

## Long-Term Care Reform and the Role of Housing Finance

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### *Abstract*

The Clinton administration's recently announced home and community-based care proposals have potentially important implications not only for long-term care policy, but also for housing policy in the United States. This article attempts to draw out some of those implications. The first section examines problems inherent in the current "medical/welfare" system of financing long-term care, which constrains consumer choice by limiting the supply of providers to control costs and by increasing medical professionals' control over the types of services provided in the name of quality control. The medical/welfare dominance of long-term care policy has resulted in an overreliance on nursing homes as providers, resulting in both escalating costs and continued consumer dissatisfaction.

The second half of the article looks at recent market and policy developments in response to consumer demand for lower cost alternatives to nursing homes. These alternatives promote more consumer autonomy and control in supportive housing arrangements. A more comprehensive services and housing policy could promote these developments in an approach that combines the security of public financing of supportive services with the benefits of consumer choice, market competition, and legal protections that characterize housing markets. In such a scenario, housing finance institutions—including government agencies, lenders, developers, and investors—could play a pivotal role in the long-term care debate not only by unlocking substantial financial resources but, equally important, by transforming the provision of long-term care services to promote consumer choice and autonomy.

### **Introduction**

In a thorough discussion of "policy choices for long-term care," the Congressional Budget Office (CBO) divided observers of the present system of long-term care (LTC) into two types of critics (there presumably being no defenders of the current system). "Fiscal critics" are those who "consider that both the level and expected growth rate of federal LTC costs are unacceptably high and that the private sector should therefore play a larger role in financing LTC services." "Performance critics" are those who "consider that the system provides too little financial protection for people who need extended and, in many cases, very costly LTC services. They also want a broader range and higher quality

of services to be available” (Congressional Budget Office 1991, x). The authors add, perhaps unnecessarily, that the latter approach tends to cost more money—potentially a lot more money.

The long-awaited release of the Clinton administration’s proposals (the Health Security Act) in late October 1993 has launched a national debate about the reform of health care and long-term care.<sup>1</sup> For most health care services, the administration has sought to bridge the difference between fiscal critics and performance critics by an approach sometimes referred to as “managed competition.” Broadly speaking, the administration’s version of managed competition seeks to tap private resources and promote more competitive health care markets in order to generate savings that can be used to improve the performance of the health care system by extending benefits to the uninsured or underinsured. In essence, the Clinton proposal seeks to combine the benefits of a more competitive market with the security of a universal insurance program.

The administration’s long-term care proposals fall short of the ambitious restructuring that characterizes the rest of its health care proposals. The Clinton plan might be described as emphasizing “performance” goals within a very limited budget. The majority of the new funding will be for what amounts to a new state block grant program to promote innovative approaches to home and community-based long-term care services. The program would be funded at only \$4.8 billion in the first year and would be increased gradually over the seven-year phase-in period, starting two years from now. For the elderly, benefits would be limited to those with severe cognitive or mental disabilities or those requiring help with three out of five activities of daily living (ADLs)—eating, toileting, dressing, bathing, and transferring in and out of bed. The modest funding levels, the long phase-in period, and the limited benefits mean that a universal insurance program for long-term care will be a long time coming.

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<sup>1</sup> This article will use the term “long-term care” in the broad sense to refer to medical and nonmedical services required by persons with functional disabilities. Such services may be received in an institutional setting such as a nursing home or in a home or community setting. Services may be provided by professionals, by trained nonprofessionals, or by family or friends. Though this article (like most articles in the field) will concentrate on the needs of older persons with disabilities, younger persons with disabilities also have long-term care needs. The types of services are typically oriented around accomplishing basic activities of daily living (ADLs) such as walking, bathing, dressing, using the toilet, transferring in and out of bed, and eating. Services may also involve instrumental activities of daily living (IADLs) such as shopping, paying bills, and other activities especially impeded by cognitive impairments.

This article begins with the proposition that the nation should establish policy goals for the provision of long-term care that parallel those of the rest of the Clinton proposals on health care services, that is, the eventual goal should be to combine the security of a universal insurance program with the benefits of enhanced competition in the market to provide long-term care services. Although the administration's initial proposals are very modest, they include two important elements that could contribute to the goal just outlined. First, by basing eligibility on disability alone, irrespective of income, the administration's initiative breaks with the welfare logic that has driven long-term care policy in the past and could lay the foundation for a broader social insurance approach to long-term care. Second, by promoting innovative home and community-based care options and more consumer choice, the Clinton proposals begin to sever the relationship between long-term care services and the setting in which they take place. If this approach were adopted on a significant scale, the result could undermine the enormously expensive medical monopoly on caregiving enforced by the current institutional bias of long-term care policy and promote competitive alternatives that are already beginning to develop in the long-term care market.

The purpose of this article is not to offer a comprehensive social insurance plan for long-term care services; rather, it attempts to demonstrate the crucial role that housing finance could play in restructuring long-term care. The argument hinges on the assumption that the structure of the financing will largely determine the types of services provided. If severing the relationship between long-term care services and the settings in which services take place is critical to promoting innovative options and greater consumer choice, it follows that a third critical dimension of long-term care reform must be the development of separate financing streams for services and for housing—but within an overall strategy in which both are serving the same goals. In a sense, the Clinton plan separates the two financing streams by simply excluding “room and board” from coverage, thus leaving completely undeveloped the financing needed to provide suitable “homes” within which the envisioned home care would take place. Conspicuously absent from the administration's proposals is any capital development strategy to finance new construction or to adapt the existing housing stock. This article seeks to show how fuller development of a housing finance policy, in tandem with enhanced public financing of home and community-based care, could combine the security of public financing for supportive services with the benefits of consumer choice, market competition, and legal protections that characterize housing markets.

To illustrate the magnitude of the policy changes required, the first section of the article examines problems inherent in the current “medical/welfare” system of long-term care. The combination of welfare financing and medical control has led to public long-term care policy that places two major types of constraints on consumer choice: (1) a capital development strategy based on limiting the supply of providers to control public expenditures for services and (2) quality control mechanisms that increase the control of medical professionals over the types of services provided. The medical/welfare dominance of long-term care policy has caused an overreliance on nursing homes as providers, resulting in both escalating costs and continued consumer dissatisfaction.

The second section of the article looks at recent market and policy developments that have responded to consumer demand for lower cost alternatives to nursing homes that promote more consumer autonomy and control. A number of innovative approaches to serving older persons with disabilities have emerged in recent years to compete with nursing homes—at least for consumers who can pay for the services and who do not need constant medical supervision. Most of these alternatives have been developed as supportive housing arrangements, using a variety of public and private housing finance mechanisms. Enhancing these housing finance mechanisms in a partnership of government agencies, lenders, developers, and investors could not only unlock substantial public and private financial resources but, equally important, could also help transform the provision of long-term care services in the following ways:

- **Finance.** While the current welfare model limits consumer choice, a more market-oriented model would emphasize competition among types of providers and services to promote responsiveness to consumers, who would have added responsibility to direct their own care.
- **Cost containment.** Long-term care services could move from sharply restricted access and price controls designed to restrain public costs to competitive alternatives that stress individualized care, deprofessionalized control of services, and more support for self-reliance and informal caregiving.
- **Quality.** The medical model emphasizes professionally determined “quality of care,” but an alternative system could emphasize a consumer-centered goal of “quality of life”

as experienced by the individual and enhanced by market diversity.

### **Problems with the current system of financing long-term care**

Daunting projections of potential need for and costs of long-term care services have prompted calls for reform at both the federal and state levels. In 1990, roughly 7 million older people needed some long-term care services—a number that is projected to rise to 12 million by the year 2020 (U.S. Senate, Special Committee on Aging 1991, 148). The costs of nursing home care for older persons with disabilities are estimated to rise at a much faster rate—from \$37.6 billion in 1990 to \$112 billion in 2020 (1989 dollars) (U.S. Senate, Special Committee on Aging 1991, 172). Medicaid, the federal/state program that provides the vast majority of public funding for long-term care services, represents the fastest growing area of state budgets—registering three consecutive years of 20 percent-plus growth in costs (O'Connor 1993). Current projections indicate that the program will grow from 14 percent of state budgets in 1991 to 22 percent in 1995 (Lemow 1992).

