A number of key trends are emerging in long-term care related to financing, new models of service delivery, and shifts in consumer expectations and preferences. Taken together, changes occurring in these areas point to a rapidly transforming long-term care landscape. Financing responsibility is shifting away from the federal government to states, individuals, and their families; providers are integrating and managing acute and long-term care services and adding new services to the continuum of care; and consumers are thinking more seriously about how to plan and pay for their future care needs, as well as how to independently navigate the long-term care system.

Key Words: Assisted living, Subacute care, Long-term care insurance, Consumer-directed care, PACE, SHMO

Emerging Trends in the Finance and Delivery of Long-Term Care: Public and Private Opportunities and Challenges

Marc A. Cohen, PhD

As the United States approaches the 21st century, the social, financial and service-delivery implications of a rapidly aging population will be brought to the fore. Both the graying of the population—the number of persons aged 65 and older increased by almost 21% over the last 10 years alone—and the graying of the federal budget—expenditures on aging-related programs are in excess of 30% of the budget—have contributed to a change in the perception about the needs of elders as well as public obligations toward meeting their needs. Due in large part to federal benefit programs, there have been dramatic improvements in the aggregate economic status of elders: Poverty rates among elders have declined from 30% in the 1960s to about 12% today. Yet, rightly or wrongly, this tremendous success has also fueled perceptions among some that elderly Americans now consume “too many” public resources at the expense of more needy groups and that expenditures on entitlements benefiting all elders, rather than just needy elders, may compromise the competitiveness of the U.S. economy. Put another way, a growing number of policymakers view programs for older adults as important “trade-off elements” in attempts to deal with American economic and social problems (National Academy on Aging, 1994). For this reason and others, many now believe that new models of long-term care financing and service delivery are needed to ensure that society can meet both the needs of elders and the health and long-term care needs of other groups.

That the need and demand for long-term care services will dramatically increase is clear. The first members of the baby-boom generation will begin to retire in about 14 years. At that time, roughly 6.6 million elders will be over the age of 85 (U.S. Department of Commerce, 1994), and these individuals have a high likelihood of needing both formal (paid) and informal (unpaid) services. Smaller family size, the increase in the average age at which couples choose to have children, and increases in age-adjusted life-expectancy among elders will all create additional competing demands on both formal and informal support networks.

Long-term care presents a substantial financial risk to individuals and their families as well as to state and federal governments. The average annual cost of a nursing home stay in 1995 exceeded $38,000, whereas among users of home health care, out-of-pocket costs total more than $370 per month (American Association of Retired Persons [AARP], 1995). Total long-term care expenditures now exceed $100 billion annually. Medicaid pays about 44% of costs, Medicare 16%, and individuals and their families 33% of all long-term care costs (Levit et al., 1994). For many states, long-term care expenditures represent the fastest growing budgetary item. For the federal government, Medicare home health care represents the fastest growing part of the Medicare budget. Thus, consumers and government alike are exploring options for reducing financial exposure to long-term care costs and reducing expenditure growth in public programs.

Providers of long-term care are not immune to the changing demands and expectations of consumers or to the requirements imposed by changes in financing and reimbursement policies. Alternative
models of care are being examined and traditional providers are playing new roles in the service delivery system. What we call a “nursing home” today may look very different in just a few years. The growth in assisted living facilities, continuing care retirement communities, and subacute care units in nursing homes have all led to a blurring of the distinction between acute and long-term care services, between informal and formal caregiving, and between institutional and home-based care. While payers of care have, in part, been responsible for many of these changes, they too are rethinking the way that they pay for and manage payments for services.

This article presents information on a number of key emerging trends in long-term care related to financing, new models of service delivery, and shifts in consumer expectations and preferences. Taken together, changes occurring in these areas point to a rapidly transforming long-term care landscape. Three major trends are likely to occur over the coming years:

1. Long-term care financing responsibility will likely shift away from the federal government to states, individuals, and their families. As states attempt to control public expenditures, individuals and their families will face greater risks for incurring catastrophic expenditures.

2. Providers will continue to respond to market competition, shifts in consumer preferences, and changes in reimbursement and financing policy by exploring ways to integrate and manage acute and long-term care services and by adding new services to the continuum of care.

3. Consumers will continue to become increasingly aware of their vulnerabilities and think more seriously about how to plan and pay for their future long-term care needs as well as how to independently navigate the long-term care system.

