The baby boom generation started life with slightly more male births than female births, at a ratio of 50.3% male to 49.7% female. According to the 2009 Census, the percentage had reversed to 49.4% male to 50.6% female. However, female life expectancy averages 81 years, which is considerably longer than male life expectancy, which averages 76. This translates to a ratio of 45.1% males to 54.9% females when the baby boomers reach 80 (U.S. Census Bureau, 2009). Statistics also indicate that 28% of adults 65 years and older (8.4 million women; 3.5 million men) reside alone. It is interesting to note that 45% of women over the age of 75 years do live alone (Federal Interagency Forum on Aging Related Statistics, 2012).

By 2030, 62% of those age 85 years and older will be women (Administration on Aging, 2012). Due to the increase in availability of quality health care, it is anticipated that by 2040, there will be 127 women for every 100 men age 65 years or older. Data from the Administration on Aging (2012) indicate that for baby boomers, 7 out of 10 married women will outlive their husbands. Additionally, since women tend to live 7 years longer than men, the implications for social policy and services are great.

Diversity in Culture and Ethnicity

Cultural diversity in the United States has evolved. The number of individuals from non-Euro American backgrounds has increased from 5.7 million in 2000 (16.3% of older adults) to 8.5 million in 2011 (21% of older adults). This number is projected to increase to 20.2 million in 2030. Thus, 28% of the older population will be from a culturally diverse background (Administration on Aging, 2012). Data from the Administration on Aging (2013) related that in 2011 the older adult population consisted of 9% African American; 7% Hispanic/Latino; 4% Asian or Pacific Islander; 1% American Indian or Native Alaskan; and 0.6% of persons identifying as being of two or more races (*race* is the term used in the U.S. Census data collection and analysis). Cultural practices affect the residential options chosen by older adults (Administration on Aging, 2012). Therefore, it is important to be aware that cultural factors influence decisions made by families, groups, and communities.

Same-Sex Marriage and LGBTQ+ Gender Identity

The U.S. Census Bureau (2014) now includes partnership status in the census. This area was once ignored and negatively impacted services available for individuals in the LGBTQ+ communities. California is the home for the largest number *overall* of same-sex households, followed by the state of New York. Vermont, Florida, and New Mexico have the highest number of same-sex households among the United States' *older adult* population. Santa Rosa and San Francisco, California, and Santa Fe, New Mexico, have the largest *metropolitan* concentration of same-sex coupled older adults (U.S. Census Bureau, 2014).

Until 2013, same-sex couples were denied equal treatment given to legally married couples with respect to spousal benefits and power of attorney. This inequity impacted Social Security, veteran's benefits, family medical leave, and Medicare, and created severe inheritance tax consequences. In 2013, the United States Supreme Court found that Section 3 of the Defense of Marriage Act (DOMA) was unconstitutional and same-sex married couples were entitled to benefits given other legally married couples. However, this ruling impacted only couples living in states that allowed same-sex marriages. This has led to increased efforts to provide these benefits in the remaining states that do not yet recognize same-sex marriage.

Some regulatory issues involving same-sex marriage and LGBTQ+ lifestyle were addressed in the Affordable Care Act of 2010, which banned lifestyle-based discrimination in healthcare insurance and service delivery (Family Equality Council, 2014). However, changes to tax and Social Security survivor law, which will be required to ensure full equity for same-sex couples, still need to be enacted (Smith, Maechtlen, & Tyman, 2014). Federal and state laws governing SNFs will also require changes in order to capture residents' rights issues relating to these societal changes.

Impacts on Long-Term Care Continuum

The impacts of these demographic and societal changes on the long-term care continuum are starting to be felt. There has been an emphasis on community-based services due to resource constraints, longer life expectancy, and lower acuity. There has been a growth in facilities targeted to specific groups of the population. As a result there are community-based organizations and assisted living and SNFs that have catered to specific cultural, ethnic, social, or national groups ever since the advent of the concept of long-term care. This includes agencies and facilities run by religious groups, such as the Catholic or Jewish faiths, by particular nationalities, such as Armenians or Italians, by fraternal and social

groups, such as the Masons or the Order of the Eagle, and by professional groups, such as the Motion Picture & Television Fund. In general, the décor, food, entertainment, and services offered are designed to meet the interests of the sponsoring group and the residents who choose to live in the facilities who may be affiliated in some fashion with the sponsoring group.

As new national groups prosper in America, they are beginning to create their own long-term care social services agencies and facilities. The 1990s saw the rise of Asian community long-term care facilities, including facilities that catered primarily to Koreans, Chinese, and Filipinos. There are efforts underway to create new facilities to serve members of Arab and Somali communities. As immigrants who arrive in the United States from other areas of the world thrive and age, it seems inevitable that this process will continue. At the assisted living level, there has been a growth in LGBTQ+ specific care facilities (Feather, 2013).

Long-Term Care and Public Policy

What Is Long-Term Care?

Long-term care (LTC) is a range of services and supports needed by persons with reduced functional capacity—physical or cognitive. This personal care need includes basic medical services, nursing care, prevention, or palliative care. However, most of them will not be a medical care service but assistance with basic personal tasks of everyday life. Health professionals often use ability to perform **activities of daily living** (ADLs) to measure functional status of a person. There are five categories of ADLs: (1) personal hygiene (i.e., ability to bathe (wash), shave, brush teeth), (2) dressing (i.e., ability to pick out appropriate clothes, put on, button, zip, tie), (3) self-feeding (i.e., ability to eat and drink), (4) functional mobility (i.e., ability to move freely within limitation, walking to and from, sitting, getting up), and (5) toileting (i.e., ability to get to and use facilities for urination and defecation, clean up properly). **Instrumental activities of daily living** (IADLs), on the other hand, are not necessarily those basic functions, but everyday tasks needed to live independently, such as shopping, housekeeping, accounting, food preparation/taking medications as prescribed, and telephone/transportation. With population aging and increased female labor-force participation, the need for care to maintain quality of life of the frail and disabled is growing. With increasing demand, decreasing supply, and limited financing mechanisms, there is a need to address access and financing challenges.

What Is Public Policy?

