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Grey Matters: Political-Economic Analyses of Long-Term Care

A dissertation presented

by

Ali Hamandi

to

The Committee on Higher Degrees in Health Policy

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Grey Matters: Political-Economic Analyses of Long-Term Care

ABSTRACT

This dissertation includes two quantitative studies on Medicaid long-term care (LTC) coverage in the United States, and one qualitative study that draws lessons from Germany's LTC system for Canada.

Chapter one is a political analysis of Medicaid LTC expenditures. Historically, public financing of Medicaid LTC has favored institutional over home- and community-based services (HCBS). However, as states face political, fiscal and social pressures to provide more care in people's home and communities, this paper provides a longitudinal, political analysis of interstate variation in spending on different HCBS programs. Fixed effects regression models are used to examine state HCBS expenditures per capita and as a share of total state LTC spending for the period 2001-2010. Generally, a Democratic governorship has a relatively strong and positive effect on HCBS spending, while a socially liberal electorate has a strong but negative effect.

Chapter two estimates the impact of HCBS waiver spending on different types of LTC spending. In 1981, Congress introduced the 1915(c) waiver program to assist state Medicaid programs with expanding their provision of HCBS. Given that a waiver for HCBS may only be extended to beneficiaries who meet their state's eligibility criteria for institutional care, policymakers have long considered the waiver program to be one that lowers Medicaid LTC

spending. However, targeting of social services is imperfect, and little is known about the financial impact of the waiver program. Accordingly, this chapter analyzes different Medicaid LTC expenditure categories using variations in waiver program spending across states and time. The results suggest that no cost savings are occurring.

Chapter three examines the German LTC system with the intent of drawing applicable lessons for Canada. In 1995, Germany implemented a national, universal social LTC insurance (LTCI) system. In contrast, the exclusion of LTC from the Canada Health Act has led to a patchwork system whereby the scope of care, and its access, varies by region. The German experience, however, can provide useful lessons for Canada. This chapter analyzes the German system's experience in both financing and providing user-directed care. The goal is to better understand the groundwork that helped establish and sustain Germany's LTCI system as it is designed, and whether Canadian policymakers can replicate some of this work in pursuing their own social LTCI system.

Dedicated to my grandparents – Izzidin Al-Bahrani and Suham Fattah,
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Chapter 1 Variation in Medicaid Long-Term Care Spending: A Political Analysis

ABSTRACT

Public financing of long-term care services and supports (LTC) has historically favored institutional over non-institutional care. However, since the passage of the Americans with Disabilities Act in 1990, there has been a growing interest in expanding home- and community-based services (HCBS). As states face both fiscal and social pressures to provide more care in people's homes and communities, this paper provides a longitudinal, political analysis of inter-state variation in spending on HCBS programs. Fixed effects regression models are used to examine state HCBS spending per capita on the elderly and as a share of total state LTC spending for the period 2001-2010. Controlling for other variables, a Democratic governorship has a relatively strong and positive effect on HCBS spending, while a socially liberal electorate has a strong but negative effect.

1.1 Background

State Medicaid long-term care services and supports (henceforth referred to as LTC) have generally favored institutional over home- and community-based services (HCBS). Reversing this trend such that there is greater reliance on the latter has long been a "key policy goal of many state Medicaid programs" (Konetzka 2014) - a goal that is often referred to as the "rebalancing" (Wenzlow et al. 2013) or "balancing" of LTC systems (Konetzka 2014).

This policy objective is attributed to the fact that people prefer to receive LTC in their homes or communities rather than in institutional settings (Guo, Konetzka & Manning 2015). This preference was advanced by the U.S. Supreme Court's ruling in in the case of *Olmstead v. L.C.* (1999), which held that the failure of public programs to offer HCBS alternatives to institutional care constitutes "discrimination" under the Americans with Disabilities Act (Duckett & Guy 2000). This ruling, and subsequent enforcement litigation, intensified federal and state efforts to provide HCBS (Miller 2011). Moreover, the idea that rebalancing care helps control LTC costs (in spite of inconclusive evidence) has served as another force for change. As has the fact that many nursing homes are in need of repair and maintenance. Thus, HCBS are an increasingly integral component of Medicaid LTC systems (Guo, Konetzka & Manning 2015).

The most obvious testament to the movement in favor of rebalancing Medicaid LTC spending is the shift in Medicaid spending on HCBS and away from institutional care (Ryan & Edwards 2015). Whereas 13% of Medicaid LTC spending went towards HCBS in 1990, 53% went to HCBS in 2014 (CMS 2018). This continuing shift towards HCBS is largely attributed to

Medicaid state plan benefits and 1915(c) waiver programs (Konetzka 2014), the distinction of which is clarified in Section 2.

The shift towards HCBS, however, has not occurred to the same extent in all states (Ryan & Edwards 2015). Moreover, states have proceeded at different paces in shifting more of their Medicaid LTC spending to HCBS. In fiscal year (FY) 2001, HCBS spending as a share of a state's total LTC spending varied from a low of ten per cent in Louisiana to a high of 52 per cent in Colorado (CMS 2018). By FY 2015, the share of HCBS spending ranged from 31 per cent in Mississippi to 82 per cent in Oregon (Eiken et al. 2017). These variations create a quasi-natural experiment for understanding the political determinants of state variation in HCBS spending (Reeves et al. 2013).

Interest in the *political* determinants of states' shift towards increasing Medicaid LTC spending on HCBS stems from the conventional view that a series of decade-long trends have created exogenous shocks to contemporary LTC provision. The aging of the population, delayed childbearing, and persistently poor quality of (institutional) care, for example, have all strained families and social welfare systems alike. Such characterizations suggest that "policymakers and families have been caught off guard by these changes, as if these changes appeared out of nowhere to unexpectedly wreak havoc with systems of social welfare provision" (Levitsky 2014). Levitsky (2014) reminds us that to the extent that there is a gap between the LTC needs of Americans and the capacity of social programs to address those needs, that gap is often the result of "deliberate efforts by political actors to prevent the recalibration of [LTC] programs" (Hacker 2004). The relative inelasticity of state HCBS policies may, for example, be partially attributed

to a powerful nursing home lobby and/or caregiver reluctance to alleviate the burden of LTC provision outside the family domain, i.e. for ideological reasons. However, before I can attempt a political analysis of HCBS provision, it is important to, as Levitsky (2014) suggests, get a sense of the "roots and experience" of the "contemporary [home care] crisis."

Home Care Provision: A Tumultuous History

Indeed, historical efforts to update social programs have been "mediated by politics" (Hacker 2004). As the 1980s were characterized by "anti-tax, antigovernment politics," social proposals endured long legislative debates and in the rare case of legislation, many were repealed (Levitsky 2014). For example, while the passage of the Medicare Catastrophic Coverage Act (1988) represented the "largest expansion of Medicare since the [program's inception] in 1965," (Levitsky 2014), its retrenchment almost two years later is "unprecedented in postwar social welfare policy" (Rice, Desmond & Gabel 1999). Amongst various reasons for this outcome, the legislation provided no additional coverage for LTC (Rice, Desmond & Gabel 1999). This experience of "policy drift" is thus "not a reflection of a country caught off guard by certain long-term trends; [it is] due to political opposition to expanded state provision" (Levitsky 2014).

Additional experiences of policy drift occurred in light of the "new or newly intensified social risks" (Hacker 2004) that other reforms produced (Levitsky 2014). For example, in an effort to control health care costs, the Social Security Amendments of 1983 established a Medicare hospital prospective payment system (PPS) (Grabowski 2007; Levitsky 2014). While it seemed likely that Medicare-covered home health care (for short-term post-acute needs) "would expand as hospitals shortened patients' stays in response to the incentives of the new system," this was

not the case (Komisar 2002). Instead, “a combination of regulatory practices and other policies constrained the benefit's use for several years” (Komisar 2002).

Changes in the eligibility and coverage rules in 1989, however, “sparked a period of rapid growth in Medicare home health use and spending” (Komisar 2002). For example, while 2.4 per cent of total Medicare spending was expended on home care in 1988, 10 per cent was expended by 1996 (Komisar 2002). This not only led to budgetary concerns, but also concerns about “fraud and abuse in the system and the rapid growth in the number of home health agencies” (Long 1998). In particular, “a deterioration of regulatory controls” led to an excess of services being delivered to both eligible and non-eligible beneficiaries (Komisar 2002). Many observers believed that the “benefit's scope had expanded from its original focus on post-acute skilled nursing and rehabilitative care and was increasingly paying for LTC” (Komisar 2002).

Ultimately, the Balanced Budget Act (BBA) of 1997 introduced significant policy changes surrounding the Medicare home health benefit “designed to control spending and promote efficient delivery of services” (Komisar 2002). A notable change included a transition away from a cost-based reimbursement system and a shift towards an interim payment system. While this shift led a reduction in the number of people eligible for Medicare home health services, many did not have alternative sources of care. For the majority of Medicare enrollees who were not eligible for Medicaid, “the primary alternatives to Medicare home health were out-of-pocket purchases of services or reliance on family members, whom, even if available, did not have the skills or training to substitute for professional home care [workers]” (Komisar 2002). Indeed, this

has contributed to an ever-growing home care services market, "with no single point of entry for families requiring care assistance" (Levitsky 2014).

In addition to the burden of having to navigate an assortment of home care companies, those requiring LTC must assess "whether and to what degree public programs will cover home health services, each of which covers different kinds of services and is administered under different rules by different authorities" (Levitsky 2014). This is especially difficult for people eligible for both Medicare and Medicaid since, "depending on the state, Medicaid home health care encompasses an overlapping, but typically more custodial, set of services comparable to those covered by Medicare" (Grabowski 2007). Thus, it is important to emphasize that, given the context in which home care services are administered, I am not suggesting that Medicaid's HCBS-driven focus is in itself good policy.

HCBS Spending in Perspective

There isn't one measure that adequately captures HCBS system performance (Wenzlow et al. 2013); "different measures are used across different studies and different care models" (Grabowski 2006). Accordingly, I consider several outcomes to capture inter-state variation in HCBS spending. While some outcomes are standardized per capita to "indicate a state's comparative standing in [HCBS spending]," the share of total LTC spending devoted to HCBS indicates a state's comparative standing in rebalancing LTC (see Section 6) (Tallon & Rowland 2011). However, beyond masking the aforementioned issues associated with the home care services market, I do not view higher HCBS spending levels as necessarily indicative of a better performing LTC system, for three key reasons.

First, there is often a greater need for institutional care in states that have older and/or sicker populations. After all, those in nursing homes are likely to be less healthy, and thus cost more, than those receiving HCBS. The latter "becomes increasingly true as less severely impaired residents substitute HCBS for nursing home care" (Konetzka 2014). Thus, the optimal amount of spending on HCBS and institutional care should be based on a state's population needs (Konetzka 2014).

Second, providing HCBS is not necessarily more cost-effective than institutional care (Konetzka 2014). As Grabowski (2006) notes, "effectiveness may include such dimensions as health and functioning, longevity, satisfaction with care, and informal caregiver (e.g., spouse) support." But these measures are often difficult to ascertain. Differences in costs would have to benchmarked against differences in effectiveness, which is a nebulous task (Grabowski 2006).

Third, the assumption that LTC recipients prefer to get care at home may not always be true (Konetzka 2014). This preference may hold "on average and for low levels of functional impairment"; however, research suggests that "preferences depend on health state, with a preference for institutional care emerging once cognitive impairment sets in" (Konetzka 2014). Thus, there may be "tipping points" where the desire to be at home diminishes (Konetzka 2014).

Therefore, in analyzing interstate variations in expenditures, I am not suggesting that higher spending on HCBS implies a better performing system. Rather, my analyses are intended to enrich understanding about the political context in which HCBS provision is extended.

The remainder of this paper is structured as follows: Section 1.2 provides information on the three Medicaid HCBS programs; section 1.3 provides a review of the literature; section 1.5 describes a multi-disciplinary conceptual framework of factors associated with inter-state variation in HCBS spending; and in sections 1.4 and 1.5, the methods and data are outlined. The results are reported and discussed in sections 1.6 and 1.7. I then conclude with this paper's limitations and policy-takeaways.

1.2 Medicaid HCBS: An Overview

In 2015, LTC spending accounted for 30 per cent of Medicaid's total spending (Eiken et al. 2017). Moreover, in 2011, Medicaid LTC accounted for around 34 per cent of all Medicaid spending (Eiken et al. 2017), benefiting about 3.2 million (Reaves & Musumeci 2015), or 6.1 per cent, of Medicaid's 52.6 million enrollees (Snyder et al. 2012). Thus, not only does LTC weigh heavily on Medicaid's budget, its costs are substantial relative to the number of people served (Colello 2013).

While Medicaid covers LTC in various settings, "the portfolio of services differs substantially by state" (Colello 2013). The original 1965 Medicaid law stipulated that eligible beneficiaries are entitled to nursing care and that states could offer home health as an optional benefit (Colello 2013). In 1968, however, Congress "amended the law to require states to provide home health care to persons entitled to skilled nursing facility care as part of their state Medicaid plans" (Lambert 2004).

Over time, the federal Medicaid statutory authority has "expanded to assist states in increasing and diversifying their Medicaid LTC coverage to include HCBS" – both as an optional state benefit or through a waiver program (the difference is highlighted below) (Colello 2013). While the former was made available in 1978 (Colello 2013), the latter was authorized in 1981 and has represented a more significant and popular expansion of HCBS (Lambert 2004).

Subsequent legislative activities that attempted to expand Medicaid HCBS provision were in part due to the U.S. Supreme Court decision in *Olmstead v. L.C.* (1999). As noted earlier, the decision "held that providing institutional care to people who could be cared for at home or in community settings constitutes a violation of the Americans with Disabilities Act" (Colello 2013). Accordingly, the Affordable Care Act (ACA) includes some options that incentivize states to expand HCBS provision (Colello 2013). For example, the ACA introduced the Balancing Incentive Payments (BIP) Program, which provides enhanced Federal Medical Assistance Percentages (FMAP) to states that spend less than half of their Medicaid LTC spending on HCBS (CMS 2018b). Generally, states have a broad range of options to select from when reconfiguring their LTC programs (Colello 2013).

Despite the patchwork of formal programs that enable states to expand their Medicaid HCBS provision, Medicaid HCBS are provided through three main pathways: mandatory home health services, optional personal care benefits, and optional 1915(c) waiver programs. Unlikely the former two schemes, waiver services do not constitute a Medicaid state plan. The remainder of this section elaborates on this distinction, whilst providing an overview of the different services that each scheme may provide.

1915(c) Waiver and State Plan Programs

The flexibility of 1915(c) waiver programs distinguishes them from Medicaid state plans. Although the latter vary by state, all state plans are required to cover certain benefits and give states the option to cover optional benefits (MACPAC 2018). Moreover, all state plan benefits must meet three federal requirements: (1) that services are "sufficient in amount, duration, and scope to reasonably achieve their purpose"; (2) services are "comparable" across beneficiaries; and (3) services are available "statewide (Schneider and Garfield 2002). In contrast, 1915(c) waivers allow states to provide benefits outside some of these rules and to test different ways of delivering services (Whitenhill & Shugarman 2011). For example, states can choose to target certain geographic areas and to "provide coverage to individuals who may not otherwise be eligible under existing Medicaid rules" (Whitenhill & Shugarman 2011). States may also apply for multiple waivers to address the needs of different target regions and groups (Amaral 2010). However, for a Medicaid beneficiary to be eligible for HCBS waiver benefits, the person must meet the state's criteria for institutional care (Wiener, Tilly & Alexcih 2002).

Notably, waiver benefits are limited to the duration of the waiver (typically three or five years) and renewed by the state subject to approval by the Centers for Medicare & Medicaid Services (CMS) (Whitenhill & Shugarman 2011). To be approved or renewed, HCBS waiver programs must demonstrate that waiver services (1) will not cost more than providing these services in an institution; (2) will constitute adequate and reasonable provider standards to meet the needs of the target population; and, (3) ensure services follow an individualized and person-centered plan of care (CMS 2018c).

The provision of HCBS also can occur though state plan Medicaid programs, i.e. as a mandatory home health benefit and/or an optional personal care benefit. Similar to waiver services, mandatory home health services are designed for individuals who meet the state-level criteria for institutional care. However, they differ from waivers in that they are provided as part of a physician's care plan. Generally, they include "part-time nursing and home health aide services provided by a Medicare approved home health agency; and medical supplies, equipment, and appliances for home use" (Amaral 2012). In contrast, waivers allow for a "more expansive" mix of services and/or equipment that do not require a physician's order (Amaral 2012). Moreover, personal care benefits may constitute services similar to those provided by waiver programs (Ng, Stone & Harrington 2015). However, although optional, they constitute a state plan and, as such, must comply by the aforementioned federal requirements (Schneider & Garfield 2002). It is perhaps this inflexibility that has made the 1915(c) waivers a relatively more popular option for states.

Federal Politics and the Growth of 1915(c) Waiver Programs

Although HCBS are administered by state Medicaid programs, it is important to recognize the political context(s) in which HCBS waivers have been administered at the federal level, which can be masked in a state-level empirical analysis. In 1981, legislative changes, supported by the Reagan administration, implanted Section 1915(c) into Medicaid law, allowing states to apply for HCBS waivers. These waivers allowed state officials to "circumvent the [abovementioned Medicaid state plan] requirements that many found onerous" (Thompson et al. 2016). Furthermore, waivers are believed to have been "deliberately" employed by the Republican-led executive branch (Hacker 2004) because the "left was strong enough to veto certain policies in

the legislative context that it has been unable to stop when pursued through the waiver process" (Teles 1998 in Hacker 2004). The establishment of the waiver program thus represented a "strategic adaptation" (i.e. a "loosening" of federal requirements related to state-level welfare activities) "to a political context preventing legislated policy reform" (Hacker 2004).

Demand for waivers proved to be high. By 1992, 155 waiver programs were already in place. However, intergovernmental negotiations during the waiver approval process proved to be long and difficult during the Reagan and first Bush administrations, which "adopted stringent interpretations of the statutory requirement that the waivers be budget neutral" (Thompson et al. 2016). This contrasted with what happened under the Clinton and second Bush administrations, which were "more permissive in accepting state cost estimates concerning budget neutrality" (Thompson et al. 2016). As of today, over 300 HCBS waivers are facilitating the delivery of HCBS nationwide (CMS 2018c).

1.3 Previous Research

Most studies of HCBS tend to focus on the 1915(c) waiver program and be descriptive in nature (i.e. Miller 1992; Miller, Ramsland & Harrington 1999; LeBlanc, Tonner & Harrington 2000; and Kitchener et al. 2006). However, some papers go beyond a descriptive analysis. Harrington et al. (2000) uses a state-level panel to determine the driving forces behind waiver expenditures between 1992 and 1997. Amongst various findings, expenditures were positively associated with a democratic governorship. Using a comparable model, Miller et al. (2000) find that state waiver expenditures between 1990 and 1996 were negatively associated with a higher African American population. This could be because states with large African American populations have higher

poverty rates and, as a result, have less money to spend on Medicaid programs. Lastly, Kitchener, Carrillo and Harrington (2003) examine state-level determinants of HCBS expenditures between 1992 and 1999, taking into account the different HCBS programs. Interestingly, a limited number of significant findings were found in relation to both home health and personal care expenditures.

While these published studies provided an early examination of possible reasons for interstate variation in Medicaid HCBS spending, they convey an outdated and narrow picture of HCBS provision.[1] For example, not one of the aforementioned papers considers the determinants of HCBS expenditures beyond 1999; non-waiver programs were rarely considered; and while one study considers the share of waiver spending in relation to total LTC spending, no paper considered the share of HCBS spending. Second, the specification method used in previous studies – random effects estimation – is, in my view, inappropriate given the nature of the question. Instead, I use fixed effects models, through which the "effects of unobserved confounders that differ between [states] but remain constant over time are eliminated" (Hu et a. 2017) (see section 5). Third, previous studies give little relevance to political variables; for instance, the partisan composition of state legislatures was never considered, nor were political contributions from the nursing home industry. Against this background, I attempt in this paper to present a more holistic and timely analysis of interstate variation in Medicaid HCBS whilst addressing these inadequacies.

[1] A dissertation by Boyer (2013) attempts to provide a more timely analysis of Medicaid HCBS provision; however, his outcomes of interest vary from mine as does his selection of independent variables. For instance, he does not examine the level of rebalancing nor control for nursing home industry contributions (see Section 4). Moreover, I have reason to believe that some of his independent variables are collinear.