Cost and quality-of-life concerns are increasing the pressure on federal and state policy makers to change the structure of long-term care finance. In contrast to more competitive markets, the current long-term care market is characterized by a lack of internal incentives for cost containment, efficient resource allocation, and responsiveness to the quality-of-life concerns of the consumers of those services. Scanlon (1992) notes that costs for nursing home care have risen by an annual average of 12.6 percent from 1970 to 1990, outpacing even the hefty increases of other health-related costs, including physician services, hospital care, dental services, and drugs. Efficient resource allocation has been confounded by a paradoxical situation in which some residents are institutionalized unnecessarily and receive expensive unneeded services while access problems deny services to many who desperately need them (Bishop 1988). Despite the enormous costs, consumer research finds persistent concerns about the quality of life in nursing homes.<sup>2</sup> Indeed,

<sup>2</sup> Paula J. Beidenharm and Janice Bastlin Normoyle, Elderly Community Residents' Reactions to the Nursing Home: An Analysis of Nursing Home-Related Beliefs, *The Gerontologist* 31 (1991), 107–14. See also survey data from the Alliance for Aging Research, Press Release, November 18, 1991, which found that “The fear of losing independence and living in a nursing home tops a series of possible worries that people might have about aging.”

going to a nursing home is almost universally dreaded by older persons, many of whom are willing to go to extraordinary lengths to avoid “institutionalization.”<sup>3</sup>

If long-term care markets were competitive, providers would have to attract consumers by offering a wide variety of services, in a variety of settings, at a range of prices to meet the enormous diversity of consumer needs, preferences, and ability to pay. Incentives for cost containment, efficient resource allocation, and quality would be built into the system by the simple fact that consumers would choose among providers on the basis of desirability and price of services as they do in other competitive markets. Bishop (1988) notes that the nursing home industry has characteristics that should make it more competitive than other health care markets.<sup>4</sup> Compared with hospital markets, for example, nursing home markets are relatively unconcentrated—that is, facilities are more numerous and ownership is more dispersed.<sup>5</sup> Construction costs and staffing requirements are modest in comparison with hospitals, which should make it easier for facilities to open in response to consumer demand. The lack of concentration and the relatively low costs of entry to the market should provide consumers with more choices. Consumers, for their part, should be more sensitive to cost because few have long-term care insurance, and they generally must pay for services out of pocket, at least initially. Because of the large amount of informal caregiving, demand is somewhat more elastic than in acute care markets, that is, consumers can and usually do wait for a time during which they could shop for the optimal situation for their preferences and ability to pay.<sup>6</sup>

To understand why competition is not working despite these factors, one must examine the policies that have driven the

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<sup>3</sup> See Rosalie A. Kane and Arthur L. Caplan, eds., *Everyday Ethics: Resolving Dilemmas in Nursing Home Life* (New York: Springer, 1990), for very moving examples of persons who even preferred prison to a nursing home.

<sup>4</sup> Unless otherwise noted, the following discussion of competitive forces in the nursing home industry relies on the excellent analysis by Bishop (1988).

<sup>5</sup> It should be noted that the number of nursing homes has been declining somewhat and the ownership by nursing home chains has been rising in recent years as the industry consolidates and repositions to compete with hospitals for the subacute market. See Suzanne Powills, *Industry Shrinks to Boost Service*, *Long-Term Care News* (August 1993), 1.

<sup>6</sup> Bishop (1988) also notes some barriers to this elasticity—notably, the high percentage of consumers who come directly from acute care hospitals (indicating a crisis-precipitated move) and imperfect knowledge on the part of consumers and their families about options in the market.

massive government intervention into long-term care markets. Although the federal/state Medicaid program funds roughly 60 percent of patient days in nursing homes (Scanlon 1992), Vladeck (1980) observes that the federal government has never had a clear long-term care policy. Instead, federal support for long-term care has largely been shaped by medical and welfare policies: “By and large, nursing home policy has been made not only with limited foresight, but largely by people who, at the time, were primarily concerned with doing something different. It is an afterthought, a side effect of decisions directed at other problems—mostly those of health care or of poverty” (30–31). The following discussion examines the combined effects of the welfare and medical policies that have driven up the costs of public funding of long-term care services while limiting the choices to those medically prescribed, which consumers often experience as least desirable.

### *The welfare system of financing*

Institutionalization generally has devastating financial effects on consumers and their families. Because of the impoverishing effects of being disabled, the public financing of long-term care services originated as an extension of welfare policy through the Medicaid program.<sup>7</sup> Unlike Medicare, which is a *universal insurance* program for all older persons irrespective of income, Medicaid is a *welfare* program for persons with low incomes and few assets. In order to qualify for Medicaid financing of long-term care services, therefore, older persons must either be poor or become poor by “spending down” their incomes and assets. In addition, while Medicare is entirely financed by the federal government, each state contributes between 21 and 50 percent of Medicaid financing, depending on characteristics such as the per capita income level in the state.

The large-scale intervention of Medicaid into nursing home funding reduces the price sensitivity of a substantial portion of the consumer market—not only consumers immediately eligible for Medicaid, but also those who are likely to spend down to Medicaid eligibility, which combined includes most consumers. For the majority of older consumers who either are or will be eligible for Medicaid funding, there is little incentive to shop around for the best price since lower costs will only affect, at most, the duration of the spend-down period.

<sup>7</sup> For a discussion of the history of long-term care policy, see Vladeck’s (1980) classic discussion.

Consumers and their families do, however, have an incentive to “game the system” by transferring their assets to meet Medicaid eligibility requirements. To families, the spend-down provisions and limits on transfers of assets appear confiscatory, especially for a service they dread and over which they have very little control. The level of asset transfer allowable is under dispute, though it is likely to be less than one might predict given the incentives to do so.<sup>8</sup> Policy makers have responded to reports of middle-class persons abusing what was intended to be a welfare program by initiating ever more restrictive and intrusive cost containment and enforcement measures to eliminate what is perceived as “welfare fraud” (Kosterlitz 1991). Indeed, the recently passed Budget Reconciliation Bill includes provisions that will tighten restrictions on transferring assets and strengthen efforts to recoup losses to Medicaid by placing liens on estates.

### *Cost containment through limiting services*

Federal regulations and requirements have contributed to the spiraling costs of long-term care by forcing states to scramble to control costs through a variety of methods, most of which have had undesirable, unintended consequences for consumers. Though states often include some home care services in their Medicaid programs, the incentives set up by the federal government strongly favor the most expensive option, nursing home care, over other options. If states elect to provide services through nursing homes, they have access to an unlimited entitlement. If, however, states choose to promote innovative home and community-based delivery systems for care, they generally must go through an elaborate process of applying for a “waiver” from the federal government in which they must prove that the cost to Medicaid will not exceed that of institutional care.<sup>9</sup>

<sup>8</sup> U.S. General Accounting Office, *Medicaid Estate Planning by the Elderly in Massachusetts*, GAO report no. B-250340 (Washington, DC, 1993). See also E. Kathleen Adams, Mark R. Meiners, and Brian O. Burwell, Asset Spend-Down in Nursing Homes, *Medical Care* 31(1) (January 1993), 1–22, for an extensive discussion of the methodological problems associated with determining the level of spend-downs.

<sup>9</sup> A program to allow states to provide home and community-based services at their own option was enacted in 1990, but the potential liability to states was so high and the federal funding so low that states have expressed almost no interest in participating in the program. See Linda Lipson and Susan Laudicina, *State Home and Community-Based Services for the Aged under Medicaid: Waiver Programs, Optional Services under the Medicaid State Plan, and OBRA 1990 Provisions for a New Optional Benefit* (Washington, DC: AARP Public Policy Institute, 1991).

The burden to prove cost savings illustrates the degree to which nursing home care continues to dominate policy making, building in powerful programmatic barriers to providing alternatives. Cost-effectiveness is not measured, as it would be in any other area of policy making, by setting a policy goal and comparing the costs and effectiveness of various means of meeting the goal. If the policy goal were to serve all persons with a specified level of disability—for example, three problems with ADLs as in the Clinton plan—states would have less difficulty in demonstrating the cost-effectiveness of providing a more balanced mix of institutional and home and community-based services. If the goal is further defined as effectively promoting a specific quality of life, the current bias in favor of institutional care might be entirely reversed. At present, cost-effectiveness is typically discussed not in terms of goal accomplishment but in comparison with the current cost of serving persons in nursing homes (Greene, Lovely, and Ondrich 1993).

In general, states have a difficult task demonstrating that the aggregate cost of increasing home and community-based care will be equal to or less than current spending levels for nursing home care alone unless their nursing homes have numerous vacancies. Why? Because if a state has tight controls on the supply of nursing home beds that result in excess demand, nursing homes will operate at or near capacity with or without additional home and community care. Adding more home and community-based care under such conditions can only result in higher expenditures than continuing current policy. On the other hand, if a state has an excess supply of nursing home beds—“cold beds” in the vernacular of long-term care policy—it can be argued that the addition of home and community-based care will likely result in more cold beds. State administrators have noted that this so-called cold bed formula of proving cost-effectiveness only by demonstrating empty nursing home beds is “arbitrary, institutionally biased and a bad way of regulating the program” (Greene, Lovely, and Ondrich 1993, 6).

Another common way to control costs is to control the supply of nursing home beds. States limit the supply through moratoria on issuing licenses or through certificate of need (CON) restrictions. In what amounts to a capital development strategy of limiting access to the market, CON laws and licensing moratoria create an artificial scarcity of supply in many states that ensures demand for services with little regard for quality of services. For developers and investors, the excess demand created through artificial controls on supply has meant that the decision to build a nursing home depends primarily on the state granting a CON. One chief executive officer of a bank that does a considerable

amount of nursing home financing may have exaggerated the degree of nursing home development today, but the following remark illustrates the importance of the CON: "Believe it or not, development is not slow on the nursing home side. Anywhere there is a CON available, people are jumping on it. Once they get the CON, they find a way to get financing" (Bowe 1993, 32). In a recent meeting, a representative of an investment firm candidly noted that, unlike regular housing development, market surveys are rarely done for nursing home finance since demand simply is not an issue. To paraphrase his comments, "All we ask from developers is to show us their CON and their Medicaid reimbursement rates."