Public policy refers to actions or decisions taken by the government that are intended to solve problems and improve quality of life of its citizens. Long-term care policies address both users and providers of long-term care services: (a) consumers, such as elderly and physically or mentally impaired individuals, (b) provider organizations, such as nursing homes and assisted living facilities, (c) workers who provide long-term care services, both informal workers, such as family (friend) caregivers, and formal workers, such as nurses and nursing home administrators, and (d) other related suppliers, such as durable medical equipment suppliers. Even in a liberal society like in the United States, which prefers market solutions, there is a need for effective and efficient government regulation, financing, and supervision in the field of long-term care. Past and current public policy practices are intended to protect consumers, workers, and payers, to control costs, to ensure adequate supply, and to improve quality of care.

Rationales (Goals) for Public Policy

Americans now work longer and live healthier (Benz, Sedensky, Tompson, & Jennifer, 2013). However, there is an increasing demand for long-term care due to increased longevity and decreased fertility rates. Numerous shifts in long-term care services will occur in the next few decades due to the increasing number of elderly and disabled people, and there will be more emphasis on home and community-based services due to their desire to remain independent as long as possible. This desire will increase the needs of family caregivers, including family members, partners, and close friends. As the needs increase, the future availability of family caregivers is declining. The caregiver ratio will decline from seven caregivers per one frail elderly today to four in 2030, and continue to decline to 2.9 in 2050 (Redfoot, Feinberg, & Houser, 2013).

Given the lack of balance between needs and supply, long-term care is not characterized as a viable market or to be perfectly fit to the conditions of the idealized competitive economy. The market tends to fail due to **externalities**, any unintended costs or benefits resulting from any action that affects someone who did not fully consent to participate in voluntary exchange (Weimer & Vining, 2005). Other reasons for the market failures include **asymmetric information**, where there is a discrepancy in information received or shared between sellers (providers) and buyers (consumers). The discrepancy results in an inefficient market due to **adverse selection**, in which high-risk individuals will be more likely to buy insurance, or to **moral hazard**, where individuals who purchase the insurance will be more

likely to utilize excessive services. In addition, the market, similar to the healthcare industry in general, is subject to individual preferences and it is a challenge to assess performance and quality objectively. Interventions are needed to alter *providers*' and *consumers*' behaviors and incentives.

Why Public Policies for LTC?

Government or public control mechanisms are intended to resolve the long-term care market failures by addressing problems and challenges as results of underlying causes. The rationales include:

- The target market is the most *highly vulnerable population*—frail and vulnerable elders and disabled people
- Long-term care is often *negatively perceived* in terms of cost and quality
- Resources are *limited*, both in financing and workforce
- *Non-viable* financing protection mechanism

Highly Vulnerable Population

Long-term care users include the elderly and nonelderly physically and/or mentally impaired population. The users can be categorized by age, conditions that caused incapacity, and place of residence (Kaye, Harrington, & LaPlante, 2010). In addition, long-term care needs vary depending on the users' circumstances—for example:

- Most children under the age of 18 incur impairment at birth or infancy. The impairment could be physical, intellectual/developmental, or both. Even though this group is a small of percentage of **long-term care services and supports** (LTSS) users, they require extensive care, which results in substantial costs.
- For working-age adults, age 18 to 44, the impairments include intellectual disabilities, paralysis and nervous system disorders, back problems, and mental disorders.
- For older adults, age 45 to 64, most of the impairment occurs at adulthood. It is mainly related to physical disabilities, but it could also be mental disabilities.
- For 65+, 50% of the physical impairment occurs after age 65, and is mainly caused by arthritis, heart disease, and diabetes.
- Cognitive impairment, such as **dementia**, is a complicating comorbidity that causes a need for LTC. Alzheimer's disease, which accounts

for a majority (60% to 80%) of dementia cases, affects 1 of 9 (11%) Americans over 65 and 1 of 3 (32%) Americans over 85, and 82% of those with Alzheimer's disease are aged 75 or older (Alzheimer's Association, 2014).

These groups are highly vulnerable and some are not capable of exercising the autonomy to make critical decisions or protect themselves from risks to their health. According to a report of the federal Department of Health and Human Services (DHHS) Office of the Inspector General (OIG), in February 2014, about 22% of Medicare beneficiaries experienced adverse events during their SNF stays and an additional 11% of the beneficiaries experienced temporary harm events during their SNF stays. Most (59%) of those adverse events and temporary harm were clearly or likely preventable. Those incidents were mostly caused by substandard treatment, inadequate resident monitoring, and failure to provide or delay of necessary care. As a result, more than half of the residents who experienced temporary harm were hospitalized and Medicare spent $2.8 billion spent on hospital treatment for harm in SNFs in FY 2011 (Levinson, 2014). In another OIG report, in May 2011, about 22% of the atypical antipsychotic drugs in nursing homes claimed were not administered according to the CMS standards. Eighty-three percent of Medicare claims for atypical antipsychotic drugs from elderly nursing home residents were associated with off-label conditions, and 88% were administered to dementia patients, a condition specified in the FDA boxed warning (Levinson, 2011).

Negative Perceptions in Costs and Quality

Very few people plan ahead for long-term care. They may be overly optimistic about their health and the ability or willingness of family members to provide needed care. When people think about retirement, they envision more time with family and friends, traveling, pursuing new or long-neglected interests, and perhaps pursuing a new career or volunteering for an organization or cause. It is a lot less pleasant to think about and plan for loss of mobility and/or mental functioning, and how to find, select, arrange, and pay for the services one will need if the worst-case scenario becomes a reality.

According to the 2013 Naturally Occurring Retirement Communities (NORC) survey of Americans age 40 and older, 30% of them were reluctant to think about getting older at all and only 35% of them were very comfortable thinking about getting older. Being older, more educated, and healthier was associated with greater comfort in thinking about getting older. Some concerns of getting older include: losing independence,

losing memory or other mental abilities, paying for care, moving to a nursing home, being a burden for families, and being alone without families or friends (Tompson et al., 2013).

The 2013 NORC survey also reported that about half of respondents agreed that just about everyone will require some LTC at some point of time, even though they are not seriously ill. However, only a few took action. For example, more than half (65%) of them reported of doing a little bit of planning or none at all and only 16% of them reported a great deal of planning. Specific actions included creating an advanced directive (most common), discussing preferences with families, setting aside money to pay for it, looking for information about aging issues or LTC, modifying their home to make it easier to live in, and moving to a community designed for an older population (Tompson et al., 2013).