1.4 Conceptual Model

While some studies on HCBS give importance to individual-level predisposing factors, the latter "underplays the discretion that states are allowed within the Medicaid program to influence HCBS [provision]" (Kitchener, Carrillo & Harrington 2003). Accordingly, the conceptual framework for my study draws upon the political science and LTC-relevant literature. I focus on two sets of variables that are believed to impact HCBS spending: (1) predisposing factors (i.e. socio-demographic and social structure variables), and (2) enabling factors (i.e. economic and political variables) (Kitchener, Carrillo & Harrington 2003). Adapted from Andersen's (1995) model of health service utilization, these two categories of variables capture the state environment in which state Medicaid programs operate, and are thus considered in my analysis of Medicaid HCBS spending. Below I describe these factors and associated hypotheses. Separately, I develop a sub-model that allows for political forces to impact changes in HCBS spending.

Predisposing Factors

Sociodemographic Factors. Among the sociodemographic variables considered in Andersen's (1995) model, age, gender, and disability are most relevant to HCBS. While older people are more likely to need LTC, only those under 85 are hypothesized to increase demand and spending on HCBS. Individuals over 85, whom are likely to be sicker and in greater need of institutional care, are expected to drive HCBS spending down. Moreover, I have no a priori hypotheses regarding the potential impact of a higher female labor force participation rate. Arguably, as a result of increased employment, women are less likely to have time to care for their dependent

relatives (Kitchener, Carrillo & Harrington 2003). On the other hand, increased employment can also imply that women prefer institutional round-the-clock care over HCBS.

Ethnicity. In line with Cagney and Agree's (2005) conclusion that "African American older persons use formal LTC at a significantly lower rate than their White counterparts," previous studies found a negative association between a larger African American population and HCBS spending (see Section 3). In the same vein, Fennell and colleagues (2013) note that "Hispanics are less likely than whites and blacks to use home health aides." Accordingly, I expect states with larger minority populations to spend less on HCBS, despite the fact that these populations may have higher disability rates (Cagney & Agree 2005).

Enabling Factors

Economic Circumstances. Given that earlier studies find higher per capita incomes to be positively associated with HCBS spending, high-income states "may be more generous in their funding of Medicaid HCBS programs" (Kitchener, Carrillo & Harrington 2003). However, lower per capita incomes may translate to increased eligibility and thus demand for HCBS programs, which can drive up spending (Kitchener, Carrillo & Harrington 2003).[2] Moreover, high poverty rates are expected to reduce a state's fiscal capacity to pay for HCBS as other Medicaid programs (i.e. for infants and maternal health care) may receive higher priority.

[2] Since the federal government determines each state's Federal Medical Assistance Percentage (FMAP) based on its income, I excluded the FMAP from my analysis due to the potential issue of multicollinearity. As Grabowski, Ohsfeldt and Morrisey (2003) note, "the per capita income measure [encompasses] the effect of the federal match rate on Medicaid expenditures."

State LTC Policies. Indeed, “HCBS spending may be positively related to a state’s use of policies designed to limit spending on institutional care” (Kitchener, Carrillo & Harrington 2003; Rahman et al. 2015). For this reason, I expect that in states with certificate of need (CON) and/or moratorium regulation policies that regulate the number of nursing beds, HCBS spending will be higher. Moreover, it is difficult to hypothesize the impact of average Medicaid per diem rates for nursing care. For example, if such rates are high, fewer funds may be available for HCBS. Conversely, “some states with relatively generous Medicaid [per diems] may also be generous in their HCBS reimbursement and thus spend more on HCBS” (Kitchener, Carrillo & Harrington 2003).

Provider Organizations. Both the number of nursing home beds in certified nursing facilities and the number of certified home health agencies can impact HCBS spending. For example, “greater numbers of nursing home beds [may] reduce the available funds for HCBS” (Kitchener, Carrillo & Harrington 2003). On the other hand, home health agencies may help identify more people that need HCBS, and raise HCBS spending. The number of agencies is oftentimes “a proxy [measure] for higher need in an area” (Kitchener, Carrillo and Harrington 2003).[3]

Political Forces

Mass Ideology. Indeed, efforts at Medicaid reform are strongly influenced by state politics (Wiener & Stevenson 1998). For example, Erickson, Wright & McIver (1993) suggest that electorate ideology is linked to Medicaid generosity, with liberal states enacting more generous

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[3] Swartz (2018) argues that the number of people working for such agencies would be more informative. While “home care is among the fastest-growing occupations in the US,” demand for home care providers is outstripping supply (Channick 2017). However, labor supply data across states and time was unavailable at time of writing.

programs (Heidbreder 2012). Similarly, Miller and Nadash (2015) note that liberal states are "more likely to champion public [HCBS] programs." However, it would seem presumptuous to assume that a more liberal citizenry spends more on HCBS generally. In discerning social from economic liberal ideology, I hypothesize that the effect of the former can go either way, while the effect of the latter will be positive.

Regarding mass social ideology, it is possible that policymakers react to voters' demands for greater HCBS due to beliefs that care at home or in communities respects "people's right to privacy, dignity, and self-determination" (Kennedy 2014). However, social ideology can also include greater expectations for the state to offer institutional round-the-clock care and rely less on traditional models of family care provision, in which case a negative effect on HCBS spending is expected. The same can be said for older and/or sicker states whose social ideology may find institutional care more appropriate. Moreover, states with more economically conservative electorates are expected to spend less on HCBS on the basis that the family caregiver model should dominate any notions of taxing and redistributing wealth to support LTC programs.

Organized Interests. In addition to mass ideology, interest groups may also influence the provision of HCBS (Wiener & Stevenson 1998). According to Birney, Shapiro, and Graetz (2007), the potential for interests "to be successful [is] higher on lower salience issues, for which the balance of political organizing [is] more likely to be asymmetrical and public opinion less fixed." Arguably, the provision of LTC – and HCBS specifically - is one such issue (Polivka

2005). This helps explain why the for-profit nursing home industry is considered to be the strongest health lobby concerning Medicaid issues (Wiener & Stevenson 1998).

The strength of the nursing home lobby is attributed to various reasons. Nursing homes are much more reliant on Medicaid revenue than are other providers. As such, industry representatives consult state officials on a frequent basis and develop personal relationships with them (Wiener & Stevenson 1998). Furthermore, the industry "is large and well financed enough [that they can] afford highly paid lobbyists, [to] commission studies to support its positions," and to make "frequent and large" contributions to state-level political campaigns (Wiener & Stevenson 1998). Thus, to the extent that states are willing to sustain the needs of private nursing homes, I predict that nursing home industry contributions will drive HCBS spending down.

Indeed, sustaining the industry's needs is not easy. As Wiener and Stevenson (1998) note, the industry is mostly looking for higher reimbursements rates, which states may not always be in a position to fund. The authors add that "a history of quality concerns and of fraud and abuse has damaged the industry's public image, and policymakers and the public may be unconvinced that more money will improve patient care." Lastly, state politicians are also influenced by other interests, namely home care associations and advocacy groups for both the elderly and disabled (Wiener & Stevenson 1998).

Partisanship. Both Democratic control of a state's legislature and/or a state's governorship have been shown to play some role in Medicaid expansion (Kousser 2002; Harrington et al. 2000). In Mississippi, for example, a Republican governor vetoed legislation that was meant to expand

HCBS provision on three occasions (Kitchener, Carrillo & Harrington 2003), likely due to fears of the so-called "woodwork effect" (Grabowski 2006). Thus, I expect both Democratic governorship and legislatures to have a positive relationship with Medicaid HCBS spending.

Political Representation. The proportion of women in state legislatures can also influence HCBS policy. Given that women are more likely to serve on health committees and bear the burden of informal LTC extended to their dependent elderly, women may be more understanding of the elderly's preferences to stay at home. In this case, I would expect that a greater proportion of women in state legislatures will have a positive relationship with HCBS spending. On the other hand, women may be more attuned to the preferences of working women, whom may prefer that care for their dependent elderly be provided outside the home.

1.5 Methods

My analysis is concerned with identifying political factors associated with state-level Medicaid HCBS spending between 2001 and 2010. To that end, I estimated fixed effects regression models of the form:

$$HCBS_{st} = \beta_0 + \beta_1 POLITICS_{st} + \beta_2 X_{st} + \beta_3 state_s + \beta_4 year_t + \varepsilon_{st} \quad ,$$

where $HCBS_{st}$ is the level of HCBS expenditures for state *s* at time *t*; $POLITICS_{st}$ is a vector of political factors; X_{st} is a vector of non-political predisposing and enabling factors; *year* is a time-specific intercept (a vector of year dummy variables); and ε_{st} is a mean-zero random error.[4]

[4] In choosing between a fixed- and a random-effects approach, Hausman tests were employed. Rejection of the null hypothesis across all models supported the case for a fixed-effects approach.

Across three specifications of the model, $HCBS_{st}$ constitutes state plan, waiver, and total HCBS spending per capita among the elderly (65+ years). In a fourth specification, $HCBS_{st}$ is the share of total LTC spending dedicated to HCBS. Bivariate relationships were also examined as a means of providing a more comprehensive analysis.

In employing a fixed effects model that exploits within-state variation in both the regressors and outcomes, I control for time-varying factors that also vary across the states. I also use annual indicators, which "net out national temporal trends" (Grabowski & Morrisey 2004). Therefore, the identification strategy in the abovementioned equation "purges the unobserved and potentially confounded cross-sectional heterogeneity" by relying on within-state variations in both the dependent and independent variables across a number of years (Grabowski & Stevenson 2008).

1.6 Data

Dependent Variables. With the state as the unit of analysis, this study considers four dependent variables concerning HCBS spending (see Table 1.1 for descriptions and sources). The nine-year period that I examine (2001-2010) was the longest one for which a complete set of data was available. Across three specifications of the model, $HCBS_{st}$ constitutes state plan, waiver, and total HCBS spending per capita among the elderly (65+ population). In a fourth specification, $HCBS_{st}$ constitutes the share of total LTC spending dedicated to HCBS. The former set of dependent variables, i.e. expenditures per capita in a given state and year, were logged. All dollar amounts are expressed in 2004 dollars using the Consumer Price Index to adjust for inflation and the 2008-09 recession over the nine years (see Table 1.2 for descriptive statistics).

As mentioned in Section 1, per capita spending levels are meant to capture a state's comparative spending in HCBS spending, while the share of LTC spending devoted to HCBS is meant to capture a state's comparative standing in rebalancing LTC spending (Tallon & Rowland 2011). These variables do not constitute measures of system performance. Their use, however, helps inform discussions about the political context in which HCBS provision is extended.

Dependent Variable	Description	Source
Total HCBS Spending ($)	Per capita state-level Medicaid HCBS spending on the elderly (65+ population); includes spending on 1915(c) waiver, state plan, and other HCBS programs not listed below	CMS Form 64 data via CMS (2018)
Total 1915(c) Waiver Spending ($)	Per capita state-level 1915(c) waiver spending on the elderly (65+ population)	CMS Form 64 data via CMS (2018)
Total State Plan Program Spending ($)	Per capita state-level state plan (including mandatory home health benefit and optional personal care benefit spending) on the elderly (65+ population)	CMS Form 64 data via CMS (2018)
Share of LTC Spending on HCBS (%)	Total state-level Medicaid HCBS spending as a share of total Medicaid LTC spending	CMS Form 64 data via CMS (2018)

Table 1.1: Description of State-Level Spending Outcomes, 2001-2010

Dependent Variable	Mean	Standard Deviation	Min	Max
HCBS $ per 65+ population[a]	1365.176	1905.79	225.987	16183.52
Waiver $ per 65+ population[b]	736.258	403.928	85.722	2381.242
State plan $ per 65+ population[c]	828.930	454.428	110.562	2968.195
Share of LTC $ spent on HCBS[d] (%)	38.827	13.431	8.734	82.819
[a,b,c,d] CPI-adjusted to 2004 dollars				

Table 1.2: Descriptive Statistics, Dependent Variables, 2001-2010

Independent Variables. State-level data for the period 2000 through 2009 were collected from various secondary sources (see Table 1.3 for descriptions and sources; Table 1.4 for descriptive

statistics). Following other studies (Harrington et al. 2000; Miller et al. 2000; Kitchener, Carrillo & Harrington 2003), the independent variables were lagged one year because they are likely to take some time to have any impact and because this alleviates some concerns related to endogeneity. A correlation matrix was produced to test for multicollinearity and none of the independent variables were found to be highly correlated (i.e. above 0.65 correlation) (Kitchener, Carrillo & Harrington 2003). Moreover, two variables were omitted from the analysis because they were deemed to be "largely fixed over time": a state's use of a certificate of need (CON) and/or moratorium to limit nursing home care and the number of certified home health agencies (Grabowski 2018).

State Selection. The District of Columbia (DC), Alaska, Arizona, Hawaii, Nebraska, and Wyoming were excluded from the analysis. I excluded DC because many policy parameters are determined at the federal level; Alaska and Hawaii were excluded because their average Medicaid per diems were unavailable; Arizona was omitted because the state does not run a 1915(c) waiver program; Nebraska was excluded because state legislators do not run with a party affiliation; and Wyoming was omitted because political contribution data were unavailable. Vermont is included in the analyses only through 2005 since it terminated its 1915(c) waiver program in 2006 in favor of the 1115 waiver program. Rhode Island is included in the analyses only up to 2008 for the same reason. Ultimately, the sample size included 443 observations from 45 states. While 32 states operated personal care programs (Ng, Stone, & Harrington 2015; Thompson et al. 2016) during the study period, only 29 of the 45 states included in this study opted for optional personal care programs. All 45 states, however, ran 1915(c) waiver and mandatory state home health programs.

Independent Variables	Description	Source
Political Variables		
Democratic Governorship	Dummy for whether state governor is Democratic (1=yes)	National Governors Association (2015)
Democratic Legislature (%)	Share of state legislature that is Democratic	The Council of State Governments (2016)
Female Legislators (%)	Share of state legislature that is female	The Center for American Women and Politics (2018)
Mass Economic Liberal Ideology Score	Index based on state-level surveys related to "taxes, social welfare, and labor regulation" (high score = more liberal)	Caughey & Warshaw (2017)
Mass Social Liberal Ideology Score	Index based on state-level surveys related to "abortion, gay rights, women's rights, and other cultural issues" (higher score = more liberal)	Caughey & Warshaw (2017)
Nursing Home Industry Strength ($)	Nursing home industry contributions to state-level political candidates and committees (expressed in $10,000)	Follow the Money (2018)
Predisposing Variables		
Very Old Population (%)	Share of state population is that 85+	US Census Bureau via CDC (2018b)
Female Labor Force Participation Rate (%)	Share of state civilian labor force that is women	State Statistical Abstracts via US Census Bureau (2018)
Black Population (%)	Share of state population that is African American, all ages	US Census Bureau via CDC (2018b)
Hispanic Population (%)	Share of state population that is Hispanic or Latino, all ages	US Census Bureau via CDC (2018b)
Enabling Factors		
Personal Income ($)	State-level per capita personal income (expressed in $1000)	US Department of Commerce (2018)
Poverty Rate (%)	Share of state population under 100% federal poverty level	US Census Bureau (2017)
Average Medicaid Per Diem (nursing care) ($)	Total Medicaid nursing home spending in the state divided by the total number of Medicaid days in nursing homes	LTC Focus (2018)
Nursing Home Beds	Number of beds in certified nursing facilities, per 100 old persons (85+)	CDC (2018)

Table 1.3: Description of Independent Variables, 2000-2009

Dependent Variable	Mean	Standard Deviation	Min	Max
Political Variables				
Democratic Governorship (yes=1)	0.431	0.496	0	1
Democratic Legislature (%)	51.61	14.183	11.429	94.203
Female legislators (%)	22.627	7.094	7.9	40.8
Mass Economic Liberal Ideology Score	-0.220	0.432	-1.610	0.908
Mass Social Liberal Ideology Score	-0.064	0.482	-1.003	1.19
Nursing Home Industry Political Contributions[a] (expressed in $10,000	11.596	23.004	0	203.296
Predisposing Variables				
Very Old Population (85+) (%)	1.657	0.353	0.855	2.465
Female Labor Force Participation Rate (%)	61.261	4.542	47.7	75.7
Black Population (%)	11.753	9.744	0.449	37.472
Hispanic Population (%)	8.999	9.516	0.683	46.031
Enabling Variables				
Personal Income[b] (per capita) ($)	33319.79	5436.782	23629.74	53720.77
Poverty Rate (%)	12.055	3.133	4.5	23.1
Average Medicaid Per Diem[c] (nursing care) ($)	148.959	29.683	82.92	230.4
Nursing Home Beds (per 100 very old persons, 85+)	0.226	0.130	0.001	0.858
[a,b,c] CPI adjusted to 2004 dollars.				

Table 1.4: Descriptive Statistics, Independent Variables, 2000-2009

1.7 Results

Bivariate Analyses. In some ways, a Democratic governorship and a Democratic legislature bear a similar relationship with HCBS spending. For instance, while a Democratic governorship has positive effects on total HCBS sending, state plan HCBS spending, and the level of LTC rebalancing, a Democratic legislature also has positive effects on state plan HCBS and rebalancing spending levels (see Table 1.5). Thus, one would expect the influence of partisanship to vary on total HCBS spending. However, this does not appear to be true when I include control variables (see results of multivariate analyses below). All else controlled for, both a Democratic governorship and a more Democratic legislature have a significant effect on per capita HCBS spending (although the strength of the relationship varies).

A similar pattern of observations was found in relation to other variables. For example, at the bivariate level, the level of political contributions made on behalf of the nursing home industry has a predictive effect on rebalancing; however, that effect wanes in the multivariate analysis. Controlling for the impact of a Democratic governorship (amongst other variables) on HCBS spending likely weakened the nursing home industry's effects. Therefore, a "multivariate analysis is necessary to hone in on the true effect of each variable while controlling for others" (Campbell 2011).

Independent Variable	**Log of HCBS $ per 65+ population**	**Log of waiver $ per 65+ population**	**Log of state plan $ per 65+ population**	**Share of LTC $ expended on HCBS (%)**
Democratic Governorship	0.069*** (.017)	0.032* (0.106)	0.047*** (0.018)	1.884*** (1.884)
Democratic Legislature (%)	-0.00009 (.001)	-0.002 (-0.002)	-0.003** (0.002)	0.077** (0.038)
Female legislators (%)	0.0009 (0.0009)	0.005 (0.004)	0.005 (0.004)	-0.095 (0.088)
Mass Economic Ideology	0.025 (0.055)	0.021 (0.061)	0.003 (0.058)	2.997** (1.422)
Mass Social Ideology	-0.130* (0.071)	-0.299*** (0.078)	-0.245** (0.073)	5.124*** (1.827)
Nursing Home Industry Political Contributions ($)	0.0007* (0.0004)	-0.0004 (0.0004)	-0.0003 (0.0004)	0.017** (0.017)
State Fixed Effects	Yes	Yes	Yes	Yes
Year Fixed Effects	Yes	Yes	Yes	Yes
N	448	448	448	448

Note: Standard errors are in parentheses.
* Significant at 10% level.
** Significant at 5% level.
*** Significant at 1% level.

Table 1.5: Bivariate Analyses of Political Factors Influencing HCBS, Waiver, State Plan Expenditures and Proportion of LTC Expenditures Spent on HCBS

Multivariate Analyses. Table 1.6 shows the panel regression coefficients for the following four, state-level fixed effects models for the period 2001-2010: log of HCBS spending, log of 1915(c) waiver program spending, log of state plan HCBS spending, and the share of HCBS spending as

a percentage of total LTC spending. The former three outcomes are based on per capita spending among the elderly (65 years and older).

Amongst the political factors, a democratic governorship is a positive predictor of all spending outcomes: a state with a Democratic governor, for example, is predicted to increase HCBS spending as a share of total LTC spending by 1.64 per cent. Such findings are consistent with those found in the bivariate analyses. On the other hand, democratic control of a state's legislature has a weak effect (at the 10 per cent level) on per capita HCBS spending and a stronger effect on rebalancing. Specifically, a more democratic legislature is predicted to increase the share of LTC spending on HCBS by 0.9 per cent. The share of female legislators has no predictive effects. Nor does economic ideology. In contrast, a more socially liberate electorate has a negative effect on all per capita HCBS spending levels. A one unit increase in a state's social ideology score, for example, is associated with a 25 per cent decrease in per capita HCBS spending. Lastly, political contributions on behalf of the nursing home industry has a significant (albeit weak) effect on per capita HCBS spending.