Emerging Trends in Long-Term Care Financing

Increased Role for States

Much of the public policy debate over the past few years has been focused on how the federal government can reduce the rate of growth of entitlement programs like Medicare and Medicaid. Expenditures on both programs have increased markedly over the past few years. For example, an examination of recent growth in Medicare expenditures suggests that although hospital and physician payments are increasing at only very modest rates, payments for Medicare home health care and nursing home care are growing at 20% to 30% per year (Prospective Payment Assessment Commission, 1995). Moreover, between 1990 and 1993, total public spending on home care increased on average from 50 to 62%; Medicare’s share of that total rose from 27 to 44% (Levit et al., 1994).

Yet these trends are very likely to change in the near future. The federal–state partnership represented by the current Medicaid program will continue to undergo fundamental changes with respect to underlying philosophy and funding levels. In the area of long-term care financing, the responsibility of states vis-à-vis the federal government will likely grow. Likely funding caps—either global or individual—on federal dollars allocated to Medicaid will mean that states may be given greater latitude to meet consumer need, albeit with fewer resources. The shift in financing responsibility will profoundly affect many of the more than 2 million elders who receive care in nursing homes every year. Moreover, anticipated changes in Medicare reimbursement of home health care to per episode prospective payment schemes may result in the program serving fewer individuals with long-term care needs; the proportion of individuals who have more than 100 visits reimbursed by Medicare grew from 4% in 1988 to over 17% by 1993 (Bishop, Skwara, & Sangl, 1995) and many of these individuals will likely receive fewer visits in the future, in part because their needs are for unskilled rather than skilled rehabilitative services. This too will increase pressure on state home health care programs (Cohen & Tuminson, 1997). Clearly, states will face tremendous challenges in trying to meet the long-term care needs of their citizens over the next decade. In part, as a result of growing financing pressures on the long-term care system, there is a developing consensus among policy makers and analysts that both the public and private sectors will need to play roles in financing care (Wiener, Clauser, & Kennell, 1995).

As states are confronted with fewer federal dollars and with increased responsibility for paying for long-term care, they too will have to find ways to target resources and control expenditures. Many state policymakers are already thinking about how to work with the private sector to share long-term care financing responsibilities. A survey of state agencies on Aging and state Medicaid agencies revealed a strong desire to work with the private sector to help address the long-term care financing “squeeze.” Respondents indicated a belief that state costs could be reduced if more informal or family caregiving was encouraged and if there was greater support for private long-term care insurance, employer-sponsored elder care programs, and residential care alternatives (General Accounting Office [GAO], 1994). Figure 1 shows the number of state agencies indicating that a particular private sector approach would likely result in a reduction in government expenditures.

Public–Private Long-Term Care Financing Partnerships.—One approach to a public–private partnership is represented by the Robert Wood Johnson Foundation’s efforts to encourage the development of the long-term care insurance market through its Partnership Programs. A number of states, including California, Connecticut, Indiana, and New York, have implemented state-sponsored programs whereby individuals are provided an incentive to purchase state-certified long-term care insurance policies. If individuals exhaust their insurance benefits, then Medicaid
would either pay benefits without regard to the asset levels of individuals or view the insurance payments as equivalent to depleting assets for the purposes of Medicaid eligibility. By the end of 1995, about 10,000 people had purchased policies under the Partnership Programs (M. Meiners, Director, Robert Wood Johnson Foundation Partnership Program, personal communication, December 7, 1995).

Some Partnership models are more successful than others. The most successful program to date has been in New York, which accounts for the bulk of Partnership sales. The reasons for its success are varied and include strong state support; an institutional mechanism by which insurers, consumer groups and the state meet and exchange information with one another; New York’s relatively benefit-rich Medicaid program; and the ease with which the model may be explained to consumers—all assets are protected after insurance benefits run out (Holubink, 1996; D. Phillips, California Partnership for Long-Term Care, personal communication, February 28, 1996).

These programs represent the first “real-world” public–private long-term care financing partnerships. Yet they have not grown to the extent expected by sponsors. Modest growth in the programs may in part be due to the fact that many people buy private insurance to avoid depending on Medicaid (Cohen, Kumar, & Wallack, 1992). Because a primary benefit of the Partnership program is guaranteed access to Medicaid benefits, some consumers may lose interest in the program. The benefits of such programs to date are that they have increased awareness about long-term care issues and insurance, they have encouraged more individuals to protect themselves against catastrophic costs, and they have given individuals who may otherwise spend down to Medicaid eligibility levels a way to protect assets and pay for their care, thus decreasing their reliance on scarce public dollars.