Another problem is that there is a widespread misperception about costs. The 2013 NORC survey of Americans 40 years or older reported that people tend to underestimate nursing home costs and overestimate home healthcare aide costs. More than half (54%) of the respondents underestimated the costs for a nursing home, 14% overestimated the costs, and only 23% correctly estimated the costs. On the other hand, more than half (52%) overestimated the home healthcare aide costs, 14% underestimated the costs, and 30% correctly estimated the costs (Tompson et al., 2013). The fact is that long-term care services are costly, and will only become more expensive in future years. In 2014, according to the Genworth 2014 Cost of Care Survey (Genworth Financial, 2014), the national median rates for different types of LTC services were:

- $212 to $240 per day for semiprivate and private rooms in a nursing home
- $3,500 per month for a one-bedroom single-occupancy assisted living community unit
- $20 per hour for a home health aide, $19 for a homemaker
- $65 per day for adult day care services

The 2013 NORC survey also reported that only 27% of Americans 40 years or older were very confident that they will have the resources to pay for the care. The survey also reported that many people misunderstand the role of Medicare as a source of payment. Forty-four percent believe that Medicare will pay for the ongoing expenses for home healthcare aides, 37% believe that Medicare will pay for ongoing expenses for nursing home

care, and 71% believe that Medicare will pay for any medical equipment and assistive device. Medicare pays only for medically necessary services for a limited time and pays only for medical equipment or assistive devices prescribed by a physician (Tompson et al., 2013).

Resources Are Limited—Unaffordable and Limited Supply

Not only is long-term care expensive, but also the costs vary across states. Even in the most affordable market (Utah), the median nursing home cost far exceeds median income everywhere (Houser, 2012). The 2014 LTC State Scorecard reported that the cost was *unaffordable for middle-income families in all states*. This condition did not improve nationally from the State Scorecard report in 2011, and even became less affordable in three

Table 1.1 Summary of National Findings*

	Nursing homes		Assisted living communities	Home care		Adult day services
	Semiprivate room	Private room		Home health aide	Homemaker	
Rate type	**Daily**		**Monthly**	**Hourly**		**Daily**
2012 average rate ($)	222	248	3,550	21	20	70
2011 average rate ($)	214	239	3,477	21	19	70
$ (% increase from 2011)	8 (3.7)	9 (3.8)	73 (2.1)	0 (0)	1 (5.3)	0 (0)
2012 median rate ($)	206	231	3,324	21	19	65
2012 highest average rate ($)	682	687	5,933	32	28	141
Location	AK, statewide	AK, statewide	Washington, DC	MN, Rochester Area	MN, Rochester Area	VT, statewide
2012 lowest average rate ($)	131	147	2,355	13	13	26
Location	TX, rest of state	OK, rest of state	AR, rest of state	LA, Shreveport Area	LA, Shreveport Area	AL, Montgomery Area
2012 annual rate ($)	81,030	90,520	42,600	21,840	20,800	18,200

*Costs are rounded to the nearest dollar.

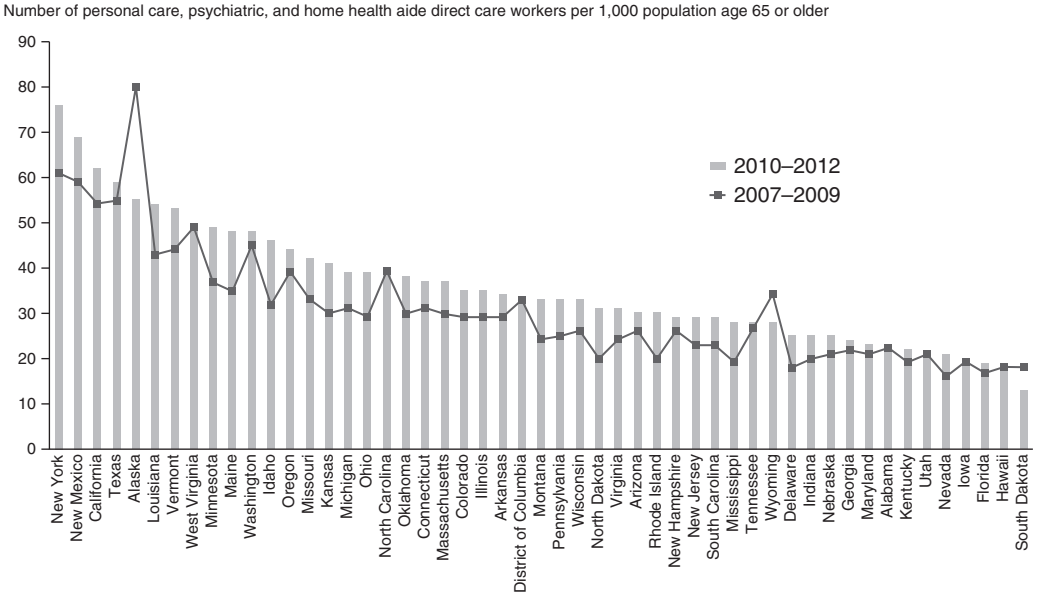
Annual rates for home care are based on 4 hours per day, 5 days per week; annual rates for adult day services are based on 5 days per week.

Source: MetLife Mature Market Institute (2012).

states (see Table 1.1). In 2014, the average cost of nursing home care is 246% of the median annual household income, ranging from 171% for the most affordable states to 382% for the least affordable states (Reinhard et al., 2014).

Not only is it unaffordable, but also the LTC "system" has a limited supply of trained workers. An adequate workforce, both clinical and non-clinical, will be a significant determining factor to address the challenges of the increasing demand for personal care and home health aides. Currently, due to workforce shortages, many states allow people to hire their family members to provide services to Medicaid beneficiaries. As a result, and due to the economic downturn during this period, the numbers of home health aide supplies in 2010 to 2012 improved compared to the 2007 to 2009 period (see Figure 1.1). The turnover rate of nursing home staffs also declined during this period (see Figure 1.2) (Reinhard et al., 2014). However, as mentioned before, the caregiver ratio is predicted to significantly decline in the next 15 years (Redfoot et al., 2013).