As anticipated, a state's very old population (85 years and older) has a negative, predictive effect on all outcomes. For example, a one percentage increase in the share of the population that is 85+ is predicted to decrease rebalancing levels by 18 per cent. Generally, a state's female labor force participation rate has little effects on HCBS spending. Moreover, while the share of the population that is Black only has predictive effects on waiver HCBS spending, the share of the population that is Hispanic has little predictive effects. Amongst the enabling variables, per capita income has a significant impact on per capita HCBS spending, while a state's poverty rate

has a significant effect on the level of rebalancing. Last, the number of nursing beds has a negative influence on all outcomes.

Independent Variable	**Log of HCBS $ per 65+ population**	**Log of waiver $ per 65+ population**	**Log of state plan $ per 65+ population**	**Share of LTC $ expended on HCBS (%)**
Democratic Governorship	0.071*** (0.018)	0.046** (0.02)	0.057*** (0.019)	1.64*** (0.454)
Democratic Legislature (%)	0.003* (0.002)	0.001 (0.002)	-0.00002 (0.002)	0.089** (0.043)
Female legislators (%)	-0.001 (0.003)	0.005 (0.005)	0.004 (0.003)	-0.115 (0.085)
Mass Economic Ideology	0.065 (0.055)	0.069 (0.061)	0.051 (0.051)	2.13 (1.383)
Mass Social Ideology	-0.250*** (0.078)	-0.368*** (0.087)	-0.302*** (0.081)	0.985 (0.985)
Nursing Home Industry Political Contributions ($)	0.001* (0.0003)	-0.0004 (0.0004)	-0.0003 (0.0004)	0.014 (0.014)
85+ Population (%)	-0.735*** (0.195)	-0.666*** (-0.666)	-0.776*** (0.204)	-17.636*** (4.948)
Female Labor Force Participation (%)	0.009 (0.006)	0.014* (0.007)	0.01 (0.007)	-0.004 (-0.004)
Black Population (%)	-0.002 (-0.002)	0.075** (0.033)	0.048 (0.031)	-1.116 (0.746)
Hispanic Population (%)	0.026* (0.015)	-0.002 (-0.002)	0.002 (0.016)	0.79* (0.79)
Per Capita Income	0.016** (0.008)	0.009 (0.008)	0.005 (0.008)	0.038 (0.191)
Poverty Rate (%)	0.008 (0.006)	0.003 (0.007)	0.0005 (0.006)	0.369** (0.152)
Average Medicaid Per Diem (nursing care)	0.0001 (0.0007)	0.0003 (0.0008)	0.0005 (0.0008)	-0.027 (0.019)
Nursing Home Beds	-0.018*** (0.006)	-0.016*** (0.006)	-0.02*** (0.006)	-0.684*** (0.141)
R-squared (within)	0.691	0.662	0.666	0.734
State Fixed Effects	Yes	Yes	Yes	Yes
Year Fixed Effects	Yes	Yes	Yes	Yes
N	443	443	443	443

Note: Standard errors are in parentheses.
* Significant at 10% level.
** Significant at 5% level.
*** Significant at 1% level.

Table 1.6: Multivariate Analyses of Factors Influencing HCBS, Waiver, State Plan Expenditures and Proportion of LTC Expenditures Spent on HCBS

1.8 Discussion

The reported findings extend understanding of interstate variation in Medicaid HCBS spending in two main ways. First, the analysis uses expenditures per capita and the share of LTC expenditures spent on HCBS as outcomes to capture how states compare in both general HCBS spending and in rebalancing spending. Second, this longitudinal analysis considers a range of political factors and estimated their association with expenditure levels between 2001 and 2010.

My analysis reports that while a Democratic governorship is associated with increased HCBS spending, a more Democratic state legislature is less consistently so. Interest group politics can help explain this finding. While Republican-Democratic "differences over supporting older citizens are more muted than differences over [other types of] public assistance programs," (see below) (Giles-Sims, Green & Lockhart 2012) Democratic governors are generally more critical of the nursing home industry relative to Republican governors (Miller et al. 2012). And, because for-profit nursing home facilities "exhibit the poorest quality of care, it may be that HCBS [spending] increases with for-profit representation under Democratic governors" (Miller et al. 2012). At the same time, Democratic governors may be more responsive than Republican governors to the disability rights movement and the interests of home care associations.

The finding that a more democratic legislature has a weak effect (at least compared to a Democratic governorship) on per capita HCBS spending can be attributed to two reasons. First, the elderly are believed to have lived "constructive lives" and to "span the socioeconomic spectrum" (Lockhart, Giles-Sims & Klopfenstein 2016). As a result, providing for this now-needy group "may be less controversial than supporting narrower segments of society, such as

single working-age minority mothers" (Lockhart, Giles-Sims & Klopfenstein 2016). Second, legislators may better relate to LTC recipients' needs given their own experiences with their dependent elderly. For instance, "state officials might empathize with the plight of families similar to their own whose inheritances may disappear as a result of having to pay nursing facility charges in the absence of state programs" (Lockhart, Giles-Sims & Klopfenstein 2016). Moreover, the significant association between Democratic legislators and rebalancing levels may be attributable to Republican concerns of the so-called "woodwork effect" (Grabowski 2006).

Although women are considered to be "closely attuned to elder care issues than are men and thus may favor HCBS over nursing facility care," (Giles-Sims, Green & Lockhart 2012), the share of women legislators is not significantly associated with both per capita HCBS spending outcomes and the share of LTC spending expended on HCBS. One possible reason for this is the "minority status" of female legislators; the latter "makes it difficult to translate sheer presence into policy outcomes on such a large scale" (Courtemanche & Green 2017). Additionally, while the model controls for political variables like mass ideology, it fails to examine any interactive effects between such variables and the presence of female legislators. One could argue, for example, that "women [are] better able to influence [others] to align on preferred policies when great situational need is present," and when public opinion is favorable.

Moreover, mass economic ideology has no predictive effects on HCBS spending. This suggests that economically liberal and conservative persons may be undivided on the idea of taxing and redistributing wealth to support the elderly. In contrast, as a state's social ideology score increases, a negative effect on per capita HCBS outcomes manifests. This suggests that a more

socially liberal electorate may have greater expectations for the state to offer round-the-clock institutional care and rely less on a traditional models of care provision.

Perhaps the most unforeseen result is the positive association (albeit at the 10 per cent level) between political contributions made on behalf of the nursing home industry and per capita HCBS spending. While the true direction of this effect may not have been discerned due to data limitations (i.e. most contributions were made biannually) or methodological constraints (see next section), certain features of the industry can help explain this finding.

As per Harrington and Grant (1990), around seven types of formal providers deliver HCBS. However, only licensed and certified home health agencies are able to provide Medicaid-financed HCBS. However, the provision of HCBS is "further complicated by those home care providers that have multiple components within a single organization" (Harrington & Grant 1990). For example, "a licensed and certified home health agency may also operate an unlicensed division or agency offering temporary nursing services to private-pay clients" (Harrington & Grant 1990).[5] Moreover, as Bos and Harrington (2017) note, some companies operate both nursing home facilities and licensed home care agencies. This suggests that some nursing home companies have an interest in expanding the scope of government-funded HCBS

[5] According to Harrington and grant (1990), "to participate in Medicare or Medicaid, a home health agency must be licensed by the state licensing authority and meet the federal Medicare certification requirements… Certified home health care agencies must also meet the conditions of participation in the federal Medicare regulations."

and increasing the Medicaid payment rate for these services[6], while at the same time maintaining a separate tier of nursing care services.

This complicated landscape also helps explain why coalitions like the Partnership for Medicaid Home-Based Care (PMHBC) was created to lobby issues related to Medicaid HCBS provision (PMHBC 2018). While the PMHBC lobbies on the federal level, its members' influence (and that of other home care organizations) in state-level policy should not be underestimated (Wiener & Stevenson 1998), especially given that the elderly are uninvolved in such debates (Silberberg, Estes and Harrington 1994) and the increasing number of mergers and acquisitions between providers. The most recent testament to the latter is an $850 million acquisition of home care provider Almost Family by LHC Group, which consequently is now "the second largest home health provider in the US" (Karlin 2018). Such merging activity is indicative of home care providers behaving like "professional monopolizers" (Alford 1977 in Silberberg, Estes & Harrington 1994), whereby their interests in a growing, profitable sector (North and Peckham 2001) may, in some ways, align with that of the nursing home industry.

Amongst the predisposing factors, the share of the 85+ population is, as expected, negatively associated with all outcomes. However, it is surprising to find that the female labor force has little impact on HCBS spending levels. This reflects the ambiguity of the relationship. On the one hand, more women working may garner support for HCBS programs on the basis that any complementary help is better than none. On the other hand, as Segelman et al. (2017) find,

[6] As Wiener, Tilly and Alexcih (2002) point out, "the Federal Government does not set minimum standards for payment rates for HCBS." In some states, Medicaid home health payment rates were not raised for decades. Moreover, payment rates vary by service (Wiener, Tilly & Alexcih 2002).

jurisdictions with higher female labor force participation may be associated with a higher risk of nursing home admission. Lastly, the fact that a state's Black population is positively associated with waiver HCBS spending suggests that the waiver program may be targeting their needs. Meanwhile, given that a state's Hispanic population has insignificant or weak effects suggests that Hispanics rely more on care within the family domain. However, access-related issues may also be playing a role.

Amongst the enabling factors, the positive association between per capita income and total HCBS spending suggests that high-income states are more generous in their funding of Medicaid HCBS programs - however not necessarily enough to impact the level of rebalancing. Meanwhile, high poverty rates have positive effects on rebalancing in spending. This may be due to higher enrollment, or HCBS expenditures appearing to be growing because the amount of Medicaid funding for LTC is decreasing (i.e. while other Medicaid programs are prioritized). While the average Medicaid per diem for nursing care has no predictive effects, the number of nursing home beds, as anticipated, does across all outcomes.

1.9 Conclusion

While this study considered a range of factors associated with state-level HCBS spending, state's desire to expand HCBS provision in the 2000s may have been hindered by both the early 2000s recession and the Great Recession. Thus, future work would benefit from a longer study period. In fact, the need for more comprehensive research is underscored by the fact that "even in a period of economic growth, interstate variations lead to inequitable access, especially among those with some of the greatest need for services" (Kitchener, Carrillo & Harrington 2003).

To that end, it would be beneficial for future work to account for a state's urban or rural population and home health care worker supply (Ng, Stone & Harrington 2015). Furthermore, the fact that both Medicare and Medicaid sometimes cover overlapping home care services was overlooked in my analysis and warrants further examination. As per Grabowski (2007), "the incentive to shift Medicaid's home care costs to Medicare has been observed in the negative relationship (at the state level) between the utilization of Medicare and Medicaid home care services."

Future research should also attempt to further study the influence of the nursing home industry as well that of other interests, such as home care associations and advocacy groups for the elderly and disabled. In particular, it is essential to understand the degree to which different interests are influencing the provision of Medicaid HCBS services and what that influence entails. Such understanding "can enlighten policymakers as to areas where they actively need to engage stakeholders in discussion and negotiation in order to cultivate support for policy efforts" (Silberberg, Estes and Harrington 1994).

Moreover, while this study provides a relatively holistic and timely state-level analysis of Medicaid HCBS spending, it masks the potential impact of federal-level politics on HCBS provision. For instance, it could the case that a more Democratic congress and/or a Democratic presidency might be associated a higher number of waivers being administered. As such, the study results should be approached with caution.

Despite such limitations, the finding reported have a number of implications for policy. The results confirm that state policymakers should expect HCBS spending to rise in state with higher personal incomes. Indeed, this can justify increased federal assistance to poorer states. The findings also help policymakers predict political pressure to expand HCBS programs. For instance, state officials may find greater "windows of opportunity" with a Democratic governor in power. Likewise, the findings may also help organized interests become more "entrepreneurial" (Birney, Shapiro & 2007). For instance, while mass social liberalism has a negative association with HCBS waiver spending, state legislators (along both party- and gender-lines) do not bear any relationship with HCBS spending. Such observations can help shape the focus of certain advocacy groups. Lastly, the significant positive relationship between state's Black populations and waiver spending suggests that 1915(c) waivers may be advantageous in targeting historically disadvantaged population groups.

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<u>Chapter 2</u> Are Long-Term Care Waivers Budget Neutral? An Interstate Analysis of Medicaid Expenditures

ABSTRACT

In 1981, Congress introduced the 1915(c) waiver program to assist state Medicaid programs with expanding their provision of home- and community-based services (HCBS). While the program was established to better accommodate people's preference to receive HCBS rather than institutional care services, it also was believed that Medicaid's costs of caring for a person would be less if the person could live at home. Accordingly, given that a waiver for HCBS may only be extended to beneficiaries who meet their state's eligibility criteria for institutional care, policymakers have long considered the waiver program to be one that lowers Medicaid LTC spending. However, targeting of social services is imperfect, and the impact of the waiver program on Medicaid expenditures is largely unknown. Using state-level data, this paper analyzes the effects of the waiver program on total Medicaid LTC spending, as well as on Medicaid institutional and non-waiver HCBS program spending between 2001 and 2010. Fixed effects models are used to analyze these expenditure categories using variations in waiver program spending across states and time. The results suggest that no cost savings are occurring as a result of the 1915(c) waiver program.

2.1 Introduction

Public financing of long-term care services and supports (hereafter referred to as LTC) has historically favored institutional care services over home- and community-based services (HCBS). However, the U.S. Supreme Court's ruling in the case of *Olmstead v. L.C.* (1999) held that the failure of public programs to offer home- and community-based care alternatives to institutional care constitutes "discrimination" under the Americans with Disabilities Act (ADA) (Duckett & Guy 2000). Since then, there has been great interest in expanding HCBS provision (Konetzka 2014).

The pressures to "rebalance" Medicaid LTC spending has led to a shift in Medicaid spending towards HCBS and away from institutional care (Ryan & Edwards 2015). Whereas 13% of Medicaid LTC spending went for HCBS in 1990, 53% went to HCBS in 2014 (CMS 2018). However, the shift towards HCBS has not occurred to the same extent in all states (Ryan & Edwards 2015); and the pace at which states have moved in rebalancing LTC spending has not been the same (Eiken et al. 2017). In fiscal year (FY) 2001, for example, HCBS spending as a share of a state's total LTC spending varied from a low of ten per cent in Louisiana to a high of 52 per cent in Colorado (CMS 2018). By FY 2015, the share of HCBS spending ranged from 31 per cent in Mississippi to 82 per cent in Oregon (Eiken et al. 2017).

While uneven, the general growth in total HCBS spending is largely due to changes in the Medicaid program (Grabowski et al. 2010). From 1965 until 1981, Medicaid-funded LTC was mostly used to cover institutional care services. However, in an attempt to address concerns about both the quality and costs of institutional care, in 1981 Congress authorized the HCBS

waiver program, otherwise known as the 1915(c) waiver program, to encourage the provision of HCBS (Swartz 2013). The program "allows state Medicaid agencies to request waivers of certain Medicaid requirements to offer community-based alternatives to institutional care" (details below) (Grabowski et al. 2010). To control spending, HCBS waiver programs are expected to be "budget-neutral, and the burden is on the states to prove that recipients of Medicaid-funded HCBS meet the eligibility criteria for institutional care" (Grabowski et al. 2010). Thus, waiver-funded HCBS are intended to not only replace the care that a beneficiary would have otherwise received in an institutional setting, but also cost less.

While the budget neutrality requirement made the waiver approval process an initially onerous one, legislative changes in 1994 "proved more permissive in accepting state cost estimates concerning budget neutrality" (Thompson et al. 2016). These changes are attributed to the advocacy efforts of the elderly and disabled, and the enactment of the ADA in 1990. The abovementioned case of *Olmstead v. L.C.* (1999) further upheld the obligation of states to provide HCBS to medically appropriate persons (Grabowski et al. 2010). As a result, while 155 HCBS waivers were active in 1992, over 300 waivers are active today (CMS 2018b).

The growing state use of the waiver program is largely due to the same reasons that the waiver program was founded: individuals prefer to receive LTC in their homes or communities rather than in institutional settings and, for people with less intensive care needs, per capita costs of non-institutional care are lower than that of institutional care. However, program administrators are finding it increasingly difficult to target waiver HCBS coverage to those who would have otherwise entered nursing homes (Grabowski et al. 2010). After all, "the historic institutional

bias in LTC coverage relates partially to a perceived moral hazard problem (or woodwork effect) whereby publicly financed non-institutional services substitute for informal services previously provided by family members and friends" (Grabowski et al. 2010).

As targeting becomes less accurate, the savings generated from HCBS provision need to increase to account for the costs of the woodwork effect (Grabowski et al. 2010). While recent multistate evaluations suggest that such savings are occurring, the evidence is weak. As Grabowski (2006) notes, "the issue of whether the expansion of Medicaid HCBS waiver programs is budget neutral (or even budget saving as some states argue) is largely unresolved." In a first review of its kind, Grabowski (2006) calls for a multi-state, longitudinal study that accounts for state and year fixed effects to control for unobserved factors that may influence both Medicaid waiver and LTC expenditures. This paper addresses this call.

The remainder of the paper is divided into the following sections. The next sub-section provides information on the structure of the HCBS waiver program and how it differs from other options that states have to expand their provision of HCBS. Section 2.2 provides a brief review of the relevant literature. Section 2.3 develops a conceptual framework while sections 2.4 and 2.5 elaborate on the empirical model and the data used, respectively. The results are reported in section 2.7 and discussed in section 2.7. I conclude with the study's policy implications.

The HCBS Waiver Program: A Background

Medicaid HCBS are provided through three main pathways: mandatory home health benefits, optional personal care benefits, and optional 1915(c) waiver programs. Unlikely the former two

schemes, waiver services do not constitute a Medicaid state plan benefit. Here, I elaborate on this distinction, whilst providing an overview of the different services that each scheme may provide.

The flexibility provided by waiver programs distinguishes them from a Medicaid state plan. Although all state Medicaid plans are required to cover certain benefits, states may also cover additional, optional benefits (MACPAC 2018). Regardless, all state plan benefits (mandatory or not) must meet three federal requirements: (1) that services are "sufficient in amount, duration, and scope to reasonably achieve their purpose"; (2) services are "comparable" across beneficiaries; and (3) services are available "statewide (Schneider and Garfield 2002). In contrast, 1915(c) waivers allow states to provide benefits outside some of these rules and to test different ways of delivering services (Whitenhill & Shugarman 2011). For example, states can choose to target certain geographic areas and population groups, and "provide coverage to individuals who may not otherwise be eligible under existing Medicaid rules" (Whitenhill & Shugarman 2011). Moreover, states may apply for multiple 1915(c) waivers to address the needs of different target groups and regions (Amaral 2010).

Waiver benefits are limited to the duration of the waiver (typically three or five years), although they can be renewed by the state subject to CMS approval (Whitenhill & Shugarman 2011). To be approved or renewed, HCBS waiver programs must demonstrate that waiver services (1) will not cost more than providing these services in an institution; (2) will constitute adequate and reasonable provider standards to meet the needs of the target population; and, (3) ensure services follow an individualized and person-centered plan of care (CMS 2018b).

The provision of HCBS also can occur though state plan Medicaid programs, i.e. as a mandatory home health and/or optional personal care benefit. Similar to waiver services, mandatory home health services are designed for individuals who meet their state-level criteria for institutional care. However, they differ from waiver HCBS services in that they are provided as part of a physician's care plan. Generally, they include "part-time nursing and home health aide services provided by a Medicare approved home health agency; and medical supplies, equipment, and appliances for home use" (Amaral 2010). In contrast, waivers allow for a "more expansive" mix of services and/or equipment that do not require a physician's order (Amaral 2010). Moreover, optional personal care benefits may constitute services similar to those provided by waiver programs (Ng, Stone & Harrington 2015). Although optional, they constitute a state plan and, as such, must comply by the aforementioned federal requirements (Schneider and Garfield 2002). It is perhaps this inflexibility that has made the 1915(c) waivers a relatively more popular option for states.

2.2 Previous Research

Despite the popularity of 1915(c) waivers, few evaluations of them have been done and they are outdated. A review of the literature identified only six waiver-focused evaluations of aggregate Medicaid LTC spending. In a study of Oregon, Washington, and Wisconsin, the US General Accounting Office (GAO) (1994) compared average Medicaid spending per beneficiary in a nursing home relative to a waiver program, and found that the cost of the former exceeded that of the latter. Accordingly, the authors concluded that HCBS Medicaid waiver programs lower LTC spending. As Grabowski (2006) notes, this conclusion has a major flaw in that "it considers average costs per recipient, rather than aggregate Medicaid spending in comparing HCBS waiver

and nursing home expenditures." Given that nursing home costs include room and board, the study's finding should not be surprising. The fact that waiver programs can incentivize people who would not otherwise have entered a nursing home to receive HCBS was unaccounted for (Grabowski 2006).