Although not an obvious “partnership,” favorable tax treatment and tax incentives for the purchase of long-term care insurance also represent a type of public–private model. Passed in 1996, the Kennedy-Kassebaum bill allows individuals to deduct premiums for private long-term care coverage under certain conditions and ensures that benefits paid under long-term care policies will not be viewed as taxable income to the recipient. This legislation may help make the insurance more affordable to some consumers, but, more importantly, it sends a signal to consumers that the federal government views the purchase of this type of protection as something that consumers should consider.

**Greater Individual Responsibility**

The likely reduction in public funding for long-term care means that individuals and their families will increasingly have to rely on themselves to plan and pay for such care. Given the greater wealth position of retiring elders, this can be done through traditional retirement savings mechanisms or through the acquisition of risk-pooling instruments like long-term care insurance. The insurance option may grow in importance because of the nature of the long-term care risk: most people face a relatively small risk for incurring a catastrophic expense. To the extent that states target limited public dollars to the indigent, middle class elders will have to face their exposure to long-term care risk; over time, insurance will become an even more attractive component of a comprehensive retirement portfolio.

Even as the long-term care insurance market grows at an annual rate of about 25%, only 4.3 million individuals purchased policies by 1995 (Health Insurance Association of America [HIAA], 1997). The reasons why individuals choose to buy or not to buy policies reflect the price of products, attitudes about insurance and the role of government, views about family responsibility and, perhaps most importantly, a lack of information about the risk, current coverages, and the availability of the insurance.

It is important to note that long-term care insurance is an option for middle and upper income elders but not for those elders with limited resources.
Because policies are age rated, the age group that may find the insurance most affordable and relevant is comprised of individuals between the ages of 55 and 70; of course, the insurance is even more affordable for younger individuals, who can purchase policies through group plans. Even as growth in this market continues, a strong and clearly defined public financing role is critical to ensure that those who cannot pay for care or who cannot afford private alternatives will be able to access needed services.

To sum up, reduced federal expenditures on long-term care will shift the financing burden to state government and to individuals. States must find ways to stretch limited dollars to meet the needs of those citizens who cannot avail themselves of private alternatives. For their part, consumers must plan and pay for greater amounts of long-term care either individually or through risk-pooling instruments such as private insurance.

**Emerging Trends in Long-Term Care Service Delivery**

The long-term care industry is in the midst of a transformation characterized by both opportunity and challenge. In fact, some of the most innovative and exciting changes in health care are in the area of long-term care service delivery. Perhaps the most important trends with the most far-reaching consequences are the growth in models that integrate acute and long-term care in the context of a managed care environment and the growth of new services designed to “fill in the service continuum,” provided by both traditional and new long-term care providers.

**Models of Managed Care and Integration**

Around the country there are a variety of new and innovative experimental models designed to combine the financing and delivery of acute and long-term care services. The belief underlying all such models is that if a single organization is responsible and at risk for managing the total care of the individual and is in charge of the total health dollar, the match between client need and services will be optimized at the lowest possible cost for a given level of quality. New payment strategies (e.g., capitation) coupled with improvements in service delivery (e.g., integration) are employed to ensure that better outcomes are produced when trade-offs are made between acute and long-term care and between medically oriented and socially oriented services. Improved patient care is posited to occur because of improved communication and coordination between disciplines and sectors.

The discussion that follows presents a number of experimental programs that attempt to incorporate varying levels of long-term care into capitated, managed acute care plans. A brief description of these models follows.

**The Social Health Maintenance Organization (SHMO).**—The Social HMO is a demonstration project that is being conducted at four sites and serves more than 16,000 enrollees. The basic model adds community care services and short-term nursing home care to a Medicare HMO’s basic service basket. The program focuses on providing a broad cross-section of the Medicare eligible population with acute care and limited community-based long-term care coverage. The purpose of the program is to administratively combine acute, long-term care, and behavioral/social health services into an integrated health service delivery system. The SHMO is reimbursed by Medicare, Medicaid, and private premiums on a prepaid capitated funding basis. A case manager helps to ensure that enrollees are placed in the least restrictive yet most cost-effective care environment.