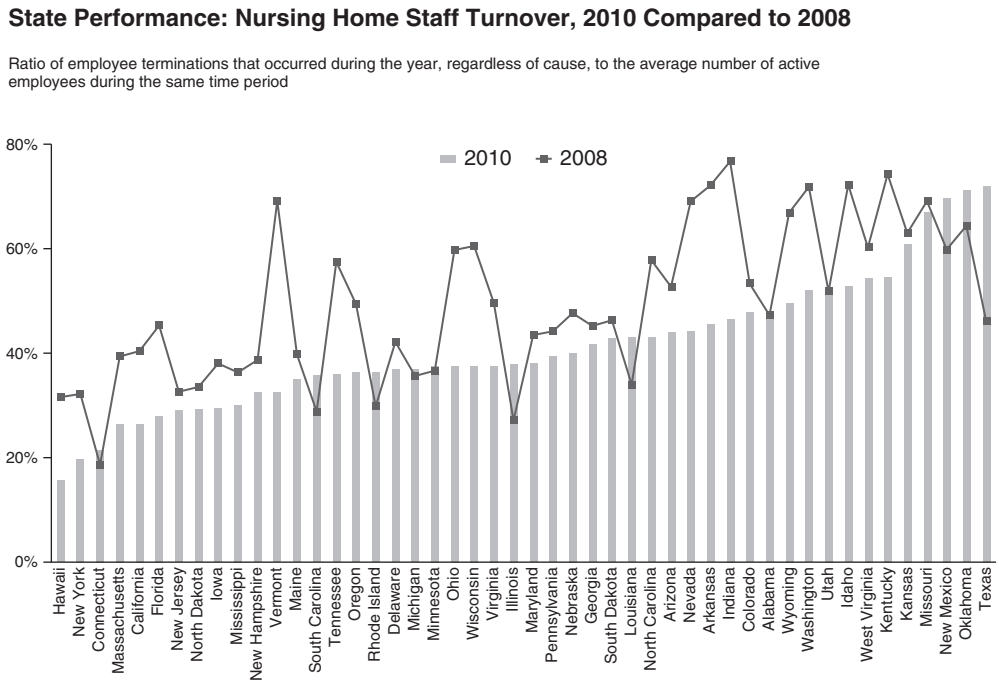
State Performance: Home Health Aide Supply, 2010–2012 Compared to 2007–2009



Data: 2007–2012 American Community Survey Public Use Microdata, 2007–2012 U.S. Census Bureau Population Estimates.

Figure 1.1 State Performance: Home Health Aide Supply

Source: State long-term services and supports scorecard (2014).



Note: Data not available for Alaska (2008–2010) and District of Columbia and Montana (2008), therefore, change in state performance cannot be shown.

Data: American Health Care Association, *Report of Findings: 2010 Nursing Facility Staffing Survey;* American Health Care Association, *Report of Findings: 2008 Nursing Facility Staff Vacancy, Retention and Turnover Survey.*

Figure 1.2 State Performance: Staff Turnover

Source: State long-term services and supports scorecard (2014).

Nonviable Financing Protection Mechanism, Both Public and Private Financing

The expenditures for long-term care impose significant burdens on families and states. Over $200 billion in annual spending on nursing care facilities, continuing care retirement communities (CCRCs), and home health accounts for more than 8% of our total health care spending annually. Of the $357 billion total long-term care spending in 2011, Medicaid paid 40% of the total (Kaiser Family Foundation, 2013). Even though Medicaid spending on LTC has been shifting toward community-based care, the expenses for long-term care services will increase sharply over the next decades (SCAN Foundation, 2012). Therefore, the pressure on federal/ state budgets and on personal budgets as well as on society is going to increase too. The

growth of the elderly population and high healthcare costs will impose a significant additional burden on family/private financial resources and publicly financed programs. Changes and supports are needed to assure the well-being of the frailest.

Private financing, in the form of LTC insurance, may alleviate the burden. However, it is not a highly desired and profitable insurance product yet. Some insurance companies have left the market due to the enormous payouts. Only 4% of LTC expenditure was financed by private insurance (Brown, Goda, & McGarry, 2012). The barriers to expansion of this market include

> limited consumer rationality, the possibility that individuals may not value consumption as highly when institutionalized, as well as the availability of imperfect but cheaper substitutes for formal insurance, such as the public insurance provided by the means-tested public Medicaid program, financial transfers from children, or unpaid care provided by family members. (Brown & Finkelstein, 2009, pp. 3–4)

Other barriers include individual preferences and beliefs and undesirable features or distrust of the private market (Brown et al., 2012). Therefore, consumers will have fewer choices for private payment and will rely more on the government for intervention.

The previously referenced NORC survey (2013) of Americans over 40, in addition to revealing widespread misperception about costs and Medicare support, found that most respondents supported public policy options, such as tax breaks, government-administered long-term care programs, and a long-term care insurance individual mandate (Tompson et al., 2013). In summary, those who favor government interventions argue that public policy provides protection to consumers, particularly for those who are not capable of making well-informed decisions, and controls over costs.

Critiques of Public Policy

On the other hand, those who favor market solutions argue that the current system is not regulated effectively. They argue that many policies are uncoordinated and duplicative. Government interventions will also restrict innovation and benefits of having competition in market solutions. Policies could also produce unintended consequences that can be desirable or undesirable. For example, public policies intended to improve quality of care in nursing homes by providing higher reimbursement rates for better outcome measures exacerbate racial inequities in care (Konetzka & Werner, 2009). State tax subsidies for private long-term care insurance

intended to increase private LTC insurance coverage and to reduce reliance on Medicaid funding for LTC produce unintended consequences, where the subsidies go to the high-income and asset-rich individuals, therefore produce no savings on Medicaid spending (Goda, 2011).

Key Historical Milestones and Major Long-Term Care Policies

Despite a variety of regulatory failures, long-term care is still a heavily regulated field. The principal policies (control mechanisms) regulate care providers and professionals/paraprofessionals working in the field. These control mechanisms are intended to improve quality of life of the society, safety, and health of its citizens by protecting consumers, workers, and payers. Public policies can be enacted in the form of acts or regulations. An act is a law that has been passed by some governing bodies, such as Congress or the president. A regulation is a more descriptive explanation of the way the legislation is actually implemented. One act can have numerous regulations. Both are imposed by a government unit—federal, state, or local government.

Federal Policies

The *Social Security Act of 1935* was a landmark piece of legislation that provided a monthly retirement benefit to people age 65. As the average life span of Americans increased and as society began moving from an agrarian orientation to a manufacturing orientation during the 20th century, there was a boom in homes for the elderly, particularly those associated with fraternal, faith-based organizations and other affinity groups. At the same time, large corporations began seeing the advantage of providing retirement programs, and a few states began providing old-age assistance programs. In 1935, with the effects of the Great Depression fresh in their minds, politicians enacted the Social Security Act, to federalize old-age pensions and get rid of the "poor farm" system that had become derelict and greatly overcrowded. The 1950 amendments to the Social Security Act mandated that any facility providing care for recipients of Social Security income had to be licensed by the state.