A 1996 study by Alexcih et al. analyzed whether HCBS waiver spending impacted total Medicaid LTC spending in three states: Colorado, Oregon, and Washington. While this study considered total aggregate Medicaid spending, the study's methodology did not account for state- and time-varying factors (Grabowski 2006). Additionally, like the GAO (1994) study, the selection of states raises external validity studies. Nonetheless, the authors find that savings were made as a result of the waiver program. More recent state-level studies have provided further evidence of cost offsets (Kaye, LaPlante, and Harrington 2009; Harrington, Ng & Kitchener 2011; Kaye 2012); however, as Konetzka (2014) notes, "these studies are inherently difficult to interpret due to potential selection bias and ecological fallacy."

Amaral's (2010) study on the effect of waiver participants on aggregate Medicaid LTC spending represents the most relevant study to date.[7] However, her study period does not extend beyond the year 2000, and she does not control for political factors. The former point is important as many of the abovementioned studies suggest that while waiver HCBS provision may increase aggregate LTC costs in the short-term, "it is clear that states offering non-institutional alternatives do not generally suffer any long-term financial penalty as a result" (Kaye, LaPlante,

[7] In his dissertation, Boyer (2013) attempts to estimate the impact of waiver spending on institutional care spending through both fixed effects and instrumental variable analyses. Unlike in this paper, he does not examine the impact of waiver spending on total LTC or state plan HCBS spending. He also does not include a decomposition analysis (see section 2.4), and his selection of independent variables vary from mine.

and Harrington 2009). For this reason, Amaral's (2010) findings "that there is no evidence of substitution from institutional care to the HCBS waiver program" may have been overlooked. Moreover, not controlling for political factors would have, in my view, confounded the results. Levitsky (2014), for example, reminds us that to the extent that there is a gap between the LTC needs of Americans and the capacity of social programs to address those needs, that gap is often the result of "deliberate efforts by political actors to prevent the recalibration of [LTC] programs" (Hacker 2004).

Overall, despite 1915(c) waivers being introduced almost three decades ago, evidence regarding their impact on Medicaid LTC spending remains weak and outdated. Following Grabowski, Ohsfeldt, and Morrisey's (2003) and Amaral's (2010) methodological approaches, this paper attempts to address this gap in knowledge.

2.3 Conceptual Framework

My empirical investigation of the 1915(c) waiver program's effect on LTC spending requires an understanding of the two different types of waiver participants (Amaral 2010). One group consists of individuals that do not participate in Medicaid until they participate in a waiver program. This group creates the woodwork effect (Grabowski 2006). The second group consists of Medicaid recipients that would otherwise be receiving institutional care. This is the group that the waiver program is intended to assist and is hereafter referred to as the *focus group*. In Table 2.1, I attempt to hypothesize the effects of both groups on three Medicaid spending categories: institutional care spending, state plan HCBS spending, and aggregate LTC spending. While the data used for the empirical analyses (see section 2.5) are not

categorized based on the types of participants, distinguishing between the two groups, as Amaral (2010) suggests, helps inform my predictions.

Medicaid Expenditure Category	HCBS Waiver Spending, by Participant Category		Total Waiver Spending, all participants
	Woodwork Group	Focus Group	
Institutional	(-)	(-)	(-)
State Plan HCBS	(?)	none	(?)
Total LTC	(+)	(+)	(+)

Table 2.1: Expected Impact of Waiver HCBS Spending

Note: The first two columns show the expected impact of waiver spending, by participant group, on different categories of Medicaid LTC expenditures. The second, third, and fourth row of the last column reflect my predictions of what I aim to estimate.

First, I predict that both the woodwork and focus group will have a negative impact on institutional care spending. This prediction is derived from two findings. In an instrumental variable, individual-level analysis, Guo, Konetzka and Manning (2015) find that a $1000 increase in Medicaid home care expenditures avoided 3 days in nursing facilities and reduced Medicaid nursing facility costs by around $350 among the elderly (65+). Similarly, Muramatsu et al. (2007) find that increased HCBS spending is associated with a 35 per cent reduced risk of nursing home admission among childless seniors. However, both of these studies do not focus on waiver spending, and Muramatsu's (2007) approach is particularly prone to ecological fallacy (Konetzka 2014). Additionally, some evidence suggests that the woodwork group can raise nursing care costs. Amaral (2010), for example, finds that during the 1990s, the number of waiver participants had a positive effect on institutional expenditures. She attributes this to the

waiver program's "flexibility." As Ng, Stone and Harrington (2015) note, states can place a limit on the number of participant "slots" per waiver. Therefore, "it is possible that if the waiver program entices people to enroll in Medicaid for the first time, but then does not provide the expected services, some of these new entrants may transition to an institution" (Amaral 2010).[8]

Moreover, there is no evidence to believe that the woodwork group would have a certain impact on state plan HCBS spending. However, given the long waitlists associated with some waiver HCBS services (Ng, Stone & Harrington 2015), and the fact that regulatory oversight of home care services has historically been weak (Komisar 2002), it may not be surprising to find state plan HCBS programs' coverage extending to non-eligible beneficiaries. Contrastingly, I do not expect institutional care recipients eligible for waiver HCBS to increase state plan program spending since the state plan HCBS would have been available for them at the point of institutionalization.

Finally, while I predict that both the woodwork and focus groups will have a negative effect on institutional expenditures, I do not expect that the effect will be large enough to offset the costs of increased waiver (and potentially state plan program) spending (Guo Konetzka & Manning 2015). Therefore, I predict that the net effects of both types of participant groups will increase total Medicaid LTC spending.

[8] Alternatively, some waiver enrollees may transfer to a nursing home because waiver services are insufficient (Amaral 2010), or because the waiver upon which they rely does not get renewed.

2.4 Methods

I evaluate the fiscal impact of the waiver program in three ways. First, I analyze the effects of waiver spending on aggregate LTC spending. In doing this, I attempt to resolve the issue of whether waiver services are budget neutral, or even budget saving as some states argue (Grabowski 2006). I then examine the effects of waiver spending on institutional LTC spending. If waiver spending is associated with higher aggregate LTC costs, it is important to know whether this is partially attributable to increased use of institutional services. Finally, I estimate the effects of waiver spending on state plan HCBS spending. Given the overlap of certain services, there is reason to believe that waiver program insufficiencies may incentivize some people to receive state plan benefits. For example, a recent Kaiser Foundation report notes that "most of the increase in overall HCBS enrollment from 2013 to 2014 is due to a 27 percent increase in home health state plan service enrollees" (Watts & Musumeci 2018).

In order to examine the effect of waiver spending on different Medicaid LTC spending categories, I estimated fixed-effects models of the general form:

$$M_{st} = \beta_0 + \beta_1 WAIVER_{st} + \beta_2 X_{st} + \beta_3 state_s + \beta_4 year_t + \varepsilon_{st} \quad ,$$

where M_{st} is the level of different Medicaid LTC expenditures (explained further below) for state *s* at time *t*; $WAIVER_{st}$ is level of waiver expenditures; X_{st} includes a vector of political, economic, and demographic control variables; *year* is a time-specific intercept (a vector of year dummy variables); *state* is a state specific intercept (a vector of state dummy variables); and ε_{st} is a mean-zero random error.

Across different specifications of the model, M_{st} consists of institutional care, state plan home- and community-based care, and total LTC Medicaid spending. These spending measures were logged.

The parameters of the above equation were estimated using a least-squares model. The state fixed effects "capture all factors that are specific to a particular state and remain largely invariant over time"; for instance, geographic characteristics (Grabowski, Ohsfeldt & Morrisey 2003). Contrastingly, the year fixed effects "capture factors that are common across all states in a particular year, such as federal nursing home policies and the progress of health care technology" (Grabowski, Ohsfeldt & Morrisey 2003). Thus, the basic identification strategy inherent in this methodological approach "purges the unobserved and potentially confounded cross-sectional heterogeneity," by relying on within-state variations in waiver spending between 2001 and 2010, and "by using those states that did face changes in policies as a control for unrelated time-series variation" (Grabowski, Ohsfeldt & Morrisey 2003).

To further analyze the effect of waiver spending on Medicaid LTC spending, I decomposed nursing home Medicaid expenditures into per diem Medicaid price and Medicaid recipient days (see Tables 2 and 3 for variable details). As per Grabowski, Ohsfeldt and Morrisey (2003), such "decomposition allows a test of whether price and quantity effects were imbedded within the overall expenditures results." For example, it could be the case that higher waiver spending "leads to a large increase in recipient days, but that this increase was not reflected in higher Medicaid expenditures due to a decrease in Medicaid [nursing home] payment rates"

(Grabowski, Ohsfeldt & Morrisey 2003). This supplementary analysis is limited to the period 2001-2009 because state per diem rates for 2010 were not available.

2.5 Data

State-level data for the period 2001 through 2010 were collected from secondary sources (see Tables 2.2-2.5). The independent variables were lagged one year because they are likely to take some time to have any impact and because this alleviates some concerns related to endogeneity.

The District of Columbia (DC), Alaska, Arizona, Hawaii, Nebraska, and Wyoming were excluded from the analysis. I excluded DC because many policy parameters are determined at the federal level; Alaska, Hawaii and Wyoming were excluded due to missing data; Arizona was omitted because the state does not run a 1915(c) waiver program; and Nebraska was excluded because state legislators do not run with a party affiliation. Vermont is included in the analyses only through 2005 since it terminated its 1915(c) waiver program in 2006 in favor of the 1115 waiver program. Rhode island is included in the analyses only up to 2008 for the same reason. Ultimately, the sample size included 443 observations from 45 states. While 32 states operated personal care programs (Ng, Stone, & Harrington 2014; Thompson et al. 2016) during the study period, only 29 of the 45 states included in this study opted for optional personal care programs. All 45 states, however, ran 1915(c) waiver and mandatory state home health programs.

As noted, this study considers examines three dependent variables concerning Medicaid LTC spending (see Table 2.2 for descriptions and sources; Table 2.3 for descriptive statistics). The key independent variable is the level of waiver spending. All monetary values were logged and

expressed in 2004 dollars using the Consumer Price Index to adjust for inflation and the 2008-09 recession, and reflect aggregate expenditures regardless of the share paid from state and federal funds.

Dependent Variable	Description	Source
Total LTC Spending ($)	State-level Medicaid LTC spending (in 1000s of $); includes spending on 1915(c) waiver, state plan, and other HCBS programs	CMS Form 64 data via CMS (2018)
Total Institutional Care Spending ($)	State-level institutional (i.e. nursing) care spending (in 1000s of $)	CMS Form 64 data via CMS (2018)
Total State Plan Program Spending ($)	State-level state plan spending (in 1000s of $); including mandatory home health benefit and optional personal care benefit spending	CMS Form 64 data via CMS (2018)
Average Medicaid Per Diem[a] ($)	Total state-level Medicaid institutional care spending divided by the total number of Medicaid days in a state's nursing homes	LTC Focus (2018)
Recipient Days[b]	Total number of Medicaid-funded days in a state's nursing homes (in 1000s); obtained by dividing total state-level Medicaid LTC spending by state's average Medicaid per diem	CMS Form 64 data via CMS (2018) and LTC Focus (2018)
[a,b] Data only available for 2000-2009.		

Table 2.2: Description and Sources of Dependent Variables, 2001-2010

Variable	Mean	Standard Deviation	Min	Max
Total LTC Spending[a] ($)	2394753	3076498	195492.6	2090000
Total Institutional Care Spending[b] ($)	1454068	1790699	91815.77	1100000
Total State Plan Program Spending[c] ($)	608517.3	818644.9	34924.32	7596411
Average Medicaid Per Diem[d,e] ($)	151.157	29.405	92.89	230.4
Recipient Days[f]	15721.29	16924.05	1137.39	100844.4
[a,b,c,d] CPI adjusted to 2004 dollars. [e,f] Based on 2000-2009 data.				

Table 2.3: Descriptive Statistics, Dependent Variables, 2001-2010

My empirical model controls for a number of political, economic, demographic and supply variables likely to influence Medicaid LTC expenditures (see Table 2.4 for descriptions and sources; Table 2.5 for descriptive statistics). Although I discuss the expected effects of the these variables below, the economic variables include a state's per capita income and poverty rate; the demographic variables include a state's elderly, Black, and Hispanic populations; and the political variables include the party affiliation of the governor and the share of a state's legislature that is Democratic. I also control for the supply of certified nursing home beds.

Higher per capita incomes are expected to reduce the number of people eligible for Medicaid and reduce Medicaid LTC expenditures. Since the federal government determines each state's Federal Medical Assistance Percentage (FMAP) based on its income, I excluded the FMAP from my analysis due to the potential issue of multicollinearity. As Grabowski, Ohsfeldt and Morrisey (2003) note, "the per capita income measure [encompasses] the effect of the federal match rate on Medicaid expenditures." Moreover, a state's poverty rate is expected to reduce a state's fiscal capacity to pay for Medicaid LTC services. In such circumstances, other types of Medicaid-funded care (i.e. for infants and pregnant women) are expected to receive higher priority.

In terms of demographic factors, a bigger elderly population (people 65 years of age and older) is likely to use more LTC services and thus, increase Medicaid LTC expenditures. Moreover, given that both African American and Hispanic persons have historically used formal LTC at a lower rate than their White counterparts (Cagnee & Agree 2005; Fennell et al. 2010), it could be the case that a larger minority population negatively impacts a state's Medicaid LTC expenditures. On the other hand, given that both these groups suffer from higher disability rates than white

persons, it could be the case that these minority groups only resort to institutional care when family/informal care is no longer possible, which can in turn drive up Medicaid LTC spending. In any case, larger Black and Hispanic shares of a state's population are expected to have a significant impact on total LTC spending.

Politically, both a Democratic governor and a more Democratic legislature are expected to increase Medicaid LTC spending. After all, "states with Democratic-controlled legislatures tend to fund their [Medicaid] programs more generously than those with Republicans in charge" (Kousser 2002). There is also evidence that Democratic governorships have predictive effects on LTC spending (Harrington et al. 2000). Finally, a greater number of certified nursing home beds is expected to increase LTC expenditures.

Variable	Mean	Standard Deviation	Min	Max
Total Waiver Spending[a] ($)	486158.5	583496.8	21710.03	5968029
Personal Income[b] (in 1000$)	33.3198	5.437	23.63	53.721
Poverty Rate (%)	12.055	3.133	4.5	23.1
Elderly Population (%)	12.771	1.595	8.511	17.524
Black Population (%)	11.753	9.744	0.449	37.472
Hispanic Population (%)	8.999	9.516	0.683	46.031
Democratic Governorship	0.43115	0.4958	0	1
Democratic Legislature (%)	51.61	14.183	11.429	94.203
Nursing Home Beds (per 100 very old persons, 85+)	0.226	0.130	0.001	0.858

[a,b] CPI adjusted to 2004 dollars.

Table 2.4: Descriptive Statistics, Independent Variables, 2000-2009

Independent Variables	Description	Source
Key Independent Variable		
Total Waiver Spending ($)	State-level 1915(c) waiver care spending (in 1000s of $)	CMS Form 64 data via CMS (2018)
Control Variables		
Personal Income ($)	State-level per capita personal income (in 1000s of $)	US Department of Commerce (2018)
Poverty Rate (%)	Share of state population under 100% federal poverty level	US Census Bureau (2017)
Elderly Population (%)	Share of state population is that 65+	US Census Bureau via CDC (2018b)
Black Population (%)	Share of state population that is African American, all ages	US Census Bureau via CDC (2018b)
Hispanic Population (%)	Share of state population that is Hispanic or Latino, all ages	US Census Bureau via CDC (2018b)
Democratic Governorship	Dummy for whether state governor is Democratic (1=yes)	National Governors Association (2015)
Democratic Legislature (%)	Share of state legislature that is Democratic	The Council of State Governments (2016)
Nursing Home Beds	Number of beds in certified nursing facilities, per 100 old persons (85+)	CDC (2018)

Table 2.5: Description and Sources of Independent Variables, 2000-2009

2.6 Results

Overall, the results do not suggest that cost savings are occurring as a result of the 1915(c) program (see Table 2.6). The first column in Table 6 reports the results for total Medicaid LTC spending, the second for Medicaid nursing home spending, and the third for state plan HCBS program spending. In both the first and third models, waiver spending had a predictive and large effect (at the 1% confidence level) on the outcome.[1] This leaves little doubt of any cost savings as a result of the 1915(c) waiver program (at least on the aggregate level).[9]

[1] The results reported are robust across various model specifications. For example, while my analyses were conducted under the assumption that the effects of waiver spending on the utilization costs of Medicaid LTC services are not contemporaneous (i.e. not occurring within the same year) (Guo, Konetzka & Manning 2015) the same effects hold when I assume the impact of waiver spending to be contemporaneous.

[9] For comparative purposes, I also performed my analyses using a random effects approach, through which waiver spending had a significant impact on all outcomes. However, "the main disadvantage of a random effects model is that it rests on the rather strict assumption that the random effects are uncorrelated with all the observable variables captured in the regression model" (Grabowski 2018). Put differently, "the assumption is that the random effects

Independent Variable	Ln total Medicaid LTC Spending	Ln total Medicaid institutional care spending	Ln total Medicaid state plan spending
Ln Total Waiver Spending[a] ($)	0.074*** (0.024)	0.021 (0.021)	0.326*** (0.04)
Personal Income ($)	0.025*** (0.025)	0.019*** (0.007)	0.004 (0.0079375)
Poverty Rate (%)	-0.007* (0.004)	-0.012*** (0.005)	-0.002 (0.006)
Elderly Population (%)	0.165*** (0.028)	0.118*** (0.038)	0.046 (0.046)
Black Population (%)	0.065*** (0.019)	0.089*** (0.025)	0.035 (0.030)
Hispanic Population (%)	0.061*** (0.009)	0.039*** (0.013)	0.018 (0.018)
Democratic Governorship	0.010 (0.01)	-0.016 (0.014)	0.046*** (0.018)
Democratic Legislature (%)	0.0004 (0.0009)	-0.001 (0.001)	-0.003** (0.001)
Nursing Home Beds	0.011*** (0.003)	0.021*** (0.004)	-0.004 (0.005)
R-squared (within)	0.577	0.202	0.768
State Fixed Effects	Yes	Yes	Yes
Year Fixed Effects	Yes	Yes	Yes
N	443	443	443

Note: Standard errors are in parentheses.
* Significant at 10% level.
** Significant at 5% level.
*** Significant at 1% level.

Table 2.6: The Effect of Medicaid Waiver Spending on Medicaid LTC, Institutional Care, and State Plan HCBS Spending, 2001-2010

With respect to the independent variables, most had a significant and similar effect (i.e. in the same direction) on total Medicaid LTC and institutional care spending. The exceptions include a Democratic governorship and the share of Democratic legislatures, both of which had an insignificant impact on both outcomes. As anticipated, a state's per capita income and elderly population had positive, predicted effects on both total Medicaid LTC and institutional care

capture all unmeasured variation at the state level that does not correlate with any of the measured effects present in the model; [thus,] if the model is not fully specified, then the random effects model may result in biased estimates" (Grabowski 2018). For this reason, the fixed effects approach is preferred.

spending, whereas the poverty rate had a negative, significant impact on both outcomes. While the shares of a state's population that are Black and Hispanic were expected to have a significant impact on spending, it is interesting to find that this impact was positive given these groups' historical reluctance to use formal LTC. Lastly, a Democratic governorship and the share of Democratic legislatures both had predictive effects on state plan HCBS spending.

Moreover, Table 2.7 reports the results of the decomposition of institutional care spending into per diem payment and resident days' effects. The results here show that total waiver spending did not have a significant effect on nursing home per diem rates. But, total waiver spending had a significant, positive effect on the number of Medicaid nursing home recipient days, which suggests that waiver spending may increase institutional care spending. This increase, however, may not have been great enough to generate a significant effect in the non-decomposed model.

Limitations. While my findings contradict conventional wisdom that 1915(c) waivers save money, there are reasons to view the findings with caution. First, "state fixed effects provide important controls for the unobserved and state-specific determinants of Medicaid expenditures that could confound policy evaluations" (Grabowski, Ohsfeldt & Morrisey 2003). However, a notable disadvantage of the fixed effects method is that such controls "exhaust much of the variation that exists in the data making it difficult to precisely estimate the coefficients of the other included explanatory variables" (Grabowski 2018).

Second, there is potential endogeneity of the Medicaid spending and waiver spending variables because a state's level of Medicaid LTC spending and waiver spending might be determined

simultaneously. This is especially a concern in the first model specification, where the primary independent variable is part of the outcome. In this case, the correlation between waiver spending and the residual is not zero, as is required to obtain unbiased estimates using ordinary least squares (OLS) regression. To address this issue, I lagged the independent variables. The standard approach to addressing this endogeneity issue is to employ instrumental variables (IV). However, it is difficult to conceive of variables that constitute determinants of waiver spending but not state Medicaid LTC expenditures.