Already in the beginning stages of its second generation, the SHMO will more heavily emphasize a geriatric service model with a case management approach. The new model will be designed to identify individuals who are at high risk for both illness and disability rather than for just long-term care needs. Six new sites have already been offered planning grants to begin the process of building on the first-generation models. More than 19 organizations applied to participate in the program, indicating the growing interest in the SHMO model across a variety of organizations. Because the initial sites have (for the most part) demonstrated financial feasibility, and there are a growing number of HMOs taking Medicare risk contracts, we may assume that these models will expand as the market becomes more competitive. The SHMO authority has been extended for three additional years, through December 31, 2000, and Congress has directed the Department of Health and Human Services to develop recommendations for making the SHMO a more permanent Medicare benefit.

**Program of All Inclusive Care for the Elderly (PACE).**—PACE represents an innovative public approach to providing long-term care services to frail elders. The distinguishing features of the PACE approach are: integrated funding and provider financial risk through capitated Medicare and Medicaid reimbursement; integrated service delivery through adult day care, case management through multidisciplinary teams; and nursing home-eligible clients choosing to receive long-term care services in the community (Branch, Coulam, & Zimmerman, 1995). The program’s focus is providing an alternative to institutional care by maintaining individual residence in the home and community setting for as long as is medically and economically feasible. Currently there are between 10 and 15 sites in various stages of PACE development; each site serves between 78 and 351 clients.

PACE assembles acute and long-term care services into a contracted service network and the full range of services are included in the benefit package. Management systems coordinate service provision under a full-risk, capitated prepaid financing model. PACE differs from the SHMO in that it focuses services only on those individuals who are nursing-home eligible, it covers all long-term care...
costs for members, all PACE members are eligible for Medicaid, and PACE sites integrate acute and long-term care services through multidisciplinary teams based in adult day centers, which all members attend (Leutz, 1995). Thus far, target clients are not as enthusiastic about participating in the program as was anticipated; moreover, the client selection process raises questions about whether “skimming” may be occurring (Branch et al., 1995). For this reason, changes in the program may be warranted to ensure that the model can be viable and attractive to state and federal sponsors as well as to consumers. Recently, the federal government made PACE a permanent Medicare benefit; states will have the option of making it a standard Medicaid benefit.

The Arizona Long-Term Care System.—In 1989, Arizona began a statewide program to provide acute and long-term care services to the state’s eligible long-term care population. By 1994, about 18,000 individuals were enrolled in the program, most of whom (66%) were elderly and physically handicapped (McCall & Korb, 1994). Eligible individuals include those with incomes up to 300% of the Supplemental Security Income (SSI) level who are certified to be at risk of institutionalization. The program covers all traditional Medicaid acute care services, as well as nursing home care and home and community-based services (See Appendix, Note 1). The program is funded by the federal, state, and county governments. In each county, the state contracts with a single organization to assume responsibility for providing services; these contractors must arrange for both acute and long-term care services. They are paid a capitated amount per enrollee that varies according to county and is set through a bidding process. By January 1994, there were eight program contractors: five county-based, two private, and one state agency. These contractors, in turn, have adopted competitive approaches to paying providers by using capitated methods (McCall & Korb, 1994).

Preliminary analyses of the Arizona program indicate that it has yielded significant cost savings compared to traditional Medicaid programs. This is true for both the acute care population, and, to a lesser extent, the long-term care population, although the savings are primarily based on disabled adults of all ages rather than elders alone. On the other hand, initial analyses suggest that when compared to the Medicaid program of neighboring New Mexico, nursing home residents in the Arizona program experience a somewhat lower quality of care (McCall, 1997). Additional investigations are underway to better understand how to improve the Arizona model and assess how the program affects the cost and quality of acute and long-term care. As states contemplate central roles in the management of their own long-term care populations, many are looking to the Arizona experience for guidance.

The Florida Robert Wood Johnson (RWJ) Long-Term Care Initiative.—Although still in its planning phase, the Florida RWJ initiative seeks to encourage the development of long-term care HMOs. To this end, Medicaid and Medicare payments would be combined into a single funding stream to eliminate fragmentation of services and cost shifting. Individuals would be entitled to the benefit package provided by traditional Medicare HMOs, and the long-term care HMO would also be at risk for copayments, deductibles, and services that include a specified amount of nursing home care, home care, and other community care. The new long-term care HMO system will deliver care through existing acute care provider networks and through the state of Florida’s existing network of elder service providers. The hope is that pooling these funding sources at the provider level will provide more flexibility in service delivery and lead to increased efficiency.