Following World War II, Congress passed the Hospital Survey and Construction Act of 1946 (also known as the *Hill-Burton Act*), which provided funding for the construction of hospitals and for state agencies to oversee its operation. This in turn provided the model for standards of design, regulation, and financing of healthcare institutions, as well as

governmental agencies having jurisdiction over them. As this funding bill provided for construction of new facilities, many of the old hospital buildings were converted to nursing home use. Additionally, the burgeoning aged population and demand for long-term care nursing provided impetus for other structures, such as hotels and large houses, to be converted; a 1950 amendment to the Social Security Act provided for direct government payment to providers and stipulated that states must provide an authority to establish and maintain standards for such institutions (Institute of Medicine & Committee on Nursing Home Regulation, 1986).

In 1954 the Hill-Burton Act was amended to provide funding for the construction of nursing homes if they were part of a hospital. This amendment also provided a strong expectation of physical design based on what had been accepted practice for hospitals with regulatory oversight by the federal government. In 1959, the *National Housing Act* was amended to create a number of programs that enhanced the mortgages and provided low-interest loans through the Housing and Urban Development (HUD) Agency for construction of nursing homes, further increasing both the number of nursing homes and the federal government's involvement. However, all of these programs were aimed at financial aspects and not quality of care or consistency in nursing home environmental standards and safety (Institute of Medicine & Committee on Nursing Home Regulation, 1986).

Passed in 1965, the *Older Americans Act* (OAA) established the U.S. Administration on Aging (n.d.) within the Department of Health, Education and Welfare (today's Department of Health and Human Services) and state agencies on aging to organize, coordinate, and provide community-based services and opportunities for older Americans and their families. The act is intended to address social service needs of the aging population in order to maintain maximum independence in their homes and communities and to promote a continuum of care for the vulnerable elderly. The act also created authority for research, demonstration, and training projects in the field of aging. The 1973 amendment expanded the reach of the act by creating substate area agencies on aging. Currently the aging services network includes 56 state agencies on aging, 655 local area agencies on aging, 233 organizations serving tribal and Native Americans, and 2 organizations serving Native Hawaiians (Administration on Aging).

Some of the 2006 amendment provisions include the following:

- Authorize the assistant secretary for aging to be responsible for elderly abuse prevention and services, and to designate an office to be responsible for the administration of mental health services authorized under this act.

- Require the secretary of health and human services to establish an Interagency Coordinating Committee on Aging.
- The 2013 amendment reauthorized the Older Americans Act of 1965, proposed (not yet passed as of December 2015) in May 2013 to:
  - Include LGBTQ+, individuals with HIV and Alzheimer's disease, veterans, Holocaust survivors, among others, within the status of greatest social need caused by non-socioeconomic factors.
  - Require the director of the Office of Long-Term Care Ombudsman to collect, analyze, and report best practices for screening of elderly abuse.
  - Require the assistant secretary for aging to assist states with the development of Home Care Consumer Bill of Rights.
  - Require the Administration on Aging to work with Health Resources and Service Administration (HRSA) and secretary of labor to identify and address the workforce shortages in the field of aging.

Congress passed Title XVIII and Title XIX of the Social Security Act in 1965, creating *Medicare* and *Medicaid*, to provide insurance assistance to elderly and low-income individuals. As a result of this bill, the Center for Medicare and Medicaid Services (CMS) was created to oversee funding and regulate the quality of care and environment. In 1967, the Moss Amendments were passed, which put into place complete regulations requiring nursing homes receiving payments from Medicare and Medicaid to comply with building and life safety codes and quality of care standards. Since they are the largest source of payers, they have imposed detailed and stringent regulation to ensure quality. The regulation monitors the staffing levels, levels of coverage provided by each health professional, minimum amounts of care required to be received, and compliance in numerous specific procedures (preadmission screening, regular assessments of the functional status, internal quality assurance mechanisms, bill of rights implementation, and many others). They control costs and regulate eligibility and reimbursement rates. They also continue look at different ways to control costs, such as emphasizing home- and community-based services.

Medicaid is a joint state and federal program that helps low-income elderly to pay for long-term care services in nursing homes or at home. Medicaid does pay for custodial care in a SNF. In most states, Medicaid will also cover services to help the beneficiaries remain at home. Medicaid will pay for personal care needs; however, it will not pay for rent, mortgage, or food. To be eligible for Medicaid, a person needs to meet *general*

requirements (e.g., citizenship or legal residency, be age 65 or older, have permanent disability determined by the Social Security Administration, be blind, be a pregnant woman, be a child or the parent of a child) and *financial* requirements (e.g., SSI recipients or with certain level of income). Eligibility rules and coverage of Medicaid vary from state to state (see Chapter 6 for Medicare and Medicaid coverage, eligibility, and reimbursement rates).

Containing the Nursing Home Reform Act, the *Omnibus Budget Reconciliation Act* (OBRA) of 1987 made significant changes in nursing home operations. On a continuing quest to address standards of care and to reduce federal reimbursements, OBRA established the Resident's Bill of Rights and provided a massive overhaul of federal regulations for both the care in and environment for nursing homes. The act intended to de-institutionalize the institution and change the care model from a traditional physical-only approach to a full-body approach, which includes physical, mental, and psychosocial aspects of each person. The Institute of Medicine's (IOM) report of 1986, entitled "Improving the Quality of Care in Nursing Homes," is widely acknowledged as the impetus of the *Nursing Home Reform Act* of 1987, in which a new set of standards applies to all nursing home facilities, not only for nursing home facilities that receive Medicaid and Medicare payments. The act leads to the development of the standardized Resident Assessment Instrument (RAI) for nursing home care management. The national minimum standard of care and rights of people who live in nursing facilities include: (a) resident rights, quality of life, and quality of care, (b) staffing and services, (c) resident assessment, (d) federal survey procedures, and (e) enforcement procedures.