Independent Variable	**Ln Medicaid Per Diem Rate**	**Ln Recipient Days**
Ln Waiver Spending[a] ($)	0.004 (0.018)	0.071*** (0.028)
Personal Income ($)	0.018*** (0.004)	0.01 (0.006)
Poverty Rate (%)	-0.002 (0.003)	-0.007 (0.004)
Elderly Population (%)	0.096*** (0.023)	0.103*** (0.036)
Black Population (%)	0.019 (0.015)	0.056** (0.024)
Hispanic Population (%)	0.012* (.013)	0.049*** (0.012)
Democratic Governorship	0.015* (0.008)	-0.008 (0.013)
Democratic Legislature (%)	-0.0008 (0.0007)	0.001 (0.001)
Nursing Home Beds	0.005** (0.005)	0.005 (0.003)
R-squared (within)	0.606	0.475
State Fixed Effects	Yes	Yes
Year Fixed Effects	Yes	Yes
N	398	398

Note: Standard errors are in parentheses.
* Significant at 10% level.
** Significant at 5% level.
*** Significant at 1% level.

Table 2.7: Decomposed Model: The Effect of Medicaid Waiver Spending on Medicaid Nursing Home Per Diem and Recipient Days, 2000-2009

Another possible approach to the potential endogeneity would have been to employ an interrupted time-series analysis to estimate the effects of a "clear cut change in policy," (Hu et al. 2017) such as the Olmstead decision. In addition to data availability issues, however, the decision is not necessarily a "clear-cut" exogenous change. As Amaral (2010) and Thompson et al. (2016) note, the 1990s reflects a dramatic expansion of the waiver program as a result of legislative changes made in 1994 even before the Olmstead decision in 1999.

2.7 Discussion

Waiver spending was found to have significant positive effects on total Medicaid LTC and state plan HCBS spending, suggesting that cost savings are not occurring as a result of the 1915(c) waiver program. Although waiver spending did not have a statistically significant effect on Medicaid institutional care spending, it did affect Medicaid recipient days in the decomposed model, further suggesting that cost savings (while insignificant) are not occurring.

The results shed some light on how the waiver program operates. As mentioned in section 2.1, waiver participants must meet their state-level criteria for institutional care in order to receive services. However, given the weak oversight of the budget neutrality requirement, it seems that targeting has, as Grabowski (2006) suggests, been less than perfect. This is reflected in the positive association between waiver spending and total LTC spending, which, in spite of the endogeneity issues discussed above, suggests the existence of a woodwork effect.

Interestingly, my results suggest that waiver spending may have unintended consequences on LTC spending beyond the woodwork effect. Specifically, while waivers were designed to discourage people from receiving institutional care services, my results in the decomposed model

suggest that they may create an incentive for more participants to believe that they might be able to receive HCBS but then enter a nursing home. This is likely attributed to an insufficient supply of waiver services.[10]

In a recent review of state policies that can restrict beneficiary access to Medicaid HCBS, Ng, Stone and Harrington (2015) find that as waiver programs place hourly or monetary limitations on their services, waitlists for HCBS are growing.[11] For example, "in 2010, 40 states reported waiting lists in 149 waivers." There were a total of 428,571 persons on these wait lists, reflecting "a 64% increase over the 260,916 persons on 102 waiver wait lists in 30 states in 2005." Meanwhile, "in 2010, the average wait time across the nation for an individual to obtain waiver services was 21 months." Such circumstances may indeed incentivize would-be beneficiaries to at least consider institutional care.

Furthermore, my results indicate that waiver spending is associated with increased state plan HCBS spending. While there were no a priori expectations in this regard, it is plausible to think that, given then abovementioned circumstances, those interested in waiver services but unable to

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[10] While it would have been unreasonable to expect Medicaid institutional care spending to decline once the 1915(c) waiver program was established in 1981 (because it takes time for home care agencies to either expand their capacity or enter the market to meet the new demand for HCBS), it is reasonable to expect that, by 2001, more people are resorting to waiver HCBS in place of institutional care services. This is unless the targeting of people eligible for institutional care (and thus HCBS) is so "loose" that the supply of waiver HCBS relative to those deemed eligible is insufficient (Swartz 2018).

[11] Shortly after the start of the 1915(c) waiver program, states had to (as a means of meeting the cost neutrality requirement) demonstrate that a bed in a Medicaid-certified institution was available or would be available if a certificate of need (CON) request were filed for each waiver participant (the so-called "cold bed" requirement). However, by the early 1990s, this rule was "loosened" and waitlists for waiver-based HCBS started to grow. At the same time, waitlists for nursing home beds were gradually eliminated. Therefore, while such waitlists are intended to limit the growth of LTC spending, they may encourage the use of other types of care and thus have a positive effect on total spending.

receive them may consider mandatory state plan HCBS. Although “home health and state plan personal care programs [offer] a more limited array of services than waiver programs,” some services overlap (Ng, Stone & Harrington 2015). Further, the fact that some states seem to be expanding their state plan programs may serve as an added incentive. For example, Ng, Stone and Harrington (2015) note that, in 2007, Kansas expanded its provision of HCBS to include personal care benefits (that is, in addition to the mandatory home care benefits already in place). Similarly, as of 2010, 21 states with the personal care option allowed (and paid) family members of participants to be providers, whereas in 2005, only 10 states offered this option.

Overall, my findings suggest that 1915(c) waiver programs have, as Amaral (2010) notes, “the potential to create a situation for spending growth rather than cost control.” While waiver program administrations have various strategies at their disposal to control costs, it seems intuitive to expect LTC spending to decrease as a result of waiver program expansion. Yet, my findings suggest that the opposite effect is occurring.

2.8 Conclusion

While previous studies have suggested that 1915(c) waivers save LTC costs, and that specifically “expansion of HCBS appears to entail a short-term increase in spending, followed by a reduction in institutional spending and long-term cost savings” (Kaye, LaPlante & Harrington 2009), my fixed effects strategy suggests otherwise. The policy implication that emerges from this finding is straightforward. From a budgetary perspective, it appears that state legislatures should reconsider their expectations of the waiver program. Based upon an analysis of nine years of data, from 45 states, it appears that those states with the greatest waiver spending also

experienced the greatest growth in Medicaid LTC expenditures. Consideration of alternative empirical specifications suggests that this finding is robust and not an artifact of the empirical strategies employed or the states selected. Although there may be unique state-specific cases where waiver programs may lead to some cost savings, this study did not find evidence in the aggregate that waiver spending limits either total Medicaid LTC, institutional care, or state plan HCBS spending.

However, as Grabowski et al. (2010) observe, while the "focus on cost savings is often a political necessity in the context of CMS budget neutrality restrictions," a better focus would be on "how to deliver HCBS in the most cost-effective manner." To that end, it would be beneficial for "future research on HCBS to move beyond analyses of costs to consider both costs and outcomes," (Grabowski et al. 2010) and for policymakers to consider the results of this study against the benefits of the increased spending.

Moreover, it is worth noting that this study did not consider the relationship between HCBS waiver provision and Medicare services. A majority of Medicaid waiver recipients are also eligible for Medicare: they are "dual eligibles." Before the ACA created the Federal Coordinated Health Care Office (the Medicare-Medicaid Coordination Office) to help coordinate care of dual eligibles, there was "evidence of cost-shifting to Medicare [by Medicaid] in terms of higher inpatient hospital days for dually eligible enrollees" (Grabowski et al. 2010). Therefore, future evaluations of 1915(c) waiver programs would benefit from examining both their cost-effectiveness and their effects on other Medicaid and Medicare programs.

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<u>Chapter 3</u> Germany's System for Long-Term Care: Lessons for Canada

ABSTRACT

Over twenty years ago, public long-term care (LTC) coverage in Germany was much like how it is in Canada today. Programs financed from tax revenues provided means-tested access to nursing home care and, in some areas, to community-based services. In 1995, however, Germany implemented a universal social LTC insurance (LTCI) system that has since served as a model to other nations. Meanwhile, although Canada's elderly outnumber its children, Canada continues to lack a national strategy for LTC. The exclusion of LTC from the Canada Health Act has led to a patchwork system whereby the scope of care, and its access, varies by region. The German experience, however, can provide useful lessons for Canada. I therefore describe Germany's social LTCI system, including its organizational features and the political and social conditions that rendered its establishment possible. I then analyze the system with the intent of drawing policy lessons concerning two issues of importance to Canadian policymakers: financing and providing user-directed care. The goal is to better understand the groundwork that has helped establish and sustain Germany's LTCI system as it is designed, and whether Canadian policy actors can replicate some of this work in pursuing their own social LTCI system.

3.1 Social Insurance for Long-Term Care: The German Model

Despite considerable media attention (i.e. Payne 2017), Canada's ability to meet the LTC needs of its aging population remains a pressing policy concern. Projections for the future, up to two times the current number of disabled elderly by the middle of the century (Bohnert, Chagnon & Dion 2014), have sparked debate regarding how much public LTC will cost in the future and whether economic growth will be adequate to finance such costs. Less discussed, however, is the nature, scope, and funding sources for future LTC services (Grignon & Bernier 2012). Such uncertainties – within the context of evolving family structures and preferences – raise a number of policy challenges for federal and provincial/territorial governments alike.

In the context of considering LTC policy alternatives for Canada, it may useful to look to Germany (Campbell, Ikegami & Kwon 2009). As of 1995, Germans 65 years of age and older accounted for around 16 per cent of the population – one percentage point less than Canada's elderly share of the population today (Grant & Agius 2017). In order "to handle the anticipated need for LTC and the financial burden in paying for them, Germany introduced a mandatory [social] LTC insurance system that became operational in 1996" (Geraedts, Heller & Harrington 2000). Germany's system has long been recognized for its political and financial sustainability, as well as for being accommodating to its beneficiaries' preference to receive care at home rather than in institutional settings. Therefore, a careful examination of the German LTC insurance (LTCI) system may provide useful insights to Canadian policy debates concerning the future of LTC financing and provision.

To better understand the development and design of the German LTCI system, I conducted a series of site visits and interviews with LTC experts and providers in Germany between 2017 and 2018. In addition, I reviewed published literature, program reports, and administrative data. In what follows, I provide an overview of the German LTCI system, including the political and social context in which it was founded, and its organizational features. In sections 3.2 and 3.3, I analyze the system with the intent of drawing lessons concerning two policy areas of importance to the Canadian government: financing and providing user-directed care.

3.1.1 Analytic Approach

I have chosen to take a case study approach for it is known to "produce important contextual knowledge that is needed for a nuanced view of reality" (Flood 2015). I expect this knowledge will help Canadian policymakers better understand the groundwork that has helped establish and sustain Germany's LTCI system as it is designed, and whether Canadian policymakers can replicate some of this work in developing their own social insurance system for LTC. Accordingly, the goals of my analysis are three-fold: (1) to determine what political and social conditions rendered a social LTCI system possible in Germany; (2) to analyze Germany's approach to financing and providing user-directed care within a social insurance framework; and (3) to draw lessons regarding revenue generation and benefit design relevant for the Canadian context.

To that end, it is important to clarify the boundaries of this paper given the variability of services and care needs associated with LTC (Fernandez & Gori 2017). In this paper, I adopt a definition of LTC used by the Organization for Economic Cooperation and Development (OECD)

(Colombo et al. 2011): “a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living.” This contrasts with short-term or acute are, which is concerned with restoring health. Indeed, LTC can also be defined by reference to care setting. Whereas acute care is delivered in hospitals and clinics, LTC is often delivered at home, at retirement homes, and in institutional facilities (i.e. nursing homes). While the analysis in financing is not restricted to any care setting, my analysis on Germany’s experience in providing user-directed care is focused on care at home.

Instead of providing a detailed survey of Germany’s social LTCI system, this paper’s aim is to shed light on the system’s unique features and to draw relevant lessons from salient policy reforms. By reforms, I mean both “major policy changes introduced with an explicit policy goal to alter [the design of the] system and incremental transformations that redefine the system even in the absence of specific changes in legislation” (Fernandez & Gori 2017). Indeed, there exists evidence in this regard from a number of countries; however, my analysis is focused on Germany because it is one of few countries that has had the greatest reform activity and evidence about its impact is more readily available. With respect to the timeframe considered, the paper focuses on recent policy reforms, reaching back no further than the 1990s.

Indeed, LTC systems vary in how they are organized. As Fernandez and Gori (2017) note, “their features and performance are interconnected with other elements of the welfare system and reflect, for example, historical, cultural, and environmental factors.” As such, the analysis in this report does not intend to come up with infallible recipes for LTC policy reform. The goal is to

examine different policies that have been adopted in response to different challenges, and to accordingly derive applicable lessons for future LTC policy in Canada.

3.1.2 Political Background

Known for "balancing universal public entitlements with personal and family responsibility," the German social LTCI scheme is the most recent augmentation to Germany's comprehensive social safety net (Nadash, Doty & Schwanenflugel 2017). Enacted in 1994, the LTCI Act joined the Health Insurance of Workers Law (1883), the Accident Insurance Law (1884), the Old Age and Invalidity Insurance Law (1889), and the Unemployment Insurance Law (1927) (Solsten 1995) to become the "fifth pillar" of the country's social security system (Busse et al. 2017). It aims to reduce the physical, mental, and financial burdens that result from frailty and dependency, and to secure basic provision for individuals at different levels of assessed need (Doetter & Rothgang 2017).

A social insurance model for LTC was adopted because it would be consistent with Germany's abovementioned social insurance systems and because it would be based on the same principle that defines Germany's statutory health insurance: solidarity (Geraedts, Heller & Harrington 2000; Busse et al. 2017). The latter "manifests itself both on the income and the provision side: all insured persons, irrespective of health risk, contribute a percentage of their income, and these contributions entitle the individuals to [LTC] benefits according to [their assessed level of] need – irrespective of their socioeconomic situation, ability to pay, or geographical location" (Busse et al. 2017). In this sense, the German LTCI system is regarded as a success story both within and outside Germany. Its establishment represents a "path-breaking" moment in a period otherwise

known for retrenchment (Doetter 2016). In what follows is a discussion of the actors, institutions and conditions that made this moment possible.

Institutions and Actors in Germany LTC Policy

Understanding the establishment of Germany's social LTCI system requires a basic knowledge of the country's political system. The political arena for LTC reform lies in the legislative branch, which comprises the parliament (Bundestag) and the Federal Council (Bundesrat). While parliament is a directly elected body, the Bundesrat represents the governments of the sixteen states (or *Lander*). In general, the Parliament has the superior role; it is empowered to elect the Federal Chancellor and has the right to enact and amend legislation (Gotze & Rothgang 2010). While the Bundesrat does not have the right to introduce legislation, "it must approve, and can veto, any bills that pertain to state government interests" (Campbell & Morgan 2005). As such, the passing of the LTCI Act required the approval of both legislative bodies (Gotze & Rothgang 2010).

Currently (and for the most of the past few decades), there are two major political parties relevant to LTC reform: The Christian Democratic Union (CDU) and the Social Democratic Party (SPD). Historically, the CDU, together with its Bavarian sister party, the Christian Social Union (CSU), represented the mainstream party of the right, "emphasizing the primacy of the family in terms of care activities" (Gotze & Rothgang 2010). The SPD, on the other hand, represented the mainstream party on the left. While the SPD favored more generous social policies, the party initially supported the male-breadwinner model because "working mothers were negatively associated with the demonized German Democratic Republic" (GDR;

commonly referred to as East Germany) (Gotze & Rothgang 2010). Due to the student protest movements of the late 1960s, however, the Social Democrats gradually shifted their attitude on female employment and extramural care, and began to support policies supporting formal care. As it turns out, the Christian Democrats led the German cabinet in the years leading up to the LTC system's establishment (1982-1998) (Gotze & Rothgang 2010).

Ultimately, German reunification (1990) "merged two contrasting types of family policy: the West German male breadwinner and the East German dual earner model… [which] pushed Germany towards a third family policy" that politicians labelled as "sustainable" (Leitner, Ostner & Schmitt 2008). Generally, sustainable family policy aims to release families from some care obligations, make up for social inequities and generate sustainable human capital by securing payments to social insurance funds (Leitner, Ostner & Schmitt 2008). The next section elaborates on the political process by which this model was finally realized.

The Long Road to Reform

While the LTCI scheme was introduced in 1995, consideration of LTC support can be traced back to the Federal Social Assistance Act of 1962 (Heinicke & Thomsen 2012). The act made clear that LTC was to be "covered by the private income or private savings of the LTC-dependent individual or the individual's family" (Zuchandke, Reddemann, Krummaker 2012) If these resources were exhausted, "helpless" individuals would be entitled to apply for public welfare (Heinicke & Thomsen 2012). Welfare payments were provided only for those identified as needy by locally funded, community-based means-tested programs (Heinicke & Thomsen 2012).

The policy rationale for this system rested on two principles: (1) that "LTC was a private risk, unrelated to one's employability and the market;" and (2) "given the specific and variant needs of the elderly and disabled, the local level would do a better job at delivering services" (Doetter 2016). By the early 1970s, various reports made west German policymakers aware that the status quo was unsatisfactory (Campbell & Morgan 2005). The average pension was "far below the standard servicing rate for nursing home care and private assets [were] regularly exhausted after one or two years" (Gotting, Haug & Hinrichs 1994). As a result, the majority of people living in nursing homes were not able to meet the costs associated with care (including room and board costs), and were thus reliant on social assistance spending. Issues related to the quality of care, facility maintenance, and supply of staff were also raised (Gotting, Haug & Hinrichs 1994). In response, the federal government encouraged the Lander to provide more community-based services. But the "emphasis on institutional care predominated" and state governments began experiencing significant strains on their budgets (Campbell & Morgan 2005). Social assistance spending on LTC increased three-fold between 1970 and 1976 and more than doubled during the decade after (Campbell & Morgan 2005).

At the same time, the feminization of the workforce led to changing expectations. Because caregivers "lacked societal support and frequently had to stop working, their financial circumstances, and thus their motivation to care for their relatives, steadily deteriorated" (Geraedts, Heller & Harrington 2000). Furthermore, respite services from short-term or part-time nursing facilities or home care agencies were almost nonexistent. As a result, the Lander governments gradually amplified their advocacy efforts for a system that better caters to the elderly and their families – so much so that a public LTCI program became a perennial topic for

political debate, with various proposals being contemplated for roughly 20 years, and 16 bills proposed during this period (Geraedts, Heller & Harrington 2000).

As debates ensued, the "first step towards a social dependency insurance scheme" was taken in the passage of the 1988 Health care Reform Act (Schneider 1999). The new law permitted the sickness funds (of the social HI system) to provide LTC assistance to "cases of severe dependency" (Schneider 1999). But this did little to address the growing LTC cost burden; if anything, the new law was a means to garner Lander support for cuts to the health care system (Campbell & Morgan 2005).

The reunification of Germany in 1990 prompted renewed efforts to help the German Lander. Between 1990 and 1994, for example, the West German Lander transferred substantial payments to the East. As "debt levels reached their highest levels since World War II, deficits threatened to strangle all levels of government" (Campbell & Morgan 2005). This is largely due to Germany's system of fiscal federalism, characterized by extensive revenue sharing between all levels of government (see section 3.2). The growing costs associated with nursing care, for example, impacted the pool of resources upon which all Land governments rely on. In this context, "the Lander viewed a redistribution of the burdens of LTC costs as essential for their fiscal well-being" (Campbell & Morgan 2005).

By the early 1990s, the Federal Government in Germany was made up of a coalition comprising the CDU, its Bavarian sister party, the CSU, and the smaller Free Democratic Party (FDP). The Social Democrats (SPD) represented the opposition in the Bundestag. However, the SPD-led

state governments comprised a majority in the Bundesrat and thus had veto power over any LTC reform process (Campbell & Morgan 2005). Many Social Democrats, including SPD-run state governments, supported the idea of social insurance for LTC. The Christian Democrats, on the other hand, were divided on the issue. For example, while CDU-led state governments advocated for comprehensive institutional changes, the Federal Government resisted any such effort. Their governing principles was "that budget consolidation must take precedence over an expansion in social security" (Gotting, Haug & Hinrichs 1994).