The trend toward programs that put the provider at risk for both acute and long-term care is likely to continue. In part, this is because long-term care services may sometimes be substituted for more costly acute care services. Thus, an at-risk provider that has an integrated financing and delivery system has tremendous opportunities to increase profitability through service substitutions. Already, greater numbers of HMOs are enrolling elderly members under Medicare-risk contracts, and it is just a matter of time before these HMOs begin to experiment more aggressively with providing a broader set of long-term care benefits (Cohen & Miller, 1997).

With that said, however, the pace of change will be greatly influenced by the extent to which payments to managed care organizations accurately reflect the risk profile of members. If certain at-risk providers are “selected against”—that is, increasing numbers of high-risk individuals join their organizations and payments do not account for this—then providers will compete over the quality of members rather than the quality of care. If, for example, an organization becomes known for providing excellent long-term care services, then frail individuals, who would likely have higher acute care costs as well, would be more likely to join such an organization. If capitated payments are not adjusted to take this into account, such an organization could face financial peril and would be forced to “cream-skim,” or cut back on those services that attract higher risk individuals. Thus, new payment mechanisms must be developed to address this critical issue and ensure that the benefits of service integration and capitation are realized by consumers.

Managed Care and Provider Networks.—Increasingly, long-term care providers are positioning themselves to become part of integrated service delivery networks with the goal of participating in a network of services that spans the continuum of care, stretching from the hospital to the nursing home to the individual home (Romano, 1994). Managed care is really about establishing networks of providers who will offer quality-controlled services at predetermined levels of reimbursement. To date, most managed care contracts have been between
nursing home providers and HMOs and preferred provider organizations (PPOs). However, many managed care networks are exploring ways to offer their members an array of long-term care services. This means that other long-term care providers and nursing homes themselves are entering arenas such as assisted living, home health care, and adult day care.

Inclusion of long-term care in a managed care network accomplishes a number of objectives. First, it helps traditional HMOs, hospitals or nursing homes differentiate themselves from competitors. Second, there is a belief that many acute care services could be provided in less costly long-term care settings without sacrificing quality. Thus, there is the potential for service efficiencies and improved financial performance. For their part, long-term care providers are often eager to become part of more integrated provider networks because they believe they can increase their profitability by working with HMOs, PPOs, and hospitals and can market their services to a new population of potential clients.

Such networks are not developed without encountering problems. It is difficult to manage care across many delivery sites and a great deal of management sophistication is required in order to understand how services and individuals can best be matched. Also, agreeing on standards and philosophy of care across different organizations and provider types is particularly challenging. Unless all participating organizations share in the financial risk, it will be difficult to ensure that patients and costs are not shifted to inappropriate levels of care. Further, there is a risk that by integrating acute and long-term care services, the latter will become “overmedicalized.” Long-term care providers that add more medically oriented services to their service baskets will also need to upgrade their staffs and equipment. Being part of an integrated delivery network also requires an increase in administrative staff members, who must ensure smooth communication and information flow between participating provider entities. This is a costly endeavor.

Finally, the appropriate technologies or clinical protocols must be available to guide the network manager in determining how to manage care and maintain quality in a cost-effective manner. Much remains to be learned in this area. Unless managed care organizations recognize the need for learning and incorporate mechanisms for doing so, they are not likely to achieve their objectives. In sum, to be a successful network, high quality and like-minded providers must attract and retain sufficient market shares and demonstrate to consumers that managed care does not mean placing limitations on quality care so that providers can reap excess profits.

Clearly, the new systems of alliances, joint ventures, and mergers that are taking place across the entire health care system influence the subsystem of long-term care providers. Consumers’ demands for more “one-stop shopping,” coupled with reimbursement pressure on providers to deliver services more efficiently, have laid the groundwork for greater integration and managed delivery systems. (See Appendix, Note 2). Moreover, enrollment among elders in managed care is increasing dramatically. Even among long-term care insurers, which traditionally have few links to provider networks, there is a move afoot to incorporate elements of care management into product designs (Jacobs & Reed, 1997). Such trends are likely to dominate both the public and private sectors for the coming decade.