There are three main contributions of the law for the nursing home operations. First, the OBRA 87 established new, higher, and much more resident-centered standards. The law established a number of rights, including freedom from abuse, mistreatment, and neglect and the ability to voice grievances without fear of discrimination or reprisal. The law also upgraded the staffing requirements and limited the use of physical restraints to very special circumstances. Second, the OBRA 87 introduced a range of enforcement sanctions. States were also required to conduct surveys without prior notice to the facilities, with the statewide interval not to exceed 1 year. Third, the OBRA 87 merged the Medicare and Medicaid survey and certification process into a single system.

The *Patient Self Determination Act* (PSDA) of 1990 required that all consumers have the right to understand the amount and type of care received in end-of-life situations, to create advance directives, and to hold providers accountable to their wishes. All healthcare providers, including nursing homes, home health agencies, hospice providers, and

other healthcare institutions, are required to provide written information to patients concerning making decisions about medical care they received. The documentation includes the right to refuse or accept the treatment and procedures and the right to create advance directives at the time of admission. The act also requires providers not to condition provision of care or discriminate against an individual based on his decision about advance directives.

Another major federal policy affecting health care in general is the 1996 *Health Insurance Portability and Accountability Act* (HIPAA). Sections of HIPAA relatively more relevant to LTC include the administrative simplification sections that address the security and privacy of health data. The provision limits the release of patient protected health information without the written consent of the patient. The HIPAA also requires use of standard formats for processing claims and payments and standards for maintenance and transmissions of electronic health records and data. In addition, HIPAA ensures that the long-term care insurance policies that meet certain standards will receive favorable tax benefits.

Further federal quality-related regulation is a mandated use of *Minimum Data Set* (MDS). The MDS started in 1998 as a tool to assess nursing home residents. The MDS assesses the following: (a) cognitive patterns, (b) communication and hearing patterns, (c) vision patterns, (d) physical functioning and structural problems, (e) continence, (f) psychosocial well-being, (g) mood and behavior patterns, (h) activity-pursuit patterns, (i) disease diagnosis, (j) other health conditions, (k) oral/nutritional status, (l) skin condition, (m) medication use, and (n) treatment and procedures. Deficiencies will be reported based on comparison of those criteria with the standards. A similar assessment tool for home health care is called the *Outcomes and Assessment Information Set* (OASIS).

State and Local Government Policies

The designated state agencies provide oversight of Medicaid implementation. They may also impose additional regulations to ensure compliance with federal regulations. The main responsibility of state government in LTC regulation is in issuing licenses for healthcare providers. The local government agencies (both city and/or county government) ensure quality by regulating a variety of public health issues, including hygiene and sanitation, food handling (preparation and service), and many others. In addition, similar to any other business, LTC providers are obliged to comply with labor protection acts and regulations that address worker and public safety, environmental standards, and state and federal tax codes.

Several states have developed initiatives with Medicaid 1915(c) Home & Community-Based Service waivers to integrate assessment, information, care management, and other services to empower clients to choose the best settings and services for their needs. Such initiatives include the following program or services: Program of All-Inclusive Care for the Elderly (PACE), Cash and Counseling, Managed Long-Term Care Services and Supports (LTSS), such as Money Follows the Person (MFP), participant-directed services, and Balancing Incentive programs, and Testing Experience and Functional Assessment Tools (TEFT) "high-functioning" LTSS.

Significant growth in long-term care spending in 1970s led to the development of *Home- and Community-Based Services* (HCBS) or the *1915(c) waiver*, enacted in 1981 (Harrington, Ng, Kaye, & Newcomer, 2009). The waiver allows states to create flexible community-based services. The standard services include but are not limited to case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, rehabilitation (both day and residential), and respite care. The programs expanded rapidly; however, the nursing home expenses continued to grow as well.

Therefore, in the 1990s, a few states launched managed long-term care initiatives. The number of states that participate in *Managed Long-Term Care Services and Supports* (MLTSS) increased from 8 states in 2004 to 16 in 2012. By 2014, the number of states projected to have MLTSS is 26 (Saucier, Kasten, Burwell, & Gold, 2012). The MLTSS arrangements vary significantly across states. They are different in the type of enrollment (mandatory, voluntary, or both), type and size of MLTSS contractors (for-profit/nonprofit/public or quasi-public entities and local/national/mixed contractors), population groups (children, specific type of disabilities, older adults), level of care, capitation rates (comprehensive or partial services), whether they offer a consumer-directed option, whether they include Money Follows the Person through their MLTSS program, engaging members, relationship with Medicare, and quality measures (see Table 1.2).

Creating community/home-based LTC services is much more emotionally preferred, but it is also economically sound (Kaye, LaPlante, & Harrington, 2009; Kitchener, Ng, Miller, & Harrington, 2006). A review and synthesis study on cost-effectiveness of non-institutionalized LTC service programs suggested very positive outcomes and savings for home- and community-based services (Grabowski, 2006; Grabowski et al., 2010). Therefore, it is imperative to investigate factors that enable the transition. One study in Minnesota suggested that LTC facilities with more residents preferring community discharge, more Medicare days, higher nurse staffing levels, and higher occupancy have higher community discharge rates. In

Table 1.2 Population Groups Included in Existing MLTSS Programs, as of July 2012

State	Program	Children	Physical disability	Intellectual/ developmental disability	65+
AZ	Long-Term Care System	V	V	V	V
CA	SCAN Connections at Home				V
DE	Diamond State Health Plan-Plus	V	v	V	V
FL	Long-Term Care Community Diversion				V
HI	QUEST Expanded Access	V	v	V	V
MA	Senior Care Options				V
MI	Managed Specialty Support & Services	V		V	
MN	Senior Health Options				V
MN	Senior Care Plus				V
NM	Coordination of Long-Term Services	V	v		V
NY	Managed Long-Term Care		V		V
NY	Medicaid Advantage Plus		v		V
NC	MH/DD/SAS Health Plan Waiver	V		V	
PA	Adult Community Autism Program			V	
TN	CHOICES	V	v		V
TX	Star+Plus	V	v		V
WA	Medicaid Integration Partnership		v	V	V
WI	Family Care Partnership		V	V	V
WI	Family Care		v	V	V

Source: Saucier et al. (2012).

addition, the rate is also higher when the facility is located within areas with higher home- and community-based services available to the community (Arling, Abrahamson, Cooke, Kane, & Lewis, 2011).