Nonetheless, many SDP-led Land governments took use of their power in the federal political process and pressured the Bundestag to adopt LTC as a legislative priority. The "turning point" occurred when then-Minister for Labor and Social Affairs, Norbert Blum (CDU), announced in 1990 that a social insurance scheme against the risk of LTC would be introduced during the next parliamentary session (Campbell & Morgan 2005). This move, incongruent with his previous beliefs (Campbell & Morgan 2005), reinforced the idea that the CDU was a "people's party that could not disregard the interests of the elder generation" (Gotting, Haug & Hinrichs 1994). However, major segments within the CDU remained opposed to this proposal. At party conventions, "a number of party officials insisted that there should be no new social initiatives in the West until the full burdens of reunification were paid for" (Campbell & Morgan 2005) Market solutions were advocated by not only those within the party, but also by employers' groups, the FDP, and the Bundesbank (Central Bank) (Campbell & Morgan 2005).

Ultimately, both CDU- and SPD-run state governments agreed on a public LTCI scheme in line with Germany's traditional social insurance path.[12] A tax-financed scheme would "drain resources out of the general tax pool" (Campbell & Morgan 2005) and a mandatory private system would be disadvantageous in the short-term as benefits would not be made available immediately (Rothgang 2010). These realities "resonated with federal policymaking elites who were faced with the high burdens of reunification and saw a new contributory program as a way to avoid further financial burdens on public budgets" (Campbell & Morgan 2005). A social insurance program was also a more politically feasible solution. Given that the SPD had a majority in the Bundesrat, the CDU-led government had to be sensitive to the SPD's preferences (Campbell & Morgan 2005).

It is interesting that post German reunification, German policymakers expanded the welfare state as a means of alleviating state-level fiscal challenges. LTCI reform also "provided political pay-off" for both the CDU and SPD (Campbell & Morgan 2005). While reform was largely possible due to "the constitutional status and power of the Lander, and the nature of Germany's fiscal federalism," (Campbell & Morgan 2005) both path dependency and policy feedback played pivotal roles in the process. These attributes, as I show in section 3.2, may prove to be fruitful for LTC reform in Canada.

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[12] While there was agreement on a social insurance scheme among most state governments, "many observers at the time expected the reform effort would founder on the contentious issue of how to distribute the costs of the new program between employers and employees" (Campbell & Morgan 2005). In Germany's other social insurance programs (i.e. for health care), employers and employees each pay half of an individual's insurance contribution. Dissatisfied with an allegedly high financial burden, however, "employers and the FDP were strongly opposed to a similar arrangement for LTC, and they demanded measures that would compensate employers for these costs" (Campbell & Morgan 2005). Ultimately, a compromise solution was reached that allowed each Lander to eliminate one mandatory paid holiday. The option was taken up in all Lander except in Saxony; as a result, employees there pay a higher contribution rate than employers (Campbell & Morgan 2005).

3.1.2 Institutional Overview

Germany's mandatory LTCI system was designed to be linked to the national mandatory health insurance (HI) system (Busse & Blume 2014).[13] In "using already established administrative systems, Germany was able to both create economies of scale in administrative capacities and also ease the implementation burden" (Rhee, Done & Anderson 2015). In what follows is an outline of how the LTCI system, while being affiliated with the HI system, is designed to be autonomous in both its financing and management of LTC benefits.

Organization

Coverage. The passage of the 1994 LTCI Act gave way for a mandatory, two-tiered LTCI system. Everyone covered by the social HI system is automatically enrolled in the social LTCI scheme. Moreover, anyone enrolled in a mandatory private HI plan is required to purchase private LTCI coverage from their health insurer. Individuals enrolled in private HI may not enroll in the social LTCI system (and vice versa). At time of writing, around 90 percent of the population was covered via the social LTCI scheme, and around 10 percent via private LTCI plans. As of 2014, more than 80 per cent of beneficiaries were 65 years or older; and more than 55 percent were at least 80 years old (Doetter & Rothgang 2017).

Administration. Social LTCI is administered by LTC funds, which are essentially "branches" of the health system's Sickness Funds (132 as of 2014) (Doetter & Rothgang 2017; Busse & Blumel 2014). Like the sickness funds, the LTC funds are self-governing; they are responsible

[13] HI is mandatory for all German citizens and permanent residents of Germany. It is provided by two means: (1) competing, non-profit, non-governmental health insurance funds otherwise known as "sickness funds" in the statutory HI scheme; and (2) "substitutive" private health insurance (Blumel & Busse 2018).

for collecting members' contributions, negotiating fee schedules, and reimbursing providers (Rothgang 2010). Since the benefits, as well as the contribution rate, are identical across all LTC funds, and given that all expenses are financed by same pool of contributions, there is no competition between LTC funds. Moreover, compulsory private LTCI is administered by private HI companies, which marks "the first time in German welfare state history that private insurance has taken on a public, regulatory task" (Doetter & Rothgang 2017). This refers to the requirement that private HI companies impose a mandate on members to buy private LTCI coverage (Doetter & Rothgang 2017).

Benefits

Eligibility. While entitlement for benefits does not depend on income, Germany's social LTCI system has historically been characterized by a narrow definition of "need for care" as a means of cost control (Doetter & Rothgang 2017; Gotze & Rothgang 2010). Historically, "three levels of dependency were distinguished depending on often assistance [would be] needed and how long it [would take] a non-professional caregiver to help the dependent person" (Rothgang 2010). Given that these measures focused mostly on physical impairments, the LTC Amendment Act (2001) introduced a special benefit of 460 euros a year for those impacted by cognitive impairments (i.e. dementia) (Gotze & Rothgang 2017). The "limited scope of benefits introduced by this reform," however, led to a poor take-up rate "with about 25 million Euros spent across years 2002-2008, or only 10% of the budget allotted for such services" (Doetter & Rothgang 2017). Given the need for a revised definition of "need for care," various other reforms were introduced, the last being the second LTC Strengthening Act (2005) (Doetter & Rothgang 2017).

As of January 2017, eligibility categories are linked to five care levels with the intent of "erasing the distinction in benefits between cognitive and physical disability" (Nadash, Doty & Schwanenflugel 2017) and providing benefits based on an individual's ability to maintain autonomy "in the face of sustained physical, cognitive, and/or psychological impairments" (Nadash, Doty & Schwanenflugel 2017). To that end, the new assessment awards points on items linked to six modules - mobility, cognition, behavior, self-sufficiency, ability to manage treatment/therapy, and social environment - with differential weighting, such that some categories count more than others (Buscher, Wingenfeld, & Schaeffer 2011; Link 2017; Wagstaff 2017).

Beneficiary Benefits. In contrast to what happens in the statutory HI system, benefits granted by a LTC fund are only made available by application and to those that have contributed to the fund for at least two years (Busse & Blume 2017). Moreover, benefits are capped and, as noted above, do not vary based on income or assets, but rather on one's assessed level of need. Those entitled to receive LTC can opt for either home care, nursing home care, and/or "day and night" care benefits, the latter referring to intermittent care in an inpatient facility. In regard to home care benefits, beneficiaries can choose to receive either cash or in-kind benefits. If the latter is selected, beneficiaries can choose to receive services from a range of non-profit and for-profit service providers with whom their insurance fund has contracted (Doetter & Rothgang 2017). Moreover, cash and in-kind benefits may be combined; i.e. if only x per cent of claims for in-kind benefits are realized, $100 - x$ per cent of the cash benefit claim would be available for the beneficiary (Rothgang 2010).

Cash benefits are non-taxable nor are they regulated (Doetter & Rothgang 2017). Thus, it is difficult to ascertain whether they are being used to pay for informal care, or whether the latter is being provided. The only form of control that takes place is when an official representative must re-assesses the beneficiary's care needs (Doetter & Rothgang 2017). Moreover, despite their lower value relative to in-kind benefits, cash benefits seemed to be the preferred type benefit amongst beneficiaries (see section 3.3).

Financing

Payroll Contributions. Germany's social LTCI program follows the "pay-as-you-go" principle. Like in social HI, social LTCI is financed by contributions that are levied in relation to income (excluding assets) up to a certain limit (in 2017, up to 3938 euros per month) (Busse & Blumel 2017). Contributions were initially set to 1.7% of gross wages and equally shared between employers and employees. By 2017, the contribution rate had been raised to 2.55% of gross wages (Doetter & Rothgang 2017). Since 2005, people who are 23 years or older and do not have children "must pay a 0.25 percentage point increased contribution rate" (Busse & Blumel 2014). In the case of unemployment, social LTCI contributions are taken up by the unemployment insurance scheme, whereas those that are self-employed and pensioning have to pay full contributions (Doetter & Rothgang 2017). Maintaining the solvency of the program is not easy: as demand grows and as benefit levels decrease relative to inflation, administrators are typically left with no choice but to raise contribution rates. However, such changes require legislative approval and are thus difficult to introduce (Nadash, Doty & Schwanenflugel 2017). No changes to the contribution rates or benefit levels, for example, were made until 2008

(Rothgang 2010). As a result, new rules on rate adjustments were put in place (Rothgang 2010) and in 2015, a pre-funding scheme was established (Colombo et al. 2011).

Out-of-Pocket Payments. A major criticism of the German social LTCI system is that "benefits are, in general, not sufficient to cover the costs of formal care at home or in a nursing home" (Rothgang 2010). Therefore, in addition to insurance contributions, beneficiaries must often make out-of-pocket payments to meet gaps in coverage (Doetter & Rothgang 2017). For example, in regard to in-kind benefits, beneficiaries receive a budget commensurate with the category of need that they are assigned after an official assessment. The beneficiary then has "full discretion as to which services he/she will take up, based on a catalogue of services available" (Doetter & Rothgang 2017). If the beneficiary needs to spend more than their benefit allows for (i.e. due to the high costs of care in their region), then out-of-pocket payments will be necessary (Doetter & Rothgang 2017).

Private Health Insurance. As noted earlier, private LTCI coverage constitutes a mandatory policy for those that hold private HI. Its members build up provisions during their healthy years and pay premiums based on risk rather than income. In contrast to private HI, however, "risk rating is much less comprehensive; for example, gender and health status are not taken into consideration in calculating premiums; pre-existing conditions may not be excluded from coverage; and private LTCI companies may not charge more than the maximum contribution rate of Social LTCI" (Doetter & Rothgang 2017). Although an important component of Germany's LTCI system, the financing of private LTCI is beyond the scope of this paper.

3.1.3 Next Steps

Remarkably, the German welfare state's expansion to the field of LTC occurred under a conservative government facing the incredible burden of reuniting East and West Germany. The program provides coverage of both home and institutional care services. Since its foundation, it has made incredible progress in addressing its policy goals, namely alleviating the financial burden of LTC off state-level budgets; expanding home and community-based services (HCBS); and providing users with more control over their care (Cuellar & Wiener 2000). In this paper, I examine the German LTCI program, focusing on issues of financing and providing user-directed care. As other countries like Canada examine the experience of Germany, what lessons can they draw upon to inform their own reform efforts? This is the focus of sections 3.2 and 3.3.

3.2 Lessons in Financing

Canada's population is aging. In 2013, seniors aged 65 and over accounted for 15 percent of the population and by 2030, this figure is projected to be 23 percent (Adams & Vanin 2016). Meanwhile, about 14 percent of seniors depend on others to assist them with activities of daily living (ADL) – a proportion that is expected to triple over the next 50 years (Grignon & Bernier 2012). As a result, policymakers face the daunting challenge of "balancing the fiscal burden on taxpayers with the need to ensure that all individuals with LTC needs receive proper care" (Blomqvist & Busby 2012) This is a pressing challenge given that "the front end of the baby boomer generation will reach 75 (a key marker of health care utilization) by 2021" (Wister 2009).

Generally, LTC costs can be financed in four ways: (1) social insurance contributions; (2) general tax revenues; (3) private LTCI plans; and/or (4) private savings (Adams & Vanin 2016). In this section, I aim to analyze the German experience with the social insurance option and to draw policy lessons relevant to the Canadian context. This analysis raises three key issues. First, it requires a general assessment of how LTC is financed across Canada. Second, a rationale for using public funds for funding LTC needs to be made. And lastly, it begs the question of how a social LTCI system can be implemented such that it is political and financially sustainable, equitable, and efficient. The German experience can help inform Canadian stakeholders wrestling with these issues.

3.2.1 Long-Term Care in Canada[14]

Canada's LTC systems are underfunded, negatively impacting patients and their families. Indeed, there has been a push to deliver more home- and community-based services (HCBS) in most provinces; however, insufficient funding means long wait times. As of 2015, for example, 4,500 and 21,500 Ontarians were on waiting lists for HCBS and institutional services, respectively - despite tightened eligibility requirements (Grant & Church 2017). This suggests that the elderly and/or their families are increasingly bearing the costs of LTC, especially women who are more likely to provide informal care (Sinha 2013). The status quo also puts pressure on the health system as there are many patients in acute care hospitals awaiting to be discharged to a LTC facility (Walker 2011).

While LTC financing varies by province, the general reliance is on a mix of tax-based financing and private, out-of-pocket payments. To date, reform ideas "largely accept this status quo and look to squeeze greater efficiencies from the public system or to incent people to save privately for their own LTC needs" (Flood 2015; Blomqvist & Busby 2014). However, given demographic trends, LTC funding gaps should not be remedied by limiting entitlement. Nor are gaps in funding likely to be counterbalanced by a voluntary uptake of private LTCI. In fact, less than one per cent of Canadians hold private LTCI contracts (Grignon & Bernier 2012). There are many possible reasons for this; for example, individuals underestimate their LTC needs in later life and have little incentive to buy private LTCI due to the safety-net of (or at least, the mistaken

[14] *This section is adapted from a grant application submitted to the Canadian Institutes of Health Research, on behalf of Dr. Colleen Flood.*

perception of) publicly financed LTC (Brown & Finkelstein 2007; Pestieau & Ponthiere 2010). Accordingly, decision makers are being prompted to consider LTC reform.

Indeed, reform is challenging; provincial budgets are already stretched and LTC services are not "explicitly considered '[medically] necessarily' services under the Canada Health Act" (Grant & Church 2017). Examining alternative finance models in other OECD countries, however, may offer some solutions. Given Germany's experience with a social LTCI program for over two decades, it is an opportune time to draw lessons from its experience.

3.2.2 The Case for Social Protection

There are two good reasons for creating public LTC coverage mechanisms to complement or substitute family or informal care arrangements (Colombo et al. 2011). First, the cost of care can be high and thus place a significant burden on both LTC users and their caregivers. Second, the need for LTC, including if and when it will develop, its duration, and intensity is uncertain (Colombo et al. 2011). Although some individuals may wish to cover this risk through private insurance, market failures suggest that the latter is inefficient on a societal level (Barr 2010; Colombo et al. 2011).

Mechanisms for prepayment and risk-pooling constitute a solution to the high costs and uncertainty associated with the need for LTC. Such mechanisms can provide protection against catastrophic LTC costs, thereby helping people protect their disposable income and assets, and averting beneficiaries from falling into poverty. They also enable access to LTC services by

offering compensation for at least some of their cost, thus helping to prevent the deprivation of necessary care due to a lack of financial resources (Colombo et al. 2011).

To that end, a mandatory social insurance program is likely to offer more advantages than the tax-financed, means-tested system found in Canada today (see Table 3.1 for a list of advantages and disadvantages) (Scheil-Adlung 2015). While the former generates stable revenues, the latter has been prone to underfunding due to competing public priorities. If everyone pays into a pool, "individuals would have access to coverage when they are chronically ill or disabled without [any] humiliation" of being placed on a waitlist or, in some cases, having to become poor to receive services (Harrington, Stephens & Wagner 2015; Macdonald 2015) (see section below). As of 2017, for example, 26,500 seniors in Ontario went without access to a nursing home bed as the waitlist for LTC services hit a record high (Rushowy 2017).

Moreover, a mandatory social LTCI system would be more efficient than relying on actuarial mechanisms. According to Barr (2010), given uncertainties about future health conditions that might cause people to need LTC and what the costs of such services might be in the future, it is unlikely that a market for private LTCI will be efficient. Insurers cannot accurately assess these factors and, as a result, the threat of adverse selection is high. Therefore, insurers price policies high to compensate not just for the adverse selection risk but also for the uncertainties about future health conditions and costs of care. His conviction that social insurance is a "better fit" in addressing the risks associated with LTC is illustrated in the German experience.

After the passage of the LTCI Act (1994), LTC was "no longer regarded as a negligible residual risk, but as a social risk demanding social protection" (Rothgang 2010). As a result, almost all of Germany's population is now covered, whether in social or mandatory private LTCI, and problems related to the uninsured are minimal. While the benefits are meant to complement informal care arrangements, "topping up" (i.e. through private savings) "can be defended both because people have different tastes, and as a political price for a mandatory system that covers everyone" (Barr 2010). Moreover, given that social LTCI is financed based on the "pay-as-you-go" principal, benefits could be granted almost immediately without a long period of capital accumulation (Rothgang 2010).

Mechanism	Pros	Cons
Tax-based LTC System	• Pool risks for whole population • Potential for cost control • Redistributes between high- and low-risk in the covered population	• Risk of unstable funding and often underfunding due to competing public expenditure
Social Insurance-based LTC system	• Generates stable revenues • Often strong support from population • Provides access to a broad package of services • Involvement of social partners • Revenues collected by autonomous, non-governmental body • Redistributes between high- and low-risk groups in the covered population	• Payroll contributions can reduce competitiveness and lead to higher unemployment • Can lead to cost escalation unless effective contracting mechanisms are in place

Table 3.1: Pros and Cons of a Social Insurance- versus a Tax-Financed-Based LTCI System

3.2.3 Canada's Policy Objectives

In analyzing Germany's experience with financing its social LTCI system, I consider four objectives raised by Canadian stakeholders: political feasibility, financial sustainability, equitable revenue collection, and efficiency. The intent of this section is to draw lessons in each of these categories.

Political Feasibility

(a) History Matters

In developing its public LTCI scheme, Germany stuck to its historical reliance on social insurance. However, while accounting for path dependency is important, it should not, as Palier (2010) suggests, "preclude an examination of the impact of different reforms on social policy." After all, Germany's LTCI reform is not only the result of evolutionary dynamics, but also the result of previous policies.

Hall (1993) argues that the process of policymaking involves three central variables: "the overarching goals that guide policy in a given field, the techniques or policy instruments used to attain these goals, and the precise settings of these instruments" (Palier 2010). Different frameworks and concepts can be used to define the overarching goals. The aforementioned concept of solidarity, characteristic of Germany's social HI system, is one example (Busse et al. 2017). Similarly, different "institutional variables" can be categorized as policy instruments (Palier 2010). The most relevant instruments, however, include a system's mode of access, benefit structure, financing mechanisms, and management arrangements (Palier 2010).

Elaborating on his framework, Hall (1993) describes three types of policy changes. The changes are meant to distinguish the differential impacts that a reform may have beyond "beyond a purely quantitative approach (i.e. more or less retrenchment), and [provide] a means for judging the degree of innovation introduced by a specific reform" (Palier 2010). The first change, a *first order change*, does not entail significant changes. It only involves alterations in the settings of instruments (i.e. raising or lowering benefit levels) without any changes in the overarching goals nor the instruments. A *second order change*, in contrast, involves the introduction of new instruments (i.e. new entitlement rules). Finally, a third order change, while rare, includes simultaneous changes in all three variables: the goals, the policy instruments, and the settings thereof (Palier 2010).

First order changes can be understood as "the initial response that governments turn to when faced with a difficulty" (Palier 2010). For example, in response to the rising levels of poverty among nursing home residents in Germany pre-reform, amendments to the social assistance law were made in 1984 (Campbell & Morgan 2005). Over time, such first order changes start to produce unintended effects. In Germany's case, social assistance spending grew and further strained state budgets. Threatened by the Lander's veto power in the German parliamentary system, policy actors "gradually acquired the conviction that they need to abandon traditional ways of doing things… [and ultimately] consented to introduce some instrumental innovations yet preserve the logic of the system" (Palier 2010). Therefore, "while a first order change may not imply profound changes as far as a historical path is concerned," it can lead to more substantial second order changes (Palier 2010).

As section 3.1 describes, the legislation of Germany's social LTCI represents a consensual reform policy, led by two political parties (the CDU and SPD) and Land-level advocacy. While a compromise on the benefit side (grades according to need classes with no full-cost coverage) was made, legislation was delayed due to debates on how to finance the new system. The issue was whether to opt for a tax-financed scheme or an additional social insurance scheme. It was a "principled conflict over either creating or warding off a precedent for future social policy development" (Hinrichs 2010). In the end, the two parties agreed to expand Germany's then four-pillared social security system with a social LTCI system – a system that would operate through the sickness funds of the social HI system. In choosing this financing route, the scheme avoided further burdening the federal budget post German reunification and applied a policy technique "most familiar and comprehensible to the public: contribution payments entitling contributors to non-means-tested benefits in the case of risk occurrence" (Hinrichs 2010). As such, one can define Germany's social LTCI legislation as a path-dependent, second order reform.