Filling in the Continuum of Care

As traditional long-term care providers become part of integrated provider networks, they are also spreading out along the continuum of care. For example, traditional nursing homes have reached out to embrace both sides of the continuum that stretches from limited supervision in the home to intensive hands-on care in subacute units in skilled nursing homes (Romano, 1994). Most clinicians would agree that patients are better off when they can access the entire continuum of care. Two of the most important trends in “continuum-filling” have been in the area of subacute care and assisted living. A discussion of why these trends are occurring and the opportunities and challenges they present to providers, consumers, and payers of care follows.

Subacute Care Services

Subacute care refers to medical or rehabilitative services provided to patients who no longer require inpatient hospitalization but do require a level of care commensurate with ongoing medical supervision (Harvell, 1996). Patients who continue to reside in an inpatient hospital due to a lack of alternative placement, but who no longer require acute care services, may be classified as “subacute.” Since 1983, hospitals have been reimbursed under a diagnostic-related group payment system. This has served to encourage hospitals to release patients as quickly as possible, which has led to dramatic declines in hospital length of stay and resulting increases in the number of individuals receiving postacute care in supportive care settings such as the nursing home (Harvell, 1996).

Opportunities.—Many long-term care providers view the pressure on hospitals to discharge patients “quicker and sicker” as an important opportunity to satisfy an unmet need. As such, many nursing homes have enhanced their service capacities and added subacute care units to the portions of their facilities that are Medicare certified. This enables them to receive Medicare payments for the provision of subacute care. This is financially rewarding because pre-tax profit margins for subacute care providers are two to three times higher than those for traditional providers; some estimate that the potential annual revenue of the subacute care industry could exceed $10 billion by the end of the decade (Lawson, 1994; Banta & Richter, 1993). Thus, to many, subacute care represents the nursing home industry’s future and the catalyst of a major transformation of the skilled nursing home to a more “low-tech” hospital setting.
The postsurgical and other medical services once available only in hospitals are now offered by nursing homes and at much lower costs, ranging from $250 to $900 per day compared to hospital charges that may exceed $1,500 per day. These subacute rates are also much higher than skilled nursing rates.

The increase in managed care enrollments has also fueled growth in the subacute industry. Because subacute services represent a lower cost alternative to hospital care, they are strong candidates for inclusion in comprehensive managed care strategies. States also have an interest in shifting long-term Medicaid covered residents who qualify for skilled care into subacute units so as to expend federal (i.e., Medicare) rather than state dollars. Finally, patients themselves may be interested in leaving the hospital for somewhat more comfortable, home-like settings such as those found in nursing facilities.

Challenges.—Even as some are predicting that within the next decade subacute care beds will come to represent as much as 25% of the bed count, others caution against its overuse. There still remains considerable confusion about what actually constitutes subacute care, how to define its true costs, whether the outcomes of care provided in subacute settings are better or worse than in hospital settings, whether long-term care providers are adequately “staffing up” to provide appropriate services, and whether managed care organizations will use subacute care as a way to reduce costs without regard to quality. How this relatively new service ultimately fits into the continuum of care will dramatically influence both provider and payer behavior over the next decade.

Assisted Living

The growth in subacute services represents an attempt by long-term care providers to expand their services to the more medical side of the health care continuum. At the more social and paraprofessional end of the continuum, an array of market opportunities have presented themselves to traditional long-term care providers. One of the more important and growing new services is the assisted living facility, which is a bridge between boarding homes and skilled nursing facilities. In general, assisted living facilities can be categorized into one of three broad types: (1) public housing, (2) units in continuing care retirement communities, and (3) freestanding facilities.

Assisted living facilities typically offer a combination of housing, health care, personal assistance, and supportive services. There are substantial variations, however, in the range of services that assisted living facilities provide and in the types of populations they serve. For the most part, assisted living facility residents are medically stable and do not require 24-hour nursing care. Most facilities provide or arrange for some level of personal care services for those individuals who require them.

Opportunities.—While there is no definitive estimate of the number of assisted living facilities in the United States, a 1992 survey by the American Health Care Association (AHCA) determined that 10% of its members operated such facilities, which offered limited nonmedical care to individuals who lived independently. Other estimates range from between 40,000 and 65,000 facilities serving as many as 1 million elders (Assisted Living Association of America [ALAA], 1991; Lewin-ICF & James Bell Associates, 1990). Assisted living has developed into a $10 billion per year industry. The growth in assisted living facilities reflects consumer demand for supportive living environments that closely parallel a homelike atmosphere. In addition, the growth in the subacute market may be leaving a vacuum in the provision of traditional, low-technology, facility-based long-term care that assisted living beds are designed to fill. Figure 2 shows the diversity in property types represented by the assisted living industry.