For older consumers needing care, the artificial scarcity of nursing home beds and the lack of alternatives mean few options to choose from. Indeed, consumers requiring nursing home care often consider themselves lucky to get in anywhere. Havighurst (1982, 356) succinctly describes a nursing home market that has been turned on its head: "Where excess demand prevails, rather than consumers selecting homes to satisfy their needs, homes select patients. As would be anticipated, patients are chosen on the basis of their relative profitability."

Access to care for Medicaid-dependent consumers is further complicated by another strategy states employ: cost control through controlling rates of reimbursement to nursing homes, often at a level below the cost of providing care. Providers, therefore, have a strong incentive to discriminate against consumers who require Medicaid, a situation that precipitates another round of (largely ineffective) legal and regulatory interventions in the market to prevent such discrimination (Scanlon 1992). Nyman (1985) has argued that while increasing Medicaid reimbursement rates would increase access for consumers on Medicaid, ironically such an increase would likely have negative effects on quality, because providers would have less incentive to compete for private-pay consumers who can demand higher quality.

Providers also tend to discriminate among Medicaid-dependent consumers by disability level. If states use flat-rate reimbursements, providers are more likely to admit residents with relatively light care needs. Several states have attempted to address this bias by what is called "case-mix" reimbursement, that is, adjusting rates for level of disability. For this approach to work, reimbursement rates must be significantly higher for persons with high levels of disability. Higher reimbursement, however, creates an incentive to assess residents at higher disability levels, leading to more service than the individual needs or,

indeed, than is good for maintaining the individual's independence (Weissert and Musliner 1991).

In terms of investment and development, the caps on Medicaid rates can mean that profits are very limited for actually providing services, especially in facilities serving a high percentage of residents on Medicaid. Instead, the Medicaid reimbursement system in many states has effectively promoted real estate speculation in the nursing home industry by providing incentives to "churn" facilities through frequent changes of ownership. States using traditional approaches tend to reimburse capital costs on the basis of historical cost. Such an approach punishes owners who are committed to caring over the long haul and rewards speculators who sell frequently. Speculators often sell at inflated values since costs are not responsive to market competition but are "passed through" in reimbursements. Though diminished because of legal changes in recent years, such practices still drive up costs to states and drive down quality to consumers since speculators have no incentive to make quality improvements that could cost money.<sup>10</sup>

Cost containment measures may keep federal and state expenditures lower than they would otherwise be, but they are generally experienced as shifting the cost burden to consumers and their families. As Scanlon notes, "To varying degrees, most states tolerate excess demand even while recognizing that its presence results in a greater share of the responsibility for assisting persons with disabilities shifted to the private sector, primarily family and friends" (1992, 46). Scanlon also notes that the vast majority of older persons with disabilities continue to live outside of nursing homes, three-quarters of them relying on family and friends to provide services rather than purchasing services. Indeed, as he points out, "The key factor that leads to entry into a nursing home is often absence of family, rather than the extent of services needed" (1992, 44).

### *The medical model of quality control*

One result of the amount of public money involved, and the fact that state licensure and CON restrictions have effectively

<sup>10</sup> Heidi Boerstler, Tom Carlough, and Robert E. Schlenker, Administrative and Policy Issues in Reimbursement for Nursing Home Capital Investment, *Journal of Health Politics, Policy and Law* 16(3) (Fall 1991), 553-72. The authors note that although federal legislation has "reduced this kind of abuse of regulations designed for the resetting of rate bases, relatively frequent sales may be expected to remain a characteristic of systems based on historical cost" (563).

created local monopolies for service provision, is a heavy emphasis on regulation rather than competition to control quality. The regulation of quality is an area where the medical orientation of Medicaid has had a particularly strong impact, leading to institutions that seek to imitate hospital settings. As Kane and Caplan (1990) note, the medical model of care extends beyond the physical environment of the nursing home—which mimics a hospital with its nurses' stations, shared rooms, and institutional architecture—to include a physician control system that “medicalizes everyday life” (307). The assumption of the medical model is that consumers are incapable of making basic decisions over their lives and, therefore, must be protected by medical professionals. Kane and Caplan (1990) describe the consequences: “‘Consent of physician’ in nursing homes is required for a wide range of matters. Physicians are asked to attest that a single room is necessary or that moving from room to room would be detrimental. In some instances, physicians’ orders are requested for residents to self-medicate, to have an alcoholic beverage, or to stay up late at night. It is as if the remainder of the resident’s life is to be orchestrated by a physician” (307).

The ability of medical professionals to control nearly all aspects of a resident’s life is reinforced by the Medicaid welfare financing system. The resident needing Medicaid support must essentially sign over all income to help pay for the care. The resident is allowed only \$30 a month as a personal needs allowance to cover all discretionary spending (American Association of Retired Persons 1993a). Denying the resident discretionary income is an important tool in reinforcing the nearly total authority of medical staff over all aspects of daily living—a control that Foldes describes using Goffman’s concept of a “total institution”: “Regimentation also mitigates against the extent to which a nursing home can assume the semblance of a resident’s ‘home.’ In the nursing home, regimentation derives not only from the setting’s characteristic as a total institution but also from its quasi-medical aspects. Many residents require some measure of medical care, and the senior staff member is typically a nurse whose professional identity is linked to a medical model of relating to people. The application to the nursing home of the medical model increases the regimentation of human interaction and decreases the independence of residents, who are viewed as ill, incapable, and in need of externally imposed direction.”<sup>11</sup>

<sup>11</sup> Stephen S. Foldes, *Life in an Institution: A Sociological and Anthropological View*, in Kane and Caplan (1990, 27–28). See also Erving Goffman’s classic work upon which Foldes’ analysis is based, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, NY: Anchor, 1961).

Support for this medical model was reflected in many aspects of the influential review of the nursing home industry by the Institute of Medicine (IOM). The panel of experts assembled by the IOM considered and rejected the arguments for allowing market forces to promote quality of life in the nursing home. After noting the strong presence of federal funding in the nursing home market and the level of disability among nursing home residents, the IOM study argued that “[t]he average resident’s ability to choose rationally among providers and to switch from one provider to another is very limited even if bed occupancy rates are low enough to make such choices feasible.” The report concludes, “Regulation is essential to protect these vulnerable consumers. Although regulation alone is not sufficient to achieve high-quality care, easing or relaxing regulation is inappropriate under current circumstances” (Institute of Medicine 1986, 5–6).

Scanlon (1992) notes that, despite the rhetoric about promoting quality through regulation, the medical model regulations of equipment, staff, and procedures have produced a sterile uniformity that has “constrained the services offered.” While such regulations have undoubtedly reduced some of the more egregious quality problems in nursing homes, they have also driven up costs and increased the incentives to restrict access to service. He concludes with a warning about extending social insurance to long-term care without addressing how the nature of the services themselves should change: “Modern nursing homes—while much improved in terms of staffing, structural quality and safety, and services compared to pre-Medicaid homes—basically retain an austere institutional character. Many resemble hospitals, only without the extensive technical equipment and with common areas for shared meals and social activities. The standard of living in no way approaches what many middle-class elderly with disabilities would enjoy in their homes or would wish to replicate if a disability resulted in entry to a nursing home. The powerful presence of Medicaid may already be reducing the range of choices in private nursing home care, and a social insurance program might reduce those choices even more sharply” (Scanlon 1992, 54).

Indeed, when all is said and done, the welfare system of financing and the medical model of control are mutually reinforcing, producing a system of care that is both expensive and almost universally disliked by consumers. The implicit method of controlling costs that undergirds the whole complex web of cost containment for long-term care ultimately boils down to restricting state subsidies to the type of service considered least desirable by the people who need the service. In contrast to

market-driven providers of services who must offer a product that is attractive to consumers, deficit-conscious policy makers worry about the “woodwork effect”—that is, if publicly financed programs offer a type of service that consumers actually find attractive, they will “come out of the woodwork” to use that service and costs will skyrocket. Since the degree of unmet need is enormous among older persons with disabilities who struggle through life outside of nursing homes, states fear that the potential woodwork effect could be very large. In short, since states have little incentive to provide more attractive alternatives to nursing homes and large incentives to cut costs, the most important method of cost containment—despite all the rhetoric about trying to improve quality of care—is to limit services to those that most consumers will do almost anything to avoid.<sup>12</sup>

### **Turning the system around: The importance of housing policy to reforming long-term care**

The Clinton administration’s proposals for home and community-based care, if enhanced by an explicit supportive housing policy for persons with disabilities, could begin to transform the relationship between the consumer and provider to promote consumer autonomy. As argued near the outset of this article, three critical elements are needed to transform the financing structure of long-term care: (1) basing eligibility on disability rather than income as a way to move away from a welfare-based program for home and community-based services; (2) providing incentives to states to promote diversity and innovation in the delivery of home and community-based services; and (3) separating the financing of supportive services from the financing of housing and everyday living costs.