Under the new scheme, both the contribution rate and benefit levels were fixed by law. By 2008, a fiscal crisis left the government with no choice but to alter the contribution rate. The rate was raised by 0.25 percentage points (from 1.7%) such that benefit levels can be updated. By " resorting to higher contributions, the 2008 reform partly reversed the 'policy drift' of the scheme" (Palier 2010). Therefore, while the social LTCI scheme was created to relieve pressure from Germany's revenue sharing system - especially as reunification shrunk the pool of tax resources available (see next section) – a poor economy left the system in despair of further reform. Nonetheless, the LTCI system remained intact (Hinrichs 2010).

This analysis of Germany's LTC reform process draws two key lessons for Canada. First, in addition to helping policymakers differentiate between first order, second order, and third order changes, the German experience points attention to the potential consequences of different types of policy change and the type of precedence to which LTC reform might be attributed. In moving past a first order change and creating a social LTCI scheme, German policymakers did not only instill new policy instruments to provide universal LTC coverage but also instruments to safeguard the new scheme as the fifth pillar of Germany's social security system.

Arguably, Canada can also move beyond first order changes, which to date have largely entailed restricting eligibility requirements to cut costs (Flood 2015). For example, there are three major social insurance programs in Canada that render a path-dependent reform possible. These programs include Employment Insurance, the Workers' Compensation system, and the Canada Pension Plan (and its twin Quebec Pension Plan). The fact that the federal government is responsible for the Canada Pension Plan may serve as an impetus for a federal LTC program. As LTC is most relevant to senior citizens, Canadians might find it appropriate (at least from a path dependency perspective) for the federal government to assume control of another "elderly program."

While it would be difficult to link a potential social LTCI system with Canada's (tax-financed) health systems in the way that Germany did, enforcing at least some principles of the Canada Health Act (public administration, portability, comprehensiveness, universality and accessibility) can prove to be promising in, for example, ensuring portability and that no incentives are in place

for people to move to another province when they get older and need LTC services. Notably, this argument holds even if the provinces and territories administer their own social LTCI programs.

From a sustainability perspective, the German experiences teaches Canadian policy actors to not only focus on policy feedbacks "that block further changes [or safeguard the system] (as in path dependency/resilience theories) but also on 'reform feedbacks' that can create opportunities for further changes over time" (Palier 2010). In not thinking about reform feedbacks, policy actors risk letting policy drift. Had the drift not been reversed in 2008, the legitimacy of the relatively new LTCI scheme would have been at stake (Rothgang 2010).

The second lesson is that governmental action is not a rational response to social problems like population aging and the increased demand for LTC. As Palier (2010) notes, "if socio-economic transformations like ageing are the triggers of welfare state reform, the timing, the content and the politics of these reforms have to be understood with reference to many more variables than just the problems they are supposed to solve" (Palier 2010). German reunification, for example, was a significant impetus for reform. So was the role of the SPD in the Bundesrat, Generally, three variables can be taken into account as policymakers consider a political move: ideas, institutions (i.e. the broader political system) and interests (Palier 2010). The next section elaborates on the latter two variables.

(b) LTC Reform: A Challenge to Canadian Federalism

The German case provides a number of lessons concerning the impact of federalism (or the broader political system) on the politics of LTC reform. First, policymakers shouldn't assume

that subnational governments always oppose an expanded federal role in social policy (Campbell & Morgan 2005). Indeed, the historically strong Québécois resistance to federal social spending contradicts this belief (Cameron & Simeon 2002; Campbell & Morgan 2005). However, some provincial and territorial governments were happy to yield responsibility for pension insurance to the federal government, while retaining their control in areas like health care. A similar situation holds in Germany, "where the Lander have sought to preserve their discretion over social assistance while allowing the federal government to assume other areas of social policy," like LTC (Campbell & Morgan 2005).

In fact, one can interpret Germany's expansive social security system as part of an "intergovernmental bargain" to lighten Land-level fiscal burdens (Campbell and Morgan 2005). As per Manow (2005), since "contributory finance was less threatening to the states and reduced their welfare burdens [see section (d)], the social insurance model [not only] became the foundation of the German welfare state," but has since expanded (Campbell & Morgan 2005). As described earlier, the expansion of Germany's welfare system to the area of LTC is by and large due to Land-level advocacy in the Bundesrat.

This points to a second lesson, which may prove to be disadvantageous for the Canadian context: "Subnational governments may be a potential force for an expansion of federal social policy, but only where they have the leverage to push for these changes" (Campbell & Morgan 2005). As noted in section 3.1, the Land governments exert their influence in the Bundesrat, which is composed of delegates that are also Land-level cabinet members. While the Bundesrat's powers are largely limited to proposals that affect states' rights, "in practice, all significant legislation

requires concurrent majorities in the Bundesrat and Bundestag, including all revenue acts. This makes the Land governments an important actor in federal politics whose interests [in LTC reform] could not have been neglected by the federal government" (Campbell & Morgan 2005). This helped make LTC reform possible.

In contrast, Canadian federalism leaves subnational governments relatively powerless in pressuring the federal government to undergo LTC reform. Provinces and territories can wield some influence; for example, through their members of parliament. However, this type of influence does "more to represent the interests of residents than [provincial and territorial] governments" (Campbell & Morgan 2005). Moreover, while the Canadian First Ministers' Conference allows subnational governments to promote their interests to the Prime Minister (typically on an annual basis), it's influence is unsystematic. Therefore, relative to the German Lander's bargaining role in federal politics, "Canadian [subnational governments] constitute one interest group, amongst many, that must vie for influence in a competitive, pluralist environment" (Campbell & Morgan 2005).

The third lesson concerns the importance of different systems of fiscal federalism; that is, "whether state and local governments have some degree of fiscal autonomy or rely on extensive revenue sharing among governmental levels" (Campbell & Morgan 2005). In Germany, the Lander have limited tax authority and, as a result, largely depend on both horizontal and vertical transfers to pay for their social responsibilities. These transfers derive from a pool of resources that is accessible by all Lander. One effect of this revenue sharing system is that the burdens faced by local governments will in the end affect the fiscal health of other governments.

Accordingly, “policymakers came to see the merit of moving the costs of LTC onto a social insurance program based on new public contributions—particularly as German reunification shrunk the pool of tax resources available” (Campbell & Morgan 2005).

In contrast, Canadian provinces are relatively autonomous and levy a significant portion of their tax base. As a result, the federal government can “impose unfunded mandates, cuts in federal spending, and reduced intergovernmental transfers to push social responsibilities down to lower levels of government” (Campbell & Morgan 2005). In turn, state and local governments are left with no choice but to raises taxes. A clear example of this is in health care. Once block funding was initiated in 1977, for example, “health care funding became a line item in the federal budget that could be arbitrarily cut or capped for fiscal or political reasons” (Sommers & Naylor 2017). In consequence, the federal share of provincial spending on health care today remains substantially lower than it was in the 1970s (Sommers & Naylor 2017). While this example further supports the case for a social LTCI program, the lack of a revenue sharing system similar to that of Germany’s may disincentive wealthier provinces to push for LTC reform. However, as the next section shows, the unique features of a social LTCI program can arguably circumvent some of the intergovernmental tensions associated with Canada’s equalization program.

(c) Social Insurance: Circumventing the Politics of Equalization

While Germany’s extensive system of equalization transfers is not uncommon among federalist nations, the government’s emphasis on equivalence of living conditions across the Lander comes with limited state-level tax authority. These attributes are believed to have blunted Lander’s incentives to be fiscally responsible. Specifically, the “strong reliance on transfers, and lack of

own source revenue that would allow governments to internalize the costs of their spending decisions, weaken incentives to spend with due consideration for debt sustainability" (Stehn & Fedelino 2009). Indeed, this phenomenon may have played a part in the rising costs of LTC before 1994. Amongst other reasons, it is also believed to have contributed to the growing dissatisfaction with the country's equalization (or revenue sharing) system (Gunlicks 2003).

Arguably, LTC reform in Germany circumvented the politics associated with equalization. Fiscal pressures gave way for universal LTC program, financed by earmarked payroll contributions, that shifts the LTC cost burden from state and federal budgets to a social insurance program (Campbell & Morgan 2005). This occurred at a time when transfer payments from the Western to the Eastern Lander was a prominent political concern (Gunlicks 2003). More recently, the Eurozone crisis added another dimension to the debate on equalization. Commentators have suggested that the Eurozone's southern countries have been demanding solidarity from Germany in a form that subjects German states to a "double transfer union" – so much so that Bavarian politicians have threatened to secede (The Economist 2012). Yet, even in the face of such criticisms, the social LTCI system continues to be a safeguarded and widely-popular program.

All this points to an important lesson: When economic differences across states become big, programs dependent on equalization transfers can impel not only inter-governmental conflict, but also nationalist movements. A social LTCI system, however, can arguably circumvent such tensions in Canada – for three key reasons.

First, since social insurance schemes are meant to address interpersonal versus interregional inequities, they are politically “insular” relative to tax-financed systems (Doetter 2017). A social LTCI system would redistribute funding between high- and low-risk groups versus between high- and low-income provinces. This helps win public support, “overcome the objections of fiscal conservatives,” and “shelter” the program from “constant [parliamentary] scrutiny” (Campbell & Morgan 2005b). Second, to some degree, “fiscal autonomy secures political autonomy” (Manow 2010). Germany’s social security systems are financed by employer and employee contributions that are ultimately pooled in an autonomous “special fund” (see next section) (Rogers 2016). This “para-state” fiscal arrangement not only circumvents the politics of taxing and spending (Rogers 2016), but also garners trust amongst the system’s contributors, including when trust in government is low (Campbell & Morgan 2005b).

The third reason relates to the unique needs of the elderly. As Figure 3.1 shows, by the end of 2013, around 7.38 million Germans, or 9.1% of the country’s population, received minimum social security benefits, including for LTC. The proportion of people receiving these benefits relative to their Land’s population was higher in eastern Germany and Berlin (19.1%) than in, for example, Bayern/Bavaria (4.5%) (Statistisches Bundesamt 2014). While these numbers may indeed be a cause of political concern, political demand for a social LTCI program has arguably been high because income is not necessarily a significant predictor of needing LTC (after all, everyone will age and frail at some point) (Hindriks & De Doner 2003). This is, in part, reflected in Figures 3.2 and 3.3, where basic security benefits in old age (65+ years) are received more frequently in western than in eastern Germany – in spite of the fact that western Lander are generally wealthier and younger (Statistisches Bundesamt 2016). For instance, while Hamburg’s

elderly population receives more social security benefits than any other state, it also seems to be the youngest and one of the wealthiest states in Germany (see Figure 4) (BBC 2013).

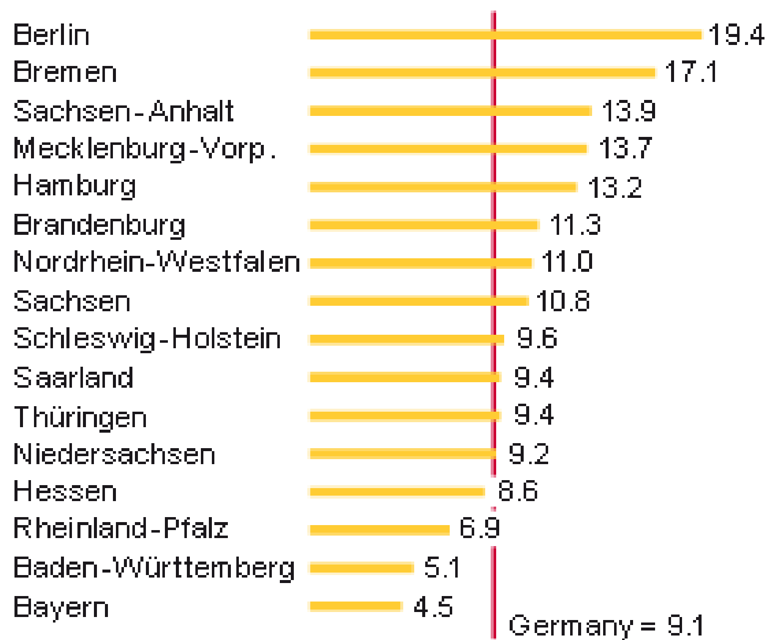

Figure 3.1: Minimum social security benefits by Land (% of population), 2013

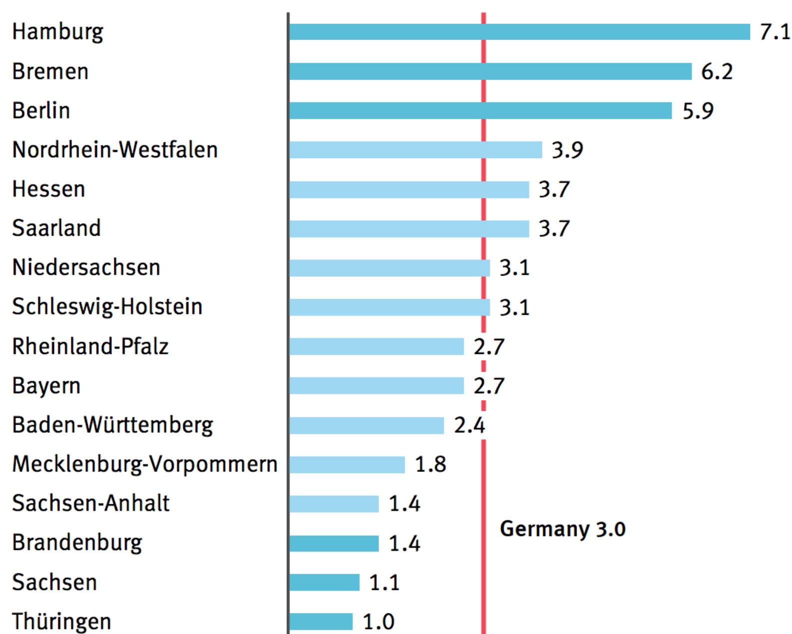

Figure 3.2: Recipients of basic security benefits in old age, by Land (%), 2014

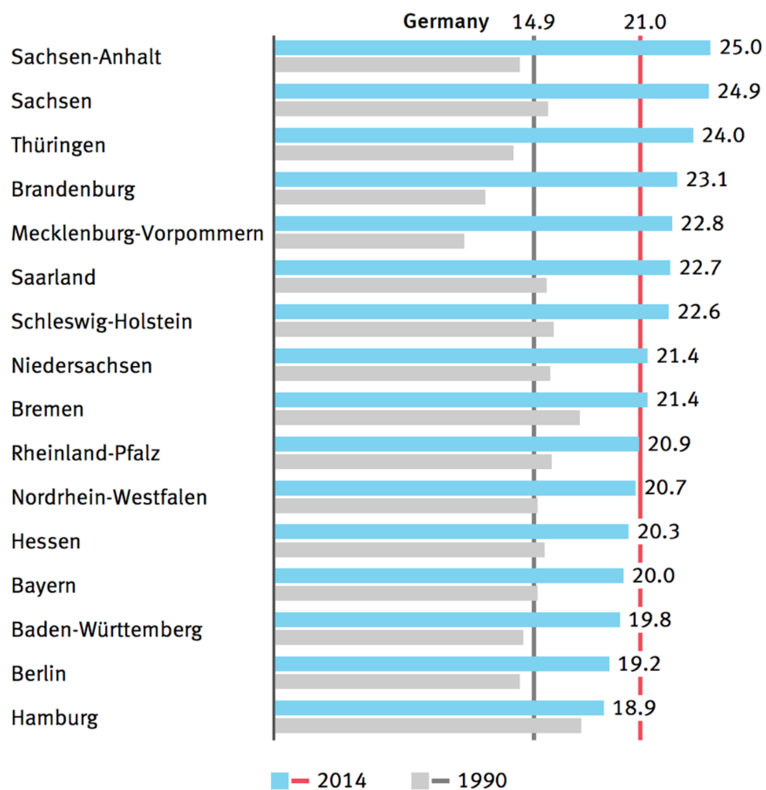

Figure 3.3: Population aged 65 and over, by Land (%), 2014

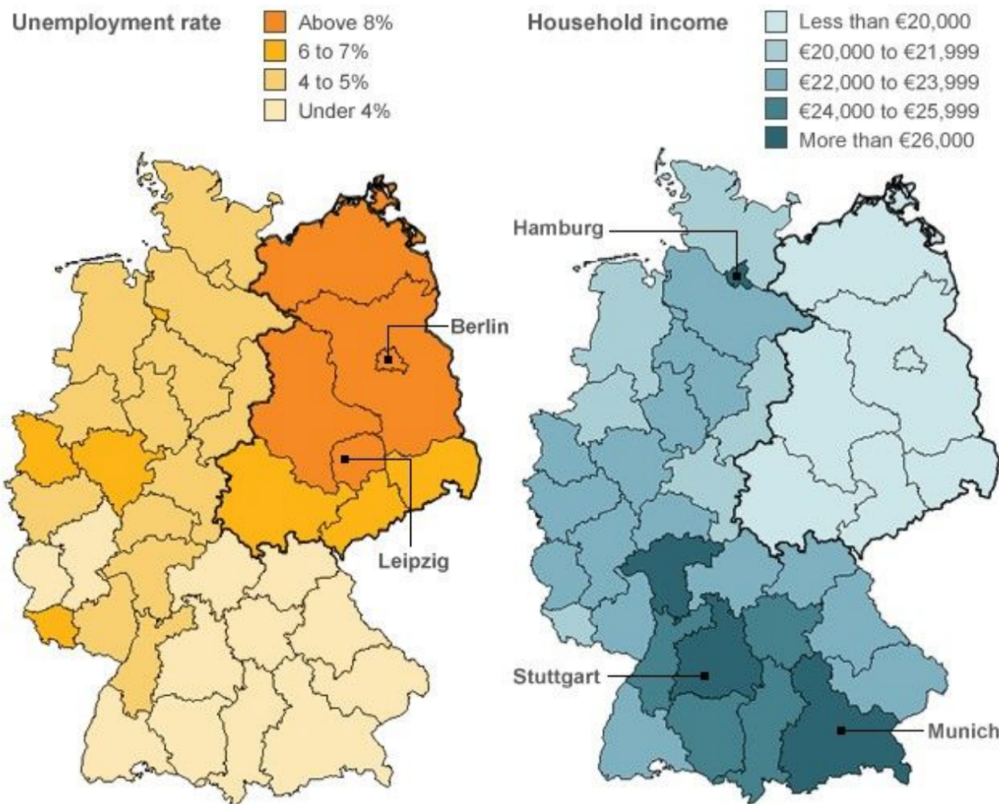

Figure 3.4: The economic divide between east and west Germany

Such observations, albeit not specific to LTC provision, help explain why “differences over supporting older citizens are more muted than differences over public assistance programs for working-age persons” (Giles-Sims, Green & Lockhart 2012). The elderly are believed to “span the socioeconomic spectrum” and, as such, providing for this group “may be less controversial than supporting narrower segments of society” (Lockhart, Giles-Sims & Klopfenstein 2016). Furthermore, public officials may better relate to LTC recipients’ needs given their own experiences with their dependent elderly. As a result, political disagreements surrounding a social LTCI program may not only be “muted” relative to tax-financed programs, but also other social insurance programs.

Germany’s situation is relevant for Canada, where the conflict over equalization stems from intergovernmental conflicts. In a seminal report by the Quebec government, for example, the notion of “fiscal imbalance” was popularized in Canadian federalism (Lecours & Beland 2012). This notion refers to a belief that “provincial governments do not have the revenues necessary to deliver services [like] health care while the federal government raises more money than it needs” (Locours & Beland 2012). Moreover, Quebec’s separatist movements has arguably made the federal government particularly accommodating to its preferences. The idea that Quebec is “the main beneficiary of equalization (allegedly because of political clout, not demographic size) has created resentment towards the [equalization] program and the federal government, especially in Alberta” (Lecours & Beland 2012).

Indeed, such conflicts are related to varying provincial and territorial senses of identity. They are the strongest in Quebec and Newfoundland and weakest in Ontario. As such, some provinces

have greater "incentive to be aggressive when they deal with the federal government on issues they can frame as affecting their interests and identities" (Lecours & Beland 2012). Yet, while any federal reform effort will be countered by some disagreement, a proposal for a social LTCI may circumvent some inter-governmental tension given the scheme's detachment from the budget process, the distinct needs of the elderly, and as the next section show, the unique features of contributory finance that any two provinces may find politically attractive.