What little evidence exists suggests that frail elders residing in assisted living settings are happier than nursing home residents and may avoid premature institutional placement. Further, caregivers of assisted living tenants may exhibit higher levels of satisfaction when compared to caregivers of institutionalized elders (Lewin-VHA, Inc., 1992). For some individuals cost savings may result when assisted living is substituted for nursing home

![Figure 2. Distribution of assisted living facilities by property type, 1992. (Source: National Center for Assisted Living, 1997.) Note: CCRC is a Continuing Care Retirement Community and a SNF is a skilled nursing facility.](https://academic.oup.com/gerontologist/article-abstract/38/1/80/620519)
care. Assisted living costs range from 30% to 100% of skilled nursing care costs (M. Raskin, Analysts, AHCA, personal communication, December 6, 1995). Assisted living facilities may also achieve economies of scale in the delivery of home health care to frail elders that would be difficult to achieve if the patients continued to live alone in their own homes. Because elders overwhelmingly prefer to stay in their own homes or reside in congregate living situations rather than nursing homes and because a noninstitutional feel is maintained in these facilities, assisted living options are likely to continue to grow and expand.

Challenges.—The growth of assisted living facilities presents new opportunities for providers and corresponding challenges for payers. Traditional long-term care providers can capitalize on a popular new living arrangement for which there is likely to be a growing demand. On the other hand, because of the wide variability in definitions about what actually constitutes assisted living, it is difficult to know if and how services provided in this setting should be reimbursed. Already, long-term care insurers are grappling with whether assisted living should be viewed as a nursing home benefit or a home health care benefit. The lack of uniform standards and licensure makes it difficult to know how to cover and define assisted living services in a way that ensures their equitable and appropriate use and that can be priced reliably in a policy or projected accurately for public programs.

Taken together, the trend toward greater integration of acute and long-term care services and the addition of new services to the continuum of care portends dramatic changes in the ways in which long-term care is delivered and paid for. The nursing home of the past will continue to evolve in two polar directions: into more sophisticated medical facilities and into more home-like places to live. Barriers between service levels are diminishing and the flow across service settings will increasingly become seamless.

Emerging Trends in Consumer Preference and Expectations

Consumer Attitudes About Government Financing

Consumer expectations and preferences shape, and are shaped by, the long-term care financing and delivery system. For example, the search for a greater private sector role in financing long-term care comes at a time when a growing number of individuals (74%) believe that they will have to plan and pay for their own needs (Cornel & Kitchman, 1995). In fact, a recent survey of a nationally representative sample of individuals aged 55 and older reveals that most (58%) do not believe that the government should pay for the long-term care needs of all individuals and that, in any event, it is very unlikely that the federal or state governments will implement new long-term care programs within the next 10 years (Cohen & Kumar, 1997; see Figure 3 and Appendix, Note 3).

Also, as shown in Figure 4, only one third of individuals favor a universal entitlement program for long-term care and about half of all elders believe that the government should target benefits only to the most needy. Put simply, the data suggest that most people do not believe it is the responsibility of the federal government to pay for everyone’s long-term care needs. These results are particularly significant because the surveyed age cohort would benefit most quickly from the implementation of such a universal entitlement program. Thus, among individuals for whom the need may be nearest, there is a growing realization that they will have to rely on themselves or on solutions offered by the private sector to pay for long-term care.

Consumer Directed Long-Term Care

As consumers rely less and less on the government to pay for long-term care, they are also more likely to demand greater flexibility in how and when they access services. When people spend their own resources on long-term care, either directly or

Figure 3. Attitudes of 1,000 individuals age 55 and over, 1995. (Source: Cohen & Kumar, 1997).
Don't Know 20%
Favor a Government Program Only for the Most Needy 48%
Favor a Universal Entitlement to Long-Term Care 32%

Figure 4. Attitudes of 1,000 individuals age 55, 1995. (Source: Cohen & Kumar, 1997.)

through participation in risk pooling programs, they expect to be able to make their own choices about how to do so. Thus, cash benefits (or greater flexibility in how expenses are reimbursed) are likely to become more common in public and private programs alike. Already, private sector insurance innovations enable consumers to purchase a level of benefits, say $100,000, that can be spent either in the nursing home or at home for home health care. This “pot of money,” or integrated benefit concept, coupled with care management to help consumers use benefits effectively, is another step in a continuing trend of offering consumers more choice and flexibility to accommodate the rapidly changing service delivery environment.