States that elect to offer the Clinton long-term care plan would phase in a home and community-based services benefit for any person with a specified level of functional disability, irrespective of income or age. While co-payments by consumers would depend on income, income or asset tests for eligibility would be forbidden. The break with a welfare approach by basing eligibility on a specified level of disability eliminates the confiscatory attitude toward income and assets for home and community-based

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<sup>12</sup> Scanlon (1992) has noted that the same problem—typically referred to as “moral hazard”—essentially exists for private providers of long-term care insurance. To control costs and minimize risks, most private insurers place tight restrictions on benefits, which limit the attractiveness of the policies to potential buyers. Such inherent problems probably sharply limit the potential growth of private insurance in financing long-term care services.

services, establishing the potential for tapping those resources for a more consumer-controlled, market-driven system of caregiving.

The most direct way the administration's proposal would transform the relationship between consumers and providers is through specific authority and incentives for innovative service delivery. States electing to offer the home and community-based program would have wide latitude in structuring the financing and the types of services offered. For example, the administration's proposal would permit services to be delivered through more traditional "agency-administered" programs or through "consumer-directed" services in which the personal assistance providers are "hired, trained and managed by the person receiving the services." Payments could go to providers or directly to consumers in the form of vouchers or cash.

State innovation may also be promoted through a cap on the federal government's level of funding—provided that the funding level is high enough to allow innovation. Without such a cap, the federal government would undoubtedly seek to limit its risks by increasing the mandates to states. Under a capped federal program, states would bear the risk of cost overruns in exchange for the freedom to experiment with innovative and efficient approaches to home and community-based care. The federal cap will present states with some difficult choices. On the one hand, states will have an incentive to participate because the federal match for the home and community-based services program will be higher than the match for the Medicaid program. To the extent that states believe that they can replace nursing home services under Medicaid with home and community-based services at a higher federal match, they may be willing to target significant services to home and community-based programs. Unfortunately, data from earlier research on home and community-based care indicate that this replacement may be very difficult to achieve.<sup>13</sup> The cap may, therefore, serve as a disincentive for state participation if the risks are perceived as too great because the federal funding level is too low. In addition, because no particular service (except for case management)

<sup>13</sup> Even a fairly optimistic recent analysis indicated that "Community services in these demonstrations do not, in the aggregate, recover anywhere near their costs. But through better service targeting at the individual level, performance can apparently be improved." Vernon L. Greene, Mary E. Lovely, and Jan I. Ondrich, The Cost-Effectiveness of Community Services in a Frail Elderly Population, *The Gerontologist* 33(2) (April 1993), 177–89. See also William Weissert, Seven Reasons Why It Is So Difficult to Make Community-Based Long-Term Care Cost-Effective, *Health Services Research* 20 (1985), 423–33.

would be required under the Clinton home and community-based services plan, states could opt for a very meager services package.

Essential to tapping private resources in a consumer-driven approach is separating the housing from the services financing. Implementing such a plan would effectively divide responsibility between public funding for a variety of home and community-based care options (depending on the state plan involved) and consumers who would be responsible for choosing and paying for their own housing. Rather than confiscating all but \$30 per month of income and placing liens on estates to pay for services over which consumers have little control, this plan would let consumers exercise a great deal more control over the setting for care.

Dividing the responsibility between financing services and housing has the potential of enlisting the considerable public and private resources already invested in housing in a program that combines the security of a social insurance program for services with the market diversity, innovation, legal protection, and consumer control that characterize housing markets. Kane and Kane (1991) have argued that innovation depends on long-term care policies that “separate the ‘nursing’ component of care (like help with bathing and feeding and care geared toward rehabilitation) from the room-and-board component. Services should meet individual needs, and one-size-fits-all routines should disappear.” They would extend the same logic beyond home and community-based care in a “radical shift” to “rethink the nursing home” as well. They suggest that such an approach would promote private savings to pay for “better living arrangements” and stimulate a range of innovative housing and services arrangements where “[t]he sharp distinctions between institutional care and home care would diminish.”

While the Clinton proposals fall short of the radical shift advocated by Kane and Kane, the combination of incentives to innovation, eligibility based on disability, and divided responsibility for financing housing and services could expedite changes in the long-term care markets that are already beginning to take place. Enhancing the role of housing finance in bringing about these changes is critically important for three reasons: (1) appropriate shelter is a major part of supporting the independence of persons with disabilities; (2) a high percentage of older consumers’ assets are tied up in home equity that could be part of a consumer-driven financing reform effort; and (3) homeowners and tenants in housing settings have more rights and more control over

services. Efforts to reform long-term care should build on developments in housing markets and, to some degree, in federal housing policy that are already leading the way in providing alternatives that are more diverse, competitive, and, therefore, more responsive to consumers with disabilities.

### *Changing long-term care through housing finance*

Housing finance and development markets are already moving to address consumer demand for innovative approaches to housing and services—at least for those who can afford such options in the absence of social insurance for supportive services. The following sections outline ways that housing finance options and programs could play a significant role in expanding home and community-based services that promote consumer choice and autonomy for persons with disabilities at all income levels.

*Home equity conversion.* Much attention has been paid to ways to tap private income and assets to pay for long-term care. Home equity, which has been estimated at between \$600 and \$800 billion for older homeowners (Weinrobe 1989), usually gets special attention. As Kane and Kane (1991) argue, making beneficiaries responsible for their own housing and everyday living expenses is one way to enlist a tremendous amount of privately held resources. Since older people express an overwhelming preference for staying in their homes (American Association of Retired Persons 1993b), financing mechanisms to facilitate aging in place as service needs increase would undoubtedly be attractive to many of them.

Home equity conversion or reverse mortgages have been discussed as one potential source of funding for long-term care services.<sup>14</sup> A reverse mortgage is a financial instrument that allows older homeowners to borrow against the equity of their homes and delay repayment until death, sale, or move from the home. Unfortunately, the analyses of reverse mortgages done so far all suffer from two critical deficiencies that limit the

<sup>14</sup> Alice M. Rivlin and Joshua M. Wiener, *Caring for the Disabled Elderly: Who Will Pay?* (Washington, DC: Brookings Institution, 1988), Chapter 8; Ken Scholen, *The Role of Home Equity in Financing Long Term Care: A Preliminary Exploration* (Madison, WI: National Center for Home Equity Conversion, 1986); Bruce Jacobs, The National Potential of Home Equity Conversion, *The Gerontologist* 26(5) (1986), 496–504; Mark R. Meiners, Financing Long-Term Care in Residential Environments, in David Tilson, ed., *Aging in Place: Supporting the Frail Elderly in Residential Environments* (Washington, DC: American Association of Homes for the Aging, 1990), 209–38.

evaluation of their potential utility under a plan like that being proposed by the administration: (1) even though they were done only a few years ago, none of these analyses anticipated important market and institutional developments that have made reverse mortgages more viable financial instruments today, and (2) all of the analyses looked at the potential of reverse mortgages to fund all long-term care services or insurance to pay for such services. No study to date has explored the potential for reverse mortgages to supplement financing for such things as home adaptations and services when coupled with a publicly funded home and community-based services program.

Rivlin and Wiener (1988) note two distinct advantages of reverse mortgages as a mechanism for financing long-term care: (1) because of high homeownership rates at all income levels among the elderly, “they are the only private sector option in which many low-income elderly could participate,” and (2) “home equity conversions potentially alleviate the problem of institutional bias in the current delivery system.” To these advantages, I would add that the structure of the instrument tends to work best for those who are most likely to need help, namely the oldest old who are living alone and who have no heirs who are counting on an inheritance. As a result, the profile of reverse mortgage borrowers mirrors many of the “risk” characteristics of those who end up in institutional environments. According to data on a federal reverse mortgage demonstration (described below), borrowers are older than average with a mean age of 76.7 years and tend to live alone; 56.5 percent are women living alone and another 14.3 percent are men living alone. Strikingly, more than three-quarters of the borrowers under the federal demonstration had no children. Borrowers tend to be house-rich but cash-poor: The average income of borrowers is under \$7,600—less than 50 percent of the national median income for older homeowners—while the average home value is roughly \$103,000—substantially above the national median of \$65,950.<sup>15</sup> While adequate data do not exist on the uses to which these loans have been put, marketing research indicates that potential interest by older consumers is strongly linked to health and long-term care concerns (National Center for Home Equity Conversion 1991).