Several other new state consumer-directed strategies available in Medicaid include the following:

- State-plan optional personal care service benefit
- 1915(c) home and community-based services waiver
- 1915(j) state-plan "cash and counseling" authority
- 1915(i) state-plan home and community-based services

Important Policies Affecting LTC Professionals and Paraprofessionals

The *Americans with Disabilities Act* is a civil rights law established in 1990 to ensure fair treatment and to prohibit discrimination against individuals with disabilities in employment, state and local government services, public accommodations, commercial facilities, and transportation. Title I of the act prohibits discrimination against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions, and privileges of employment. It covers employers with 15 or more employees. Title II of the act protects qualified individuals with disabilities from discrimination in receiving services, programs, and activities provided by state and local government entities. Title III of the act prohibits discrimination in public accommodations and commercial facilities, and requires compliance with Americans with Disabilities Act (ADA) standards. Together with other federal laws, such as the **Civil Rights Act**, it ensures protection for consumers by guarantee of equal access and treatment for all. The act also ensures the protection of the rights of the disabled, including the ability to access public spaces and buildings.

The *Occupational Safety and Health Act* (OSHA) of 1970 is legislation to assure safe and healthful workplaces by setting and enforcing standards, and by providing training, outreach, education, and assistance. Many services delivered in nursing homes and residential care facilities involved occupational hazards, such as blood-borne pathogens and biological hazards, workplace violence, or ergonomic hazards due to resident lifting, transferring, and repetitive tasks. According to the Bureau Labor of Statistics, in 2010, nursing homes and personal care facilities had the highest lost workday rate due to injury and illness (LWDII) among private industries. The rate was 4.9 compared with 1.8 for private industries in

general. Nursing aides, orderlies, and attendants had the highest rate of musculoskeletal disorders of all occupations. In 2010, the rate was 249 injuries per 10,000 workers compared with 34 per 10,000 workers for all occupation (Occupational Safety and Health Administration, n.d.). For more details on OSHA components, rules, citations, and penalties, see Chapter 5.

The *Department of Labor Wage and Hour Division* (WHD) was created with the enactment of the Fair Labor Standards Act (FLSA) in 1938. The division enforces the FLSA, government contracts labor standards statutes, the Migrant and Seasonal Agricultural Worker Protection Act (MSPA), the Employee Polygraph Protection Act (EPPA), and the Family and Medical Leave Act (FMLA).

The *Fair Labor Standards Act* (FLSA) determines the minimum wage, overtime pay, record keeping, and youth employment standards affecting workers in private sector and government. The federal minimum wage, effective as of July 24, 2009, is $7.25 per hour (as cited in http://www.dol.gov/whd/minimumwage.htm). States may also have minimum wage laws. Currently, there are only four states that have a minimum wage less than federal minimum wage. The rest of the states have either no minimum wage or a wage equal to or higher than the federal minimum wage. Employees are entitled to the higher minimum wage. The Patient Protection and Affordable Care Act of 2010 amended section 7 of the FLSA to require employers to provide reasonable break time for nursing mothers for 1 year after childbirth. Employers are also required to provide a place to express breast milk.

The *Family Medical Leave Act* (FMLA) of 1993 entitles eligible employees to take unpaid, job-protected leave for specified family and medical reasons. The employees are entitled to have 12 unpaid workweeks of leave in a 12-month period. The occasions include the birth of a child, to care for the newborn child, a child adoption, to care for core family members who have serious medical conditions that make the employee unable to perform essential duties of work, and any qualifying exigency due to active military duty of the employee's core family members. To take the leave, the employees have to give 30-day notice to their employer.

The *State Worker's Compensation Acts* were enacted by nine states in 1911. Currently, each of the 50 states has its own program. It varies in terms of who is allowed to provide coverage, the scope of coverage, levels of benefits, payment arrangement, and employer costs. Some states exempt mandatory coverage for special categories of workers, such as certain agricultural workers, charity or religious organization employees, or household workers. Employers with a fewer number of employees are exempted from mandatory coverage as well (Sengupta & Reno, 2007).

The *Equal Employment Opportunity Commission* (EEOC) enforces federal laws that make it illegal to discriminate against job applicants or employees based on the person's race, color, religion, sex, national origin, age, disability, or genetic information. The laws enforced by EEOC include:

- Title VII of the Civil Rights Act of 1964: It is illegal to discriminate against people based on race, color, religion, national origin, and sex.
- The Pregnancy Discrimination Act (PDA): This act amended Title VII to make it illegal to discriminate against a woman due to her pregnancy, childbirth, or medical condition related to pregnancy or childbirth. The law also makes it illegal to retaliate against a person who complains or participates in an employment discrimination investigation.
- The Equal Pay Act (EPA) of 1963: This act makes it illegal to pay different wages to men and women if they perform equal work in the same workplace.
- The Age Discrimination in Employment Act (ADEA) of 1967: This act prohibits discrimination against people who are 40 or older.
- Title I of the Americans with Disabilities Act (ADA) of 1990: This act prohibits discrimination against a qualified person with a disability in both the private sector and government. The law also requires employers to accommodate a person's physical or mental limitations.
- Section 102 and 103 of the Civil Rights Act of 1991: This law amended Title VII and ADA to permit jury trials and compensatory and punitive damage awards in intentional discrimination cases.
- Section 501 and 505 of the Rehabilitation Act of 1973: This law prohibits discrimination against a qualified person with a disability in the federal government.
- The Genetic Information Nondiscrimination Act (GINA) of 2008: This act makes it illegal to discriminate against a person due to genetic information. Except for Title I of this act—use of genetic information in health insurance—the provisions are enforced by the Department of Labor's Employee Benefits Security Administration (EBSA), with the Department of Health and Human Services' Office of Civil Rights enforcing Section 105 of Title I GINA.

Examples of State-Specific Laws

California Assembly Bill (AB) No. 663 amends Section 1562.3 and 1569.616 of the Health and Safety Code, and amends Section 9719 of the Welfare

and Institutions Code, relating to care facilities in California. The existing law requires administrators of an adult residential care facility or an administrator of a residential care facility for elderly to have training in business operations and the psychosocial needs of facility residents. The law also requires the Office of the State Long-Term Care Ombudsman to sponsor training of ombudsmen, which needs to be completed prior to certification as an ombudsman. This bill would require the administrator and ombudsman training to include training in cultural competency and sensitivity in issues related to aging in the (LGBT) community.

The *Residential Care Facilities for the Elderly* (RCFE) Reform Act of 2014 proposed 12 bills to address some problems reported during investigation of 7,000 assisted living facilities in California. On July 24, 2014, the California governor signed **AB 1572** (one of the bills of the RCFE Reform Act), which requires facilities to allow residents to create or maintain resident councils.