The idea of providing cash to disabled individuals is not, however, confined to the private market. A number of states, including Colorado, California, Wisconsin, Maryland, and Pennsylvania, have programs that provide cash allowances to disabled persons (Firman, 1995). The cash may be used to purchase services from a home care agency or referral service, to pay a friend or relative to care for or live with the disabled individual, or to finance moving to an assisted living facility or other housing option. When given the choice, for the same price, most individuals prefer cash to service benefits. Perhaps one of the best developed programs is found in Germany. There, for example, disabled individuals can choose to receive either services prescribed by a case manager or a monthly cash payment that is roughly half of the costs of needed services. Well over 80% of the disabled individuals opt for the cash payment (Firman, 1995).

Currently the Robert Wood Johnson Foundation is funding a “cash and counseling” initiative, the primary purpose of which is to develop new information to help policymakers, state government officials, and others decide if and how to establish cash payments and counseling to pay for long-term care. The cash component of the program would provide disabled individuals with a monthly cash allowance and the counseling component would furnish people with consumer information and assistance in choosing and arranging for long-term care support. The major purported benefits of a cash and counseling approach include empowerment of consumers, support for families and other informal caregivers, a unified model for serving persons of different ages and disabilities, administrative ease, lower unit costs of care and lower total costs to government, and encouragement of consumer-directed chronic care systems.

As states experiment with how best to pay for long-term care, such programs may become more attractive because they make it easy to forecast costs, reduce liabilities associated with direct contracting and provision of services to consumers, and lower administrative expenses. Insurers are also likely to continue to develop products that maximize consumers’ abilities to make decisions about the levels and types of care needed to meet their needs. For consumer-directed care to work, however, consumers need to be educated about the options available in their communities and to know how and when to access services.

Conclusion

Many emerging trends in long-term care financing and service delivery are mutually supportive. For example, as traditional long-term care providers add new services to the continuum of care, they assist managed care organizations in their efforts to find lower cost alternatives to more expensive levels of care. Moreover, as payers are able to align capitation payments more closely with actual risk profiles, HMO service baskets will likely expand as managed care organizations compete over the quality of service rather than the quality of members.

There are, however, trends in managed care that may be antithetical to trends in consumer preferences. For example, as greater numbers of integrated, at-risk systems of care are established, how can consumer-directed long-term care be implemented? Will the emphasis on care management mean that consumers have less input into decisions about their care or will such organizations instead maximize consumer decision making as a way to ensure and enhance market share? Will consumer directed long-term care be cost-effective or will...
consumers be driven to maximize values other than cost-effectiveness (e.g., reducing caregiver burden and stress)?

Because the models discussed in this article are in their initial stages of development, it would be premature to suggest that these issues cannot be addressed. It may very well be that the successful managed care organization of the future will be the one that strikes a balance between consumer preference and cost-containment. What is certain is that these and other issues will be played out in the context of a public system that is downsizing and a private system that is gearing up to assist the consumers who are trying to navigate their way through a dynamic and shifting service delivery system. As the United States moves into the 21st century, such a context presents tremendous opportunities and challenges to the public and private sectors alike.

References

Received December 18, 1995
Accepted February 3, 1997

Appendix

1. There is a cap on the amount of home- and community-based care services used by the physically disabled population that will be reimbursed by the federal government.
2. As discussed in a subsequent section, seniors’ concerns about greater freedom of choice as well as their traditional reluctance to join HMOs and managed care organizations must also be overcome. Changes in Medicare reimbursement policy, as well as the growing number of new retirees who have had experience with HMOs and managed care, suggest that even among the elderly population, over time, such networks are likely to be the rule rather than the exception.
3. A telephone survey was conducted in March 1995. Sample characteristics closely approximated census data with respect to age, gender, marital status, and education level. However, because the income status of sampled individuals was somewhat higher than what was reported in the census, the sample was reweighted to account for this. This assured that results could be generalizable to the U.S. population aged 55 and older.