<sup>15</sup> U.S. Department of Housing and Urban Development, *Preliminary Evaluation of the Home Equity Conversion Mortgage Insurance Demonstration* (Washington, DC, 1992). For parallel data on borrower characteristics in non-FHA insured reverse mortgage programs, see National Center for Home Equity Conversion, *Home Equity Conversion in the United States: Programs and Data* (Washington, DC: AARP Public Policy Institute, 1991). Generally the data are remarkably consistent, except that non-FHA programs tend to serve borrowers with somewhat higher home values.

Reverse mortgages are a good example of how federal housing policy can support a comprehensive effort to promote the independence of frail older persons. Until recently, reverse mortgages were available in relatively few areas and were offered by small state or local government programs or small entrepreneurial companies. The cost of the early entrepreneurial loans to consumers could be quite high (i.e., they had high effective interest rates) because of at least three factors: (1) the risk associated with a new product, (2) the high cost of marketing an unknown product to consumers, and (3) the difficulties associated with raising capital.

In 1987, Congress passed legislation creating the Home Equity Conversion Mortgage (HECM) Insurance Demonstration using the Federal Housing Administration (FHA) to insure reverse mortgages in much the same way that regular "forward" mortgages have been insured. The purpose of the demonstration was to enable people to stay in their own homes while meeting basic needs by tapping their own equity. The HECM demonstration has promoted development of this promising industry in three ways.

First, the HECM demonstration has established the financial infrastructure for reverse mortgages. The FHA insurance model established insurance principles and credible calculations of risk for this product. Moreover, with FHA insuring the risk, Fannie Mae began providing funding for these mortgages and developing an extensive network of lenders to originate the loans. Servicers also set up a system to service FHA-insured reverse mortgage loans. All of these factors helped to bring the pricing of reverse mortgages into a reasonable and predictable range.

Second, the publicity surrounding the HECM demonstration and the counseling required by the program have generated a substantial increase in consumer awareness, interest, and acceptance. For example, inquiries about reverse mortgages regularly outpace all other correspondence to the American Association of Retired Persons (AARP). FHA-insured HECM loans are now available in 43 states. More than 5,000 HECM loans have been closed (roughly 3,200 within the last year), and volume is increasing every month (Fannie Mae 1993, unpublished data). Increased consumer awareness and volume of business should help reduce marketing and processing costs as this industry grows.

Third, the HECM demonstration has also spawned conventionally financed (non-FHA-insured) competitors from major financial institutions. A large insurance company and a major pension fund recently announced reverse mortgage programs (*AARP Housing Report* 1993), and Fannie Mae is expected to announce a conventional reverse mortgage program next year. These products are moving the industry out of the speculative entrepreneurial phase into a more mature market that should benefit consumers. New reverse mortgage products have incorporated some of the conventions established by the HECM demonstration while including innovations that should create new options for consumers in a more competitive market.

Public policy discussions might look at ways to promote reverse mortgage financing of supportive services for homeowners at risk of institutionalization. Because of the nature of the financial instrument, much of the insurance cost of reverse mortgages must be paid up front, either by an out-of-pocket payment or by financing the charges and reducing the equity available for the loan. A subsidy of the upfront cost would make reverse mortgages more feasible for those with lower home values and would increase participation from consumers who have been discouraged by the high closing costs.<sup>16</sup> If targeted to those at serious risk of institutionalization, a subsidy for reverse mortgages used to pay for home adaptations or services to supplement a federal home care insurance program could allow many frail older people to stay at home longer by tapping their own resources.

Two cautionary notes are needed in evaluating the potential for reverse mortgages at this point. Though consumer interest has grown substantially, the number of loans actually written is still relatively small. Reverse mortgages will not work for everyone. Moreover, encouraging the use of home equity in a consumer-controlled approach may eventually clash with Medicaid policy, which is looking increasingly to estate recovery programs to pay for nursing home care. If Medicaid becomes too aggressive in attempting to recover its costs from home equity, consumers may be driven away from reverse mortgages for fear of jeopardizing potential nursing home benefits.

The reverse mortgage is an example of housing finance institutions responding to consumer demand and government leveraging to create a financial instrument that could be an excellent complement to a national home and community-based care program, especially for homeowners with modest incomes and

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<sup>16</sup> This idea owes its genesis to Ken Scholen.

other assets. The HECM program could serve as a model for tapping private equity and investment dollars in a way that promotes consumer independence and choice.

*Supportive housing.* An array of supportive housing types has developed in the private market for older persons who decide to move in order to receive services. A recent survey by the American Seniors Housing Association (ASHA) indicates dramatic changes in the unsubsidized elderly housing market. After the seniors housing industry was burned by efforts in the late 1970s and early 1980s to market housing to recently retired couples that offered “little or no access to supportive services or health care,” the 1993 survey “shows that the seniors housing industry has repositioned its focus over the past decade to meet the day-to-day needs of seniors who need some assistance with the activities of daily living, but do not require 24-hour skilled nursing care” (American Seniors Housing Association 1993, 8). Reflecting this “repositioning,” the survey found that the mean age of residents was 82 years old and 76 percent were women.

One approach to combining housing and services that was developed originally by the not-for-profit sector is the life care community or continuing care retirement community (CCRC). CCRCs generally offer three levels of care on one campus: (1) independent living apartments with relatively light services, (2) assisted living apartments or rooms with more personal care services, and (3) nursing home services for residents needing heavier medical care. Sherwood, Ruchlin, and Sherwood (1990) cite data indicating 683 CCRCs in 1987 with about 200,000 older residents, a number they believe considerably understates the actual number in operation. They also note more activity by for-profit firms, often as an extension of nursing home, hospital, hotel, or housing businesses.<sup>17</sup>

As a combination of housing and services insurance, CCRCs are generally financed by some combination of an entry fee and monthly rent and fees, though some are structured as a strictly fee-for-service contract. Residents generally pay for these fees out of the equity from the sale of a home (Sherwood, Ruchlin, and Sherwood 1990). Usually some level of base services is included in the package, with heavier services available for an additional fee. Newcomer, Roderick, and Preston (1992) found that CCRCs could prevent or delay some nursing home care by offering assisted living on the campus, but that “length of stay in independent living is reduced by the use of assisted living.”

<sup>17</sup> See also the 1993 ASHA survey for confirmation of the growing role of the for-profit sector.

The addition of assisted living services to existing housing sites and the development of freestanding assisted living facilities are attracting considerable attention from developers, investors, and policy makers.<sup>18</sup> Responses to the 1993 Retirement Housing Survey by *Contemporary Long Term Care* magazine document a major industry shift taking place. As they summarize, "Expansion of the continuum of care by adding assisted living and skilled nursing services was also a continuing growth strategy, although adding assisted living services was the preferred choice. In this year's survey the respondents reported operating 16,898 on-premise assisted living units, up from 13,211 last year, and 11,262 in 1991. While the number of nursing units still far exceeds the number of assisted living units, growth in this area may have peaked: This year the respondents reported a total of 27,242 on-premise nursing beds, virtually unchanged from 27,127 last year" (*Contemporary Long Term Care* 1993, 35).

Tenants in assisted living facilities tend to be very old women living alone: The median age in a nonrandom national survey was 83 years old. Disability levels are high, with all providers in this survey indicating that at least some tenants would be eligible for nursing home services (Kane and Wilson 1993). In Oregon, the one state that provides substantial Medicaid funding for assisted living services, the median age was 85 years and the disability levels were much higher than in facilities of other states. All of the residents receiving Medicaid and virtually all of the private-pay tenants in Oregon were eligible for nursing home services (Kane and Wilson 1993).

The growing assisted living industry is another area where policy coordination from housing and services financing programs could tap private equity and investment dollars to promote choice and autonomy for frail older consumers. The assisted living industry currently finds itself in a position

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<sup>18</sup> See the following extensive reviews of assisted living: Rosalie A. Kane and Keren Brown Wilson, *Assisted Living in the United States: A New Paradigm for Residential Care for Frail Older Persons?* (Washington, DC: AARP Public Policy Institute, 1993); Robert L. Mollica, Richard C. Ladd, Susan Dietsche, Keren Brown Wilson, and Barbara S. Ryther, *Building Assisted Living for the Elderly into Public Long Term Care Policy: A Guide for States* (Portland, ME: National Academy for State Health Policy, 1992); Barbara Manard, William Altman, Nancy Bray, Lisa Kane, and Andrea Zeuschner, *Policy Synthesis on Assisted Living for the Frail Elderly*, Final Report to the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services (Washington, DC, 1992); and Victor Regnier, *Assisted Living Housing for the Elderly: Design Innovations from the United States and Europe* (Florence, KY: Van Nostrand Reinhold, 1993).

analogous to the early entrepreneurial stage of the reverse mortgage industry. Though assisted living is the fastest growing segment of the senior housing industry, the costs associated with this type of service have generally been out of reach for older persons with low or moderate incomes. For developers, capital has been expensive (i.e., has a high interest rate) and hard to raise because of the perceived risks associated with a new industry. One of the main factors that has driven up costs has been investor uncertainty caused by the lack of public insurance (with a few notable exceptions such as the Oregon Medicaid waiver plan) to cover the risks of potentially high costs of long-term supportive services.<sup>19</sup>

Recent policy developments could positively affect the financing of assisted living facilities. The Housing and Community Development Act of 1992 included an expansion of the Section 232 mortgage insurance program, which had been authorized to insure mortgages for nursing homes and board and care facilities, to cover the financing of assisted living facilities. As with the HECM demonstration, the significance of this act could extend well beyond the program itself in at least three ways.