The *California Partnership for Long-Term Care* (Partnership) is an innovative program launched in 1994 by the California Department of Health Care Services together with a few selected private insurance companies dedicated to educating Californians about planning for their future long-term care needs. The partnership just launched www.RUReadyCA.org as an independent source that provides information on high-quality long-term care insurance policies.

The Patient Protection and Affordable Care Act (PPACA) and LTC

Several LTC-related provisions in the ACA were created to address two main issues: costs and quality. Efforts to contain costs include expanding supports of Medicaid HCBS options. The most prominent LTC-related provision in the ACA is the CLASS Act (it is currently suspended). The CLASS Act was created to address the most imperative problem of LTC—financing. The act intended to create a government-run LTC insurance program within the parameters of the enrollment, eligibility, premium, coverage level, and administration. However, the act was repealed due to its inability to show evidence of solvency over a 75-year period (a statutory mandate) (Gleckman, 2011). Without the CLASS Act, the *Affordable Care Act* provisions mostly consisted of several programs and supports in helping people to receive long-term care service and supports in their home or the community. The law continues supports for the existing mechanisms/programs and creates new alternatives and financial

incentives for states to provide home- and community-based services and supports (Reinhard, Kassner, & Houser, 2011). The supports include:

- The *State Balancing Incentive Payments* program, authorizing grants to states to increase access to non-institutional long-term care service and supports, which started October 1, 2011. The program offers a targeted increase in the Federal Medical Assistance Percentage (FMAP) tied to the percentage of a state's noninstitutional LTSS spending.
- The *Home and Community-Based Services (HCBS) State Plan Option*, which expands HCBS to more individuals and ensures the quality of services provided.
- *Community First Choice* provides enhanced federal funding to states that elect to provide person-centered home and community-based attendant services and supports to increase individuals with disabilities' ability to live in the community.
- *Money Follows the Person* (MFP) provides individuals with LTSS that enables them to move out of institutions and into their homes or other community-based settings. Forty-four states, including Washington, DC, participate in the MFP demonstration, part of the 2005 Deficit Reduction Act (DRA). The funding allows states to offer help to Medicaid beneficiaries transitioning from institution settings to community-based settings. Under the ACA, Medicaid beneficiaries who reside in LTC institutions for 90 consecutive days are eligible to participate (instead of 6 months to 2 years) and the funding is going to be extended until September 2016 (a total of $2.25 billion will be allocated for 2012 to 2016 or $450 million each fiscal year [FY]). Any unused funds awarded in 2016 can be utilized until 2020.
- Demonstration grants for *Testing Experience and Functional Assessment Tools* (TEFT) in LTSS test quality measurement tools and demonstrate e-health in Medicaid LTSS.

Efforts to improve quality include provisions affecting LTC workers both in institutions (nursing home) or communities (personal attendant and family caregivers). There are a few demonstration projects and grants to support training of LTC-related professionals and paraprofessionals. The ACA also includes several provisions to ensure and improve quality of nursing home care and to prevent elderly abuse and neglect. The provisions include disclosure of more detailed information, implementation of compliance and ethics programs, improvement of the Nursing Home Compare website, and adoption of standardized complaint forms. Also there are several national demonstration projects on culture change and

the enhanced use of information technology and pay-for-performance in nursing homes.

Summary

In the next few decades, the graying of the baby boomers, increased longevity, lower fertility rates due to labor-force participation, and some other demographic trends will change the future of long-term care in the United States. With current policy directions, there will be major changes ahead. Increasing demand for any interventions or strategies to support independent living will become more and more popular. As the demand for long-term care service and supports continues to grow, it is important to seek alternatives for those increasing needs. Particularly with limited available resources, both labor and capital resources, it is imperative to create innovative ways to tackle the challenges. Public and private control mechanisms were created to control escalating costs and ensure adequate access and quality of care. Current policies that emphasize sociodemographic and culturally sensitive home- and community-based services need to be continued and supported. Quality measures need to be refined. Resources need to be properly allocated and redistributed.

Key Terms

The following terms are important to the chapter. Some of the terms may also be found in other chapters, but they may be used in different contexts.

Act: A law that has been passed by a legislative body

Activities of daily living: Routine activities of everyday life that individuals must perform in order to survive comfortably (ex. dressing, bathing, toileting)

Adverse selection: Unintended consequences due to imbalanced shared information in which individuals with higher risks of using services are more likely to purchase insurance

Asymmetric information: Imbalanced shared information

Custodial care: Help with activities of daily living, such as help to bathe, walk, shop, eat, and dress

Dementia: A wide range of symptoms associated with a decline in memory or other thinking skills that reduce a person's ability to perform everyday activities

Externalities: Unintended costs or benefits of certain actions/conditions

Instrumental activities of daily living: Skills needed to maintain independence (ex. preparing meals, homecare, paying bills and banking, shopping, managing medications)

Long-term care services and supports (LTSS): Any task that helps older adults and people with disabilities accomplish everyday tasks

Moral hazard: Unintended consequences due to imbalanced shared information that results in excessive use of services by individuals who purchase insurance

Public policy: Actions taken or decisions made by the government that are intended to solve problems and improve the quality of life of its citizens

Regulation: A law that describes how an act is implemented

Review Questions

1. Why should government regulate long-term care providers and practitioners?
2. What are the potential contributions and impacts of ACA on LTC?
3. Your state is concerned about increasing Medicaid spending on long-term care services and supports, and long-term care insurance is not growing as expected. What are some of the policy alternatives that could be used to increase the long-term care insurance rate?
4. What are the best alternatives besides expanding home- or community-based services?

Case Study

Public policies comprise authoritative decisions to address public issues and problems. Most public policies are intended to maximize benefits of the society. However, they often produce unintended consequences. The complexity of the issues and variability of the causes create unthinkable and unpredictable consequences. The graying of the baby boomers and lack of adequate and sufficient protection mechanisms need immediate attention. Using the U.S. demographic projections and the current existing financing mechanisms for long-term care, do the following:

- Assess the need for government involvement in creating major policy changes.

- Discuss several alternatives to government intervention.
- Discuss the pros and cons (barriers and unintended consequences) of each alternative.
- Decide whether we should keep market involvement to allow flexibility and innovation in solving problems.

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