First, the regulations and underwriting standards to be developed for this program could do a lot to standardize the assisted living industry. The statute indicates that financing is to be provided for single-person occupancy apartments (except where couples desire to live together) with bathrooms and kitchens. Regulations and underwriting standards for this program would be the first federal standards of any kind for this promising type of supportive housing. Since the program can also insure equity takeout loans, it has the potential to respond to policy changes in long-term care services by providing the financing needed to convert nursing homes into assisted living facilities. This financing option should provide the opportunity for discussion between policy makers in the areas of housing finance and supportive services.

Second, the Section 232 assisted living program could be used to develop the financing infrastructure in a manner analogous to the earlier HECM program. For example, mortgage insurance for assisted living facilities could be included under a newly authorized “risk-sharing” demonstration among FHA, the state housing finance agencies, and government-sponsored enterprises

<sup>19</sup> See chapter on “Challenges to Developers of Assisted Living,” in Kane and Wilson (1993, 63–76). See also a summary of opinion from industry leaders in Mel Gamzon, *Assisted Living Reigns: Growing Interest from Investors Drives Growth*, *Contemporary Long Term Care* (June 1993), 31 ff.

(GSEs; e.g., Fannie Mae and Freddie Mac). Such an approach would provide a vital link to the financial resources and sophistication of the state housing finance agencies and the GSEs, but also could promote innovative service delivery by moving the origination and underwriting to the state level. Many state housing finance agencies have already established working relationships with state social service and health agencies to finance assisted living and other supportive housing arrangements. Because of escalating Medicaid expenditures, states have a powerful incentive to promote innovative approaches to long-term care that link housing and supportive services—an incentive that would increase under the Clinton administration's home and community-based care plan. Creating a risk-sharing financing arrangement that moved much of the decision making to the states would be an appropriate role for FHA to play in financing assisted living facilities.

Brandon and Eisert (1992) have suggested a more expansive version of this approach in the creation of a new GSE dedicated to financing supportive housing opportunities for the elderly. They argue that the scale of production needed to promote major transformations in long-term care markets requires an independent GSE to tap the financial markets. From a congressional budget perspective, GSE financing has the advantage of not being counted "on budget." From the perspective of developers, an independent GSE would likely be more market responsive than government agency financing. An independent GSE could overcome the rigid jurisdictional barriers that characterize government agencies to recruit professionals with both housing and services backgrounds. For states that will be strapped with the responsibility of implementing both acute and long-term care reforms at the same time, a GSE could offer critical technical assistance in the financial packaging required to provide options such as assisted living. Finally, an independent GSE would have the financial clout to match that of the health care financing agencies—an important political dimension needed to bring about change from a medical model of caregiving.

Third, financial maturity for this industry will be achieved when competition develops among conventional lending sources. At this point, no such conventional lending exists. Projects must arrange their financing in an ad hoc manner, usually by soliciting investment partners such as pension funds, insurance companies, or real estate investment trusts that demand high rates of return. If the Section 232 program spawns more interest from lenders and investors and competition from conventional sources

of capital, consumers would benefit from the greater availability and affordability of assisted living options.<sup>20</sup>

*Serving persons with low incomes.* Because no social insurance has existed for services in supportive housing settings, such options have been restricted largely to older persons with substantial means. Opening opportunities to those with low or moderate incomes and assets will be a major challenge under approaches such as the administration's that separate housing and services financing. If consumers needing long-term care services are to be responsible for their own housing, financing housing alternatives for those with low incomes demands an active housing policy. The need for housing policy development is especially pressing since housing assistance, unlike other low-income assistance programs such as Medicaid or Supplemental Security Income (SSI), is not an entitlement.

One way to address the issue would be through more targeting of federal housing resources to low-income older homeowners and renters with disabilities. According to data from the 1987 American Housing Survey (AHS), 60 percent of older households with income under \$5,000 were homeowners (Redfoot and Gaberlavage 1991). Because home values for low-income homeowners tend to be lower than average, home equity conversion is not a viable option for many older homeowners. Home repairs and modifications can be a very important supporting factor in providing home care services for older homeowners who want to stay put (Newman et al. 1988). Projecting the housing situation in 2010, Struyk, Turner, and Ueno (1987) suggest that the percentage of older homeowners whose homes have structural deficiencies will increase, even surpassing the percentage of renters whose residences have such deficiencies. The number of persons whose homes need various kinds of modifications to support aging in place will also increase (Struyk, Turner, and Ueno 1987). Home repair programs funded under Community Development Block Grant, HOME, and Farmers Home Administration Section 504 could be enhanced and targeted to modifications to support in-home services.

For frail older persons who need specialized housing and rental assistance, the existing stock of subsidized elderly housing projects in nearly every market area of the country could be more effectively tapped. Virtually every major federal housing assistance program—including public housing, Section 202

<sup>20</sup> See Kane and Wilson (1993, 70) for a discussion of financing problems in assisted living.

elderly housing, Sections 221(d) and 236 multifamily mortgage insurance, Section 8 new construction and rehabilitation, Section 515 rural multifamily housing, and low-income housing tax credits—has funded a substantial amount of housing for older persons. According to AHS data, roughly 1.7 million older persons (29 percent of all older renters) receive some form of rental assistance (U.S. Senate, Special Committee on Aging 1991).

These housing programs could be contributing more to a comprehensive long-term care strategy that emphasizes home and community-based service delivery approaches. “Risk factors” related to nursing home admission—age, gender, family status, and disability level—are also characteristics of the federally subsidized elderly housing population. Elderly housing projects are increasingly serving the oldest old: A 1992 survey of public housing found that 45 percent of the residents of elderly projects were 76 years old or older (Djoko and Sherwood 1992). These data parallel a 1988 survey of Section 202 elderly housing that found an average tenant age of 74 years and a strong relationship between the age of the project and the age of residents. Older projects had substantially older tenants owing to the aging in place of residents and the increasing age at admission. Many projects, especially older projects, report an average resident age over 80 years old (Heumann and Gayda 1989).

The 1988 Section 202 survey also found that 81 percent of residents were women, a gender ratio that is generally similar in other housing programs (Heumann and Gayda 1989). A 1985 study of congregate service needs in federally assisted housing found that only 19 percent of vulnerable residents were married and 32 percent had no living children—giving them weak informal supports in the event of a disability (U.S. House of Representatives, Select Committee on Aging 1987). Using data from the 1978 AHS and the Long-Term Care surveys of 1982 and 1984, an Urban Institute report estimated that 365,000 residents of federally assisted housing need some help with ADLs. Using a more restrictive definition, the same researchers estimated that roughly 105,000 residents were at real risk of institutionalization.<sup>21</sup> These numbers have almost certainly increased substantially since the data were collected because of the aging of the resident population in federally assisted housing and legal

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<sup>21</sup> Raymond J. Struyk, Douglas B. Page, Sandra Newman, Marcia Carroll, Makiko Ueno, Barbara Cohen, and Paul Wright, *Providing Supportive Services to the Frail Elderly in Federally Assisted Housing* (Washington, DC: Urban Institute, 1989). It should be noted that HUD is under congressional mandate to reexamine and update the estimates of levels of disability in the elderly housing stock.

changes with respect to admissions and terminations of persons of all ages with disabilities.

These data clearly demonstrate a large and growing problem for the managers of federally subsidized housing and an opportunity for policy planners with respect to long-term care reform. By targeting services to older persons who have low incomes, federally subsidized housing programs very efficiently target a large portion of the older population at risk of needing institutional care. Moreover, the extensive network of housing projects designed for older persons nationwide potentially provides a very efficient base for delivering home and community-based services both to residents of the housing projects and older persons in the surrounding communities. Despite this potential, a 1992 Government Accounting Office study of elderly housing issues indicated that the Department of Housing and Urban Development (HUD) lacked fundamental information on the physical state of the buildings or the service needs of the residents. Moreover, the report noted that HUD had no overall plan for the modernization, retrofitting, or management of elderly housing facilities to address the aging in place of residents (U.S. General Accounting Office 1992).

Housing policy has only recently taken steps to become more accommodating to the provision of services for frail older people. The 1990 National Affordable Housing Act included provisions that would make it possible to develop assisted living projects with Section 202 funding. The act also authorized service coordinators in Section 202 and public housing, revised the Congregate Housing Services program to include retrofitting of current projects for services provision, and created the HOPE for Elderly Independence Program to couple services and rental assistance. The 1992 Housing and Community Development Act built on these accomplishments by (1) extending the authority to provide services coordinators to virtually the entire stock of federally subsidized housing for the elderly<sup>22</sup> and (2) creating a review and planning process for housing financed under Sections 202, 221(d)3, and 236, under which elderly projects are directed to document the service needs of residents.

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<sup>22</sup> For discussions of the importance of service coordinators in promoting consumer choice among tenants in federally subsidized elderly housing, see the following: Susan C. Lanspery, Supportive Services in Senior Housing: New Partnerships between Housing Sponsors and Residents, *Generations* (Spring 1992), 57–60; Judith Feder, William Scanlon, and Julian Howard, Supportive Services in Senior Housing: Preliminary Evidence on Feasibility and Impact, *Generations* (Spring 1992), 61–62; and Joan Retsinas and Nicolas Retsinas, Housing/Home Care Pilot Earns Rave Reviews, *Long Term Care Management* (June 4, 1992), 5–6.

Not all of these programs have yet been implemented, so their impact is not yet known. Perhaps some hope can be taken from this year's increased appropriation for services coordinators. In making its appropriations, the Senate Appropriations Committee included report language to HUD directing completion of a study on the extent of need for congregate services in federally subsidized housing. The committee also included the following directive in its report on elderly housing: "The Committee believes that fiscal year 1994 is not a year in which elderly housing activities should be cut given the prominent ... [role] that it will have in the debate on health care reform. The Committee directs the Department to provide it with a strategy by February 1, 1994, on how it intends to use elderly housing programs within the Department to specifically further the goals to be outlined in the President's strategy for health care reform. Such a strategy should outline multiyear funding expectations for this purpose" (U.S. Senate 1993). If HUD complies with this directive, the administration will have broken new ground in linking its housing and long-term care policies.<sup>23</sup>

The combination of facilitating the use of private resources for reverse mortgages and assisted living through mortgage insurance programs with more targeting of direct subsidies to frail older homeowners and renters will have a substantial impact on marshalling the housing resources needed to parallel the home and community-based services program now being proposed by the administration. However, even if the resources described here were significantly enhanced, they would not address the housing needs of all persons with disabilities who need assistance. Moreover, with the very limited growth of housing assistance that exists today, any significant retargeting of existing housing resources to serve persons with disabilities will be at the expense of persons who are otherwise eligible for housing assistance but have no disabilities. Most older renters spend more than the HUD affordability standard of 30 percent of income for housing (U.S. Senate, Special Committee on Aging 1991, 194). A survey of elderly housing projects indicated that eight applicants are waiting for every vacancy (Heumann and Gayda 1989). Policy makers will have to acknowledge that these conditions will worsen for older renters with no significant disabilities if

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<sup>23</sup> For discussions of the jurisdictional barriers to integrating housing and services policies, see Donald L. Redfoot and Katrinka Smith Sloan, Realities of Political Decision-Making on Congregate Housing, in Lenard W. Kaye and Abraham Monk, eds., *Congregate Housing for the Elderly: Theoretical, Policy, and Programmatic Perspectives* (New York: Hayworth Press, 1991); and Jon Pynoos, Linking Federally Assisted Housing with Services for Frail Older Persons, *Journal of Aging and Social Policy* 4(3/4) (1992), 157-77.

scarce existing resources are more targeted to those with disabilities.

To provide housing assistance to all who need it when housing and services financing are separated would require making housing an entitlement for persons with disabilities. In the current political climate of budget constraints, especially with respect to entitlements, creation of a new entitlement for housing seems unlikely. A more politically plausible variant of a housing entitlement to persons with disabilities was proposed a few years ago by Representative Stark, Chairman of the Health Subcommittee on Ways and Means. To address the abysmal condition of many board and care facilities, he proposed a federal supplement to the SSI program, which provides a minimal income support to older persons and persons with disabilities who have essentially no other income. State SSI supplements are currently one of the major means of public financing for board-and-care facilities that house many very low income residents with disabilities. A federal SSI supplement could expand upon that model for persons with disabilities who have extremely low incomes to enable them to pay rent in supportive housing settings of all kinds. An SSI approach might be more politically palatable because costs would be constrained in three ways: (1) eligibility is restricted to the elderly and persons with disabilities, (2) the income and asset eligibility standards are significantly lower for SSI than for housing assistance, and (3) an SSI supplement could be restricted to residents of specialized facilities.

The means for providing a decent range of choices for home and community-based long-term care services to the poorest of the poor will clearly require more policy development. Until some funding stream is found, frail older persons with low incomes will continue to find themselves in the only housing for which they currently have an entitlement—nursing homes paid for under Medicaid.

### *Controlling costs by giving consumers more control*

Comparing the cost-effectiveness of various settings for long-term care services presents major research challenges. If the question is cast as, “Can a comprehensive long-term program including home and community-based services provide services to everyone who needs them at a cost that is less than the *current public expenditure* for nursing homes?” the answer is, “Very unlikely.” If the question is cast as, “Can a comprehensive

long-term care program including home and community-based services provide services to everyone who needs them at a cost that is less than the *public costs that would be incurred* through a universal program that is restricted to nursing home care?" the answer is, "Probably yes—with reasonable gatekeeping by case managers." Finally, if the question is cast as, "Could *total public and private costs of long-term and acute care* be decreased by providing a comprehensive long-term care program including home and community-based care?" the answer is, "Almost assuredly yes—as long as all costs are accounted for."

Providing the answer to the cost-effectiveness of various long-term care policy options requires not only comparing the cost of providing comparable levels of services in different settings but also accounting for the systemwide effects of offering different approaches to care. Some of the dimensions that must be considered are public versus private costs, federal versus state costs, housing versus services costs, long-term versus acute care costs, and cash versus human costs. Offering an enhanced home and community-based care program will alter the current financing on all of these dimensions in ways that are difficult to tally up in some grand accounting scheme. Some of the cost effects of such a policy shift are, however, predictable and make the case for greater overall efficiencies of providing more competitive, consumer-responsive services.

While the data on home care in scattered-site housing are somewhat mixed, research has generally found that, on a per person basis, supportive services are much less expensive to provide to all but the most disabled persons in residential settings other than nursing homes.<sup>24</sup> For example, Heumann (1991) attempted to hold disability level and debt service costs constant in a study that "conservatively" estimated a cost savings of roughly \$4,400 per person per year by providing services in congregate housing rather than nursing homes. Kane and Wilson (1993) found that the cost of providing assisted living services in Oregon (where virtually all of the tenants were eligible for nursing home care) was 62.4 percent of the cost of nursing home care for those paying privately and 64 percent of the cost of nursing home care for those receiving Medicaid assistance.

Kane and Wilson (1993) argue that rapidly increasing nursing home rates as compared with assisted living rates can be largely attributed to legislative and regulatory changes related to

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<sup>24</sup> For a discussion of some of the methodological problems in comparing costs across care settings, see Manard et al. (1992, V-24 to V-27).

service delivery and staffing. The typical nursing home provides a set of services, often driven by regulation, to all residents irrespective of need. In contrast, services are not provided unless needed in home care or supportive housing-type settings. Indeed, as long as one is capable, taking responsibility to cook, clean, and maintain one's own living space is life-enhancing. By providing individualized care, residential care settings eliminate a great deal of unnecessary and debilitating service at considerable cost savings (Kane and Wilson 1993).

Supportive housing options of various types can also save on expenses by virtue of design and staffing. For example, private rooms or apartments with doors that tenants can lock may cost more to build, but such features can enhance privacy and can prevent tenants with Alzheimer's disease who wander (a common symptom of the disease) from creating management and oversight problems due to intrusions on other residents. Staff is only as professional or specialized as is really required by the job. By using staff to provide a variety of services, most assisted living facilities can maximize staff flexibility to meet peak serving times. As an added benefit, staff morale appears to improve with added responsibility in a more upbeat environment.

Even if per person costs are reduced through home and community-based care, the policy argument over containing public costs must deal with utilization rates, that is, whether a "woodwork effect" will result in higher overall costs when a more attractive package of services is offered. The best test of the potential woodwork effect comes from Oregon, which began aggressively promoting a variety of home and community-based alternatives to nursing homes in 1981. James Wilson, administrator of Oregon's Senior and Disabled Services Division, summarized over a decade of experience in 1993 testimony to Congress: "During our first two years of operation (the 1981/83 biennium) our agency paid for the care of an average of 13,147 persons per day. Of those 8,061 were in nursing homes and 5,086 were in our medicaid funded community-based care system. Today we are paying for the care of 7,389 persons in nursing homes (in spite of the fact that the population most at risk of needing nursing home care, those aged 75 and above, has been growing at a rate of over three per cent per year throughout the 1980s) and 12,588 persons in home and community-based settings. Our current average net cost per person in a nursing home is about \$1,800 per month. In community-based care it averages \$475 per month. Had we continued to serve persons in nursing homes at the same rate, adjusted for population growth and inflation, as we did prior to our agency having been created, we would have

spent \$108,087,379 more during the last biennium than we actually did" (Wilson 1993).

Some researchers have argued that aggregate costs may not decrease because an increase in less expensive home and community-based care "may be offset by concomitant cost increases in nursing home care" (Manard et al. 1992). In other words, siphoning off potential nursing home residents who have relatively light care needs will cause the average cost of nursing home care to go up to reflect the higher level of care required for the remaining residents—with no net savings to long-term care budgets. Indeed, industry observers have noted that the "repositioning" of the elderly housing industry described earlier is one factor in a parallel repositioning and diversification of the nursing home industry (Molis 1993). Many nursing home providers are expanding or converting to providing assisted living services. Others are intensifying medical and rehabilitative services to provide more subacute or transitional care services during a prolonged convalescence or rehabilitation period—often following a stay in an acute care hospital.

Fully assessing the fiscal impact of this reorganization of long-term care services requires looking beyond long-term care programs to important developments in acute care. A recent issue of a trade magazine for nursing home providers noted that the growth of nursing home interest in providing subacute care has been spurred by the cost advantage nursing homes have over hospitals in providing extended care and by Medicare rules that have applied pressure to minimize hospital stays. Such pressures are likely to intensify as managed care systems grow and move into more "integrated care" systems extending beyond the normal bounds of acute care coverage (Molis 1993).

What the data on reorganizing long-term care markets suggest is that competition and public policy are already beginning to drive providers into the level of care they can most efficiently provide. Policy debates that focus on only one segment of services—whether health care, long-term care, or housing—or one segment of payers—federal, state, or private—are bound to distort the overall picture of costs and benefits. As the policy debate shifts to providing more extensive public funding for health and long-term care services, addressing the role of competition in promoting the efficiency of the whole system becomes all the more compelling. The potential of housing finance to promote this systemic reorganization should not be ignored.

*Promoting quality through promoting choice*

Perhaps the greatest costs of the current system are those least quantifiable—that is, the costs in quality of life to individuals and their families. As noted above, the primary competitors of nursing homes are families and informal caregivers. The amount of stress that families are willing to endure, the opportunity costs borne by caregivers (especially women),<sup>25</sup> and the suffering experienced by frail older people who need services but will not go to a nursing home are the ways the costs of the current system of long-term care finance are experienced by older people and their families.

However, when we examine an approach that relies on less regulation, less professional care, and more self-reliance and choice, questions invariably arise over quality of outcomes. Too often, the outcomes controlled by regulation are restricted to “quality of care” factors that are easily measurable but may or may not have any relationship to the “quality of life” *as experienced by those receiving care and their families*.<sup>26</sup> For policy makers wanting to promote quality long-term care services, the question is whether market-driven diversity can be counted on to produce adequate quality in both senses.

As noted above, the case for a medical model of quality control through extensive regulation is largely grounded in the presumed incapacity of consumers to make rational judgments about their own care—a position that challenges the foundation of the argument for promoting market competition as being most responsive to consumers. Proponents of allowing more market control over quality have responded with several counter-arguments. Nyman (1985) attacked the empirical foundation of the regulatory argument through two studies of consumer behavior in nursing home markets, finding that consumers responded conventionally in ways “indicative of rational economic behavior.” Nyman acknowledges the need for “technical regulations that protected patients from aspects of the home’s operation that are difficult to assess” and suggests the possibility that “regulations themselves can be designed to promote choice.” However,

<sup>25</sup> For a discussion of the stresses and opportunity costs of caregiving, see Roberta Cronin and Juanda Kirk, *The Financial Impact of Multiple Family Responsibilities on Midlife and Older People: An Exploratory Study* (Washington, DC: AARP Women’s Initiative, 1991); and Phyllis H. Mutschler and Judith R. Miller, *Eldercare: An Issues Overview* (Washington, DC: Washington Business Group on Health, 1989).

<sup>26</sup> See the useful distinction between “quality of care” and “quality of life” made by the Institute of Medicine (1986), especially Chapter 2.

he insists that the process of regulation based on the assumption that consumers are incapable of rational choice is “generally inconsistent with the goal of promoting quality of life.” Translating psychological studies on choice and locus of control into the language of economics, Nyman notes that “choice itself contributes to utility.” He concludes, “Although more work is clearly necessary to convincingly determine the extent of their [consumer] rationality and the role that it plays in the assurance of quality, these studies suggest that the implicit justification of regulation—consumer ignorance and irrationality—may be in doubt” (811).

Havighurst (1982) addresses this issue by arguing that not all or even most consumers must be capable of rational choice for competition to improve quality in long-term care services. Especially under conditions where providers must maintain high occupancy levels to make a profit, competition can promote quality if providers must improve their services to attract consumers who are capable of rational choice, even if such consumers are in the minority. As Havighurst puts it, “Although many nursing home residents would be incapable of meaningful choice..., not all consumers need to be well informed in order for patient choice and competition to induce the provision of services of reasonable quality; it is the marginal rather than the average customer whose preferences most influence provider behavior” (355).

Perhaps the strongest argument in favor of allowing greater competition on quality among the providers of long-term care services lies in the nature of the services themselves. Scanlon (1992) argues for “recognizing the difference between health care’s goal of maintaining health and long-term care’s goal of maintaining a lifestyle.” He concedes that consumers are not in a good position to make decisions about technical aspects of medical treatment options. On the other hand, “Individuals can ... compare the quality of different nursing homes, since many of the services offered are ordinary consumer goods like housing, food, and recreation” (53).

Greater reliance on market diversity and competition in long-term care can promote service innovation and consumer choice that translate into a higher quality of life. Such an approach will, however, undoubtedly increase certain risks to individuals. For example, living in one’s own home increases the risk that services will not be immediately available in an emergency. Having a kitchen in an assisted living apartment increases the risk of being burned. Instead of relying on uniform regulations

aimed at minimizing all risks, advocates of greater choice for consumers with disabilities have pressed for a process of “negotiated risk” (K. Wilson 1992). The negotiated risk approach recognizes that eliminating risk too often comes at the cost of eliminating independence and diminishing quality of life. As Richard Ladd, the administrator who had much to do with the creation of the Oregon program, put it, “Safety is the most important value for regulators. It’s the quality of life that should count most, not safety. In pursuing quality of life, I’m willing to take a lot of risk” (Mollica et al. 1992, 19).

In this respect, disability groups have been much more in the forefront in pursuing the “dignity of risk” than have aging groups. Rather than taking a reformist approach to improving care, many disability groups long ago largely abandoned efforts to reform institutional care in favor of a civil rights approach to promoting consumer choice and assuming risk. As Litvak, Zukas, and Brown (1991) succinctly put it, “Human rights include risk-taking and making choices about one’s own life. Personal independence means having opportunities to make those individual choices based on available and understandable options.”

Disability groups have had substantial legislative success in recent years with a civil rights strategy. As with the race-based civil rights groups that preceded them, one of the primary areas for legislative and judicial action has been housing. In particular, the Fair Housing Amendments Act of 1988 included persons with disabilities as a protected class. Along with the Americans with Disabilities Act of 1990, the Fair Housing Amendments Act is being used to challenge zoning and life safety regulations that have restricted consumer choice in housing markets for persons with disabilities. Of particular interest is a recent decision by the U.S. District Court in Maryland that vacated large portions of the Montgomery County life safety regulations on the grounds that they were discriminatory to the older tenants who were told that they were too disabled to continue living at a board-and-care facility (U.S. District Court 1992). If sustained and extended, the logic of this and similar cases could challenge the very foundations of regulations of “appropriate levels of care” as determined by medical professionals.<sup>27</sup>

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<sup>27</sup> For a review of case law in this area, see Stephanie Edelstein, “Federal Fair Housing Law and the Frail Older Tenant,” unpublished paper for the American Bar Association, Commission on Legal Problems of the Elderly (1993). As civil rights law on disabilities relates to federally subsidized housing, see HUD Occupancy Task Force, Preliminary Report (Washington, DC, August 27, 1993).

Implicit in the logic of a negotiated risk approach to promoting the quality of life for persons with disabilities is a market model based on contractual relationships between providers and consumers of long-term care services. A negotiated risk approach to a large degree changes the basis for quality control from an institutional- and professional-based provider/client relationship to a landlord/tenant basis—a relationship that would be enhanced by separating the housing and services financing. Negotiating alternatives on a more contractual basis has the potential to recognize individual needs and preferences, thereby promoting dignity and autonomy. The capacity of the individual to negotiate and make choices must, of course, be weighed. However, a negotiated risk approach starts with the assumption that individuals and their families are more likely to act in the interests of those needing care than are medical professionals and state regulators.

## Conclusion

The challenge to policy makers as they discuss reforms to the nation's health care and long-term care systems is to provide services through programs that foster market innovation and diversity in order to be more responsive to consumers. The ends of consumer responsiveness and cost-effectiveness might be enormously enhanced by more attention to housing options and greater involvement by the housing finance and policy community. The housing community could offer not only additional sources of funding and financial sophistication, but also a critical financial and policy basis for altering the relationship between consumers and service providers. Building on public and private housing resources, promoting important design and technological innovations stimulated in part by the housing markets, and incorporating legal relationships and protections inherent in housing settings should be fundamental elements of discussions of long-term care reform at this critical juncture.

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