(d) Contributory Finance: A Powerful Idea

In Germany, payroll contributions finance health, pension, disability, unemployment compensation, and now LTCI (Rothgang 2010). In Germany's case, payroll contributions are paid by both an employee and employer as a percentage of wages; however, in some countries, or for some programs, the worker or employer take full responsibility. Income taxes, on the other hand, are not earmarked; they end up being part of general revenues and used for general spending (Campbell & Morgan 2005b).

Although countries vary in how they finance social programs, there seems to be a direct trade-off between the use of payroll contributions versus income taxes as a financing mechanism. Countries like Canada have low payroll contribution rates but rely heavily on income taxes; meanwhile, countries like the Netherlands and Germany take on an opposite pattern (Campbell & Morgan 2005b). Indeed, the extent to which countries depend on payroll contributions or income taxation influences the politics of the welfare state. Tax expert Eugene Steuerle (1992) has argued that "progressive income taxes, with high marginal rates, are highly visible to the public and often stimulate political opposition" (Campbell & Morgan 2005b). For example, the

majority of countries that have witnessed anti-tax political movements since the 1970s are those that rely heavily on income taxation (Campbell & Morgan 2005b). As Canadian policymakers debate options for reform, such tax revolts suggest the political limits of income tax financing.

Generally, the political power of payroll contributions as an expansive mode of finance is associated with three features: payroll contributions' lower visibility compared to income taxes; their appeal to individual self-interest; and the means by which they are collected. For example, while the process of filing taxes involves directly acknowledging how much of one's income will go towards the government, social security payments are accounted for by the time someone receives their paycheck. The employer share of the contribution is even less visible (although it may be reflected in the labor market by, for example, a shift towards lower wages). Second, people view their social security payments as contributions to their own LTC plan as opposed to a tax imposed by government. The term "insurance" conveys the sense that the government is protecting the contributor against the potential loss of income (Campbell & Morgan 2005b).

A third powerful feature (at least in Germany) is that contributions are paid to autonomous LTC funds that are independent of the federal budget process. As a result, the funds hold a great deal of legitimacy - even when trust in the federal government is low. Notably, these funds are typically "managed by social partners – usually representatives of labor and business – and labor unions have fiercely protected the payroll taxes that nourish these funds" (Campbell & Morgan 2005b). The takeaway here is that an independent organization, responsible for collecting and pooling resources, helps overcome the vulnerability of the LTC system to political priority

setting. However, this does not mean that the fund is exempt from government regulations that help ensure effective operations.

All in all, the expansion of LTCI to Germany's social security system reflects the viability of payroll contributions as a financing mechanism. Had policymakers considered this mechanism "off the table, future expansions of the welfare state [would have been] difficult and constrained by the fiscal health of the federal government" (Campbell & Morgan 2005b).

Financial Sustainability

A major lesson to draw from Germany's LTC financing experience is that social insurance provides a stable funding base (Norman & Weber 2009). Unlike programs supported from general revenue, an insurance program does not compete with other public funding priorities nor require legislative advocates to ensure a basic level of funding – although premium increases would require legislative action, as would any funding increases derived from general revenues. In regard to the latter point, Canadians can learn to avoid what happened in Germany, where the legislature has been reluctant to increase contributions rates to keep pace with the value of LTC services. The German parliament did not make such adjustments from its 1995 program launch until 2008 (except those relating to childless contributors) (Rothgang 2010).[15]
Despite the need for adjustments, German politicians eschewed any policy changes for years, permitting insufficient funding and benefit levels to stay in place. However, letting policy "drift"

[15] An additional premium of 0.25 percentage points was imposed on childless contributors in 2005. By 2009 (that is, after contribution rate adjustments were made in 2008), the contribution level for childless people was 2.2 per cent versus 1.95 per cent for people with children. The rationale for this policy is that people with children are more likely to opt for cash benefits, which given their lower value relative to in-kind benefits, cost the government less (Colombo et al. 2011).

in this fashion is as consequential as cutting funding (Campbell & Morgan 2005b). As noted earlier, it also undermines the legitimacy of the program (Rothgang 2010). One positive is that, despite the drift, there have been no successful efforts to fundamentally alter the LTCI system. Thus, while social insurance may provide a resilient funding base, the latter does not necessarily suffice in the absence of regulatory checks or updates.[16]

As Norman and Busse (2004) note, "there is no simple answer to the question of how much should be spent on LTC, and adequacy is best judged in the context of a country's total resources" and priorities. However, the fiscal health of a social LTCI program is subject to the state of the overall economy. In Germany, for example, although revenues exceeded expenses immediately after LTC reform, annual deficits were reported between 1999 and 2007 (see Table 2). While expenses kept pace with inflation, there weren't enough contributions to pay for them. Two recessions during this period left unemployment rates high and wages low (hence the aforementioned policy drift). Fortunately, due to the swift recovery of the German economy after the Great Recession and the increased contribution rates legislated in 2008, the social LTCI system soon began generating surpluses again (Gotze & Rothgang 2010; Rothgang 2010).

While recessions are difficult to predict, the German experience provides some lessons as to how to curtail their impact. One lesson includes accounting for different sources of income. In Germany, LTCI contributions are levied on income from gainful employment only. Although employment income has historically been a reasonable proxy for ability to pay, this is

[16] One cautionary strategy to this issue includes "phased implementation" (Gotting, Haug & Hinrichs 1994); that is, the accumulation of a financial reserve before full benefits are granted (Glendinning & Moran 2009) (see Table 2).

no longer true. As Norman and Busse (2004) note, "the trend towards self-employment is increasing at the expense of employment; more people have more than one job"; and non-traditional sources of income are becoming more prevalent. Accounting for the precarious nature of the labor market and/or contributors' assets (i.e. rents, capital gains, etc.), however, would not only broaden the contribution base (and make the system fairer), but would also help ensure a sufficient amount of revenues during tough economic times.

	1995	1997	1999	2001	2003	2005	2007	2009	2011
Revenue	8.41	15.94	16.32	16.81	16.86	17.49	18.02	21.31	22.24
Expenses	4.97	15.14	16.35	16.87	17.56	17.86	18.34	20.33	21.92
Surplus / deficit	3.44	0.80	-0.03	-0.06	-0.70	-0.37	-0.32	0.98	0.32
Financial reserve	3.93	3.77	3.61	3.27	2.82	2.01	2.06	2.78	2.93

Table 3.2: Expenditures and Revenues of the statutory LTCI system (billion $), 1995-2011

Note: *A cautionary strategy included the accumulation of a financial surplus in the first year of the program (contributions were collected from January 1995 but the full range of benefits was only paid from July 1996) (Glendinning & Moran 2009).*

Another lesson entails curtailing the use of income ceilings as they can also lead to an insufficient contributions base. This can happen during economic downswings and upswings alike. During an economic upswing, for example, the sum of capped contributions may not grow in proportion with the growth of national income (and thus the price of LTC services). As demand grows, a funding dilemma may ensue, regardless of whether benefits are capped (Lu & Hsiao 2003; Wagstaff 2007).

Moreover, the German system shows that a universal policy design does not prevent the use of capped benefits. This gives governments some fiscal predictability as to what future LTC costs

might entail. While a means-test is not employed, the LTCI system is based on a relatively narrow definition need for care and entitlement for LTCI benefits have (until 2017) been based on the beneficiary's assessed level of physical need (Rothgang 2010). Of course, there are disadvantages associated with cost containment strategies of this kind. First, due to benefit caps, out-of-pocket payments can be high (Rothgang 2010) and even encourage the growth of grey markets of migrant caregivers (Rodrigues & Schmidt 2010). Second, the narrow definition of dependency has meant that people with dementia have been entitled to benefits "only insofar as they need help with ADL, as physical assessments do not evaluate or take into account their general need for supervision" (recent reforms have changed this, however; see section 3.1) (Rothgang 2010).

Finally, the German LTC system points to the importance of pre-funding; that is, a scheme to build up assets to fund future LTC costs. In 2015, the German government introduced a 0.1 percentage point increase in the LTCI contribution rate. The collected funds will be placed in a "buffer fund that will only be spent from 2035 onward in order to level the effects of the country's demographic transition" (Rodrigues 2014). Some benefits associated with pre-funding include "mitigating sudden increases in contribution rates (also referred to as "tax-smoothing") in order to finance a stable set of benefits or services over time, as well as mitigating the risk of shifting obligations to future generations in the form of higher taxes or debt" (Colombo et al. 2011).

In practice, pre-funding requires the government to sustain budget surpluses over a prolonged period. However, this can trigger political tension since surpluses are typically subject to

switchyard policies or the funding of other policy and/or political priorities, including contribution rate reductions. Such issues can be overcome, however, by tying pre-funding to specifically LTC. For instance, the federal government in Canada has introduced public pension reserves to pre-fund future public pension's obligations. Similar consideration could be given to establishing similar public reserves with respect to LTC expenditures (Colombo et al. 2011).

Equitable Revenue Collection

Equity is affected both by the ways that revenues are raised and how those resources are allocated, the former being the focus here. This concept of equity presents itself in three variants: (1) horizontal equity – "that the revenue option should treat those alike in like situations"; (2) vertical equity – "that revenue should be raised on the basis of ability to pay"; and (3) intergenerational equity – "that the tax, transfer and government expenditure system should not be structured such that one generation receives benefits far in excess of the taxes it pays relative to some other generation, which bears the burden of financing the difference" (Rode & Rushton 2002). There are a number of cases in which these types of inequities can arise and that Canadian policy actors can learn to avoid.

Horizontal inequity in Germany's LTCI system is a widely known concern. Being defined by gainful employment income alone, for example, does not necessarily reflect an individual's financial situation; thus, individuals with similar abilities to pay "on paper" may end up paying different amounts for similar coverage (Wagstaff & Doorslaer 1996). Income ceilings raise further horizontal equity concerns; someone earning 500,000 euros of income per year will pay the same contribution rate as someone earning 50,000 euros per year.

Similar issues raise vertical equity concerns. While contributions are proportional to employment income, income from other sources – more common amongst the wealthy - are unaccounted for. As discussed in the previous section, employment income is no longer a reasonable proxy for ability to pay. Additionally, because there are maximum ceilings to contributions, the very wealthy will contribute a relatively smaller share of their employment income to the LTCI system (Mot et al. 2012). Moreover, although the private LTCI scheme is beyond the focus of this paper, it is worth noting that a tiered system – even if mandatory - can leave certain, high-income beneficiaries paying less than if they were enrolled in the social LTCI scheme. This limits the risk-pooling mechanism that is fundamental to a social insurance system.

Another important consideration is how the system strikes a fair balance between current and future generations. The question here is which generation is bearing the costs of care. For example, in a system that includes some pre-funding, care will be in part paid for by the generation who uses it. By contrast, in a strictly pay-as-you-go system, much of the care of elderly people will be paid for by a younger, working-age generation (Mot et al. 2014). Thus, there are concerns that "pay-as-you-go schemes may exacerbate imbalances between generations" (Mot et al. 2014). While the German experiences provides limited lessons in this regard, the Canadian government would be wise to consider a pre-funding policy.

Efficiency

Generally, the concept of efficiency presents itself in two ways: technical and allocative efficiency. The former refers to the maximization of output for a given level of inputs or,

conversely, the minimization of inputs for a given level of output. As Mossialos et al. (2002) point out, although there is no clear evidence as to which funding methods determine the highest level of technical efficiency in the production of care, high administrative and transaction costs are not uncommon in the revenue collection process. Therefore, an important policy target lies in minimizing administrative costs. In this regard, the German LTC system "fares poorly as it is unable to benefit from administrative savings or economies of scale that would obtain under a more centrally administered system" (Siadat & Stole 2005).[17] Specifically, "management and operational responsibilities are devolved to the [LTC] funds," producing a system where tens of funds individually collect contributions, transfer contributions to an umbrella fund (which then sends money back to the individuals funds), purchase care, and pay providers (Siadat & Stole 2005). This is an important takeaway for Canada should it contemplate a multi-layered revenue collection system.

Moreover, allocative efficiency is attained through the maximization of welfare given constrained resources. It can refer to allocations between LTC and other areas of public spending, as well as allocations within the LTC sector itself (Mossialos et al. 2002). In regard to the former, while a tax-financed system "is vulnerable to the outcomes of government-wide negotiations," it allows for "a more open debate about public spending tradeoffs between [LTC] and other sectors" (Wagstaff 2007). Such debates tend to happen less in a social insurance system except during political debates on whether the system's contribution rates should be modified to cover losses. Part of Germany's concern in the health care sector, for example, is as

[17] Arguably, however, Germany was able to create economies of scale by linking the LTCI system with the health system's already established sickness funds (see section 3.1).

that as contribution rose, the cost of care increased accordingly. According to Wagstaff (2007), "had the Germans had a continuous political debate about the tradeoffs between health and other sectors, they might have made ended up devoting a smaller share of GDP to health." As of 2016, Germany's share of GDP devoted to health care is the fifth highest in the OECD (OECD 2018). Therefore, a social LTCI system can lead to cost escalation unless effective contracting mechanisms are in place.

Moreover, while mandatory, Germany's tiered LTCI system does create incentives for both adverse and risk selection. For example, the option for high-income individuals to purchase private LTCI may lead high-income good risks to opt into the private system and pay relatively low premiums (Siadat & Stole 2005). This raises allocative efficiency concerns within the LTC sector. As such, while a social insurance system is recommended for the Canadian context, a mandatory tiered system is not.

3.2.4 Key Takeaways

Based on my analysis of Germany's LTC financing experience, the key policy takeaways for Canada are as follows:

LTC: The Case for Social Protection

- There are two good reasons for establishing pubic coverage mechanisms to cover at least some LTC. First, the cost of LTC can be high. Second, the need for LTC, including if and when it will develop, its duration, and intensity is unknown (Colombo et al. 2011).

- Mechanisms for pre-payment and risk-pooling, characteristic of a social insurance system, can provide protection against catastrophic LTC costs, enable access to at least some required LTC services, and grant benefits almost immediately (Colombo et al. 2011).
- In contrast to a tax-financed scheme, a social insurance approach would provide a stable funding source that would not be prone to annual budget appropriations (see Table 1 for a list of advantages and disadvantages) (Scheil-Adlung 2015).
- Given the risk of adverse selection and the general uncertainty associated with both future LTC needs and costs, private LTCI plans are expensive and constitute an inefficient strategy (Barr 2010).

Objective 1: ***Political Feasibility***

- Shifting towards a social insurance approach in financing LTC in Canada will require policymakers to move beyond "first-order" reforms (i.e. restricting LTC eligibility requirements as a means to save costs) and towards a path-dependent "second-order" reform similar to what occurred in Germany (i.e. employing a social insurance LTC scheme similar to the federally administered Canada Pension Plan) (Hall 1993; Palier 2010).
- Policymakers should not assume that the provinces and territories will oppose an expanded federal role in LTC policy as, for some policy areas, history suggests otherwise. Moreover, should the need arise, provincial and territorial governments will be relatively powerless in pressuring the federal government to adopt LTC as a priority (Campbell & Morgan 2005). This is due to the lack of direct provincial

and territorial representation in the Canadian parliament and the nature of fiscal federalism in Canada, where there is relatively greater independence between levels of government.

- A social LTCI program can arguably circumvent the politics associated with the Canada's equalization program, and the impacts thereof on intergovernmental relations. One reason for this is that income isn't necessarily a significant predictor of needing LTC, which means that wealthier provinces (and perhaps those with more elderly persons) may be more reliant on social LTCI benefits.
- The political strength of payroll contributions lies in three features: their lower visibility compared to income taxes; their appeal to self-interest; and the fact that are typically collected by an autonomous, non-governmental body (Campbell & Morgan 2005b).

Objective 2*: **Financial Sustainability***

- While a social insurance system may provide a stable and resilient funding base, the latter does not necessarily suffice in the absence of regulatory updates to both the contribution rate and benefit levels (Rothgang 2010). One cautionary strategy to this issue includes the accumulation of a financial reserve before benefits are granted (see Table 2) (Glendinning & Moran 2009).
- In terms of contribution rates, it is reasonable to impose a higher rate on contributors without children than those with children. This is because childless persons are more likely to use in-kind institutional services, which in Germany's

case, are of higher value than both cash benefits and in-kind home care services (Colombo et al. 2011).

- A social LTCI is subject to financial crises, which can occur during economic downturns and upswings alike (Wagstaff 2007). Because of income ceilings, for example, the sum of contributions may not grow in proportion with the growth of national income (and thus, the prices of LTC services). As demand grows, a funding dilemma may ensue, even if benefits are capped (Lu & Hsiao 2003).
- If a social LTCI system was to be financed by income contributions alone, the precarious nature of the labor market will pose a risk to the system's fiscal health. Accounting for this and other sources of income (i.e. rents, capital gains, etc.) would be fiscally wise (Norman & busse 2004).
- Fiscal sustainability is also dependent on how comprehensive the LTC system is. For example, the German experience shows that a universal policy design does not prevent the use of capped benefits based on a beneficiary's disability level. This gives governments some predictability when it comes to future LTC costs (Colombo et al. 2011; Rothgang 2010).
- Some earmarked pre-funding can "mitigate sudden increases in contribution rates in order to finance a stable set of benefits over time" (Colombo et al. 2011).

Objective 3: ***Equitable Revenue Collection***

- Not accounting for additional sources of income (i.e. capital gains, rents, etc.) in revenue collection raises both horizontal and vertical equity concerns (Mot et al. 2012).

- If maximum ceilings to contributions are placed, the very wealthy will pay a relatively smaller share of their employment income. This also raises horizontal and vertical equity concerns (Mot et al. 2012).
- A pre-funding policy can help build up assets and address concerns related to intergenerational equity (Mot et al. 2014).

Objective 4: ***Efficiency***

- Within Germany's social LTCI system, management and operational responsibilities are devolved to the LTC funds, producing a system whereby over a hundred funds individually collect contributions, transfer these contributions to an umbrella fund (which transfers money back), purchase care, and pay providers (Siadat & Stole 2005). Canada would arguably benefit from the technical efficiency gains that it would obtain from a more centrally administered system.
- A social LTCI system can lead to cost escalation unless effective contracting mechanisms are in place (Wagstaff 2007).
- A mandatory tiered system would compromise on allocative efficiency (Siadat & Stole 2005).

3.3 Lessons in User-Directed Care

The incorporation of user-directed home care (i.e. having the choice between a cash benefit and an in-kind home care service) in the German LTC system is associated with three goals. First, it's consistent with the notion of making the system more demand versus supply driven (Wiener, Tilly & Cuellar 2003). The intention here is to empower users by giving them more control over their care while, at the same time, increase competition among formal care providers. Second, user-directed home care is believed to control the overall rate of growth in LTC expenditures. This belief is based on the fact that, on an individual basis, home care costs less than institutional care services. Last, the third goal aims at incentivizing informal caregiving and reducing the risk of institutionalization (Wiener, Tilly & Cuellar 2003). Accordingly, this section aims to draw lessons from Germany's user-directed care experience in addressing the same goals shared by Canadian policymakers: improving user direction, controlling costs, and incentivizing informal caregiving.

3.3.1 User-Directed Care in Perspective

LTC services are generally provided in two ways: as in-kind services and/or as cash benefits (or near cash payments, like vouchers or personal budgets) for the beneficiary to employ the services that best accommodate his/her needs. In-kind services can be nursing or ADL services provided at home, can consist of respite services for a family caregiver (i.e. day care), and can include institutional care provision (i.e. in a nursing home). In the context of home care, some OECD countries provide both in-kind services and cash benefits (i.e. Germany), while others rely mostly on in-kind services (i.e. Canada) (Colombo et al. 2011). In Germany, cash benefits seem

to be the preferred form of home care benefits (see section 3.3.3) (Doetter & Rothgang 2017), and will comprise the focus of my analysis.

Cash benefits "provide care recipients with more choice to receive the services they need, by the provider they choose, at the conditions of their liking" (Colombo et al. 2011). However, countries vary in the way they implement cash-benefit schemes. In Germany, for example, there is little control over the use of the benefit, while in other countries, only accredited or approved service providers can be hired and expenditure is supervised. Furthermore, the German system gives beneficiaries the choice to receive cash benefits, in-kind services, or a mix of both – regardless of one's place of residency (Rothgang 2010). In contrast, the Korean social LTCI system, for example, only provides cash benefits to those living in regions where there is a lack of formal providers (Rhee, Done & Anderson 2015; Colombo et al. 2011).

Cash benefits aim to contribute, but not fully cover, the costs of LTC. In Germany, for example, the value of a cash benefit is lower than that for in-kind services for all levels of need. Moreover, countries differ in the way the benefit amount is calculated (Colombo et al. 2011). In Germany, it is a flat rate dependent on the beneficiary's level of disability (Rothgang 2010); in some countries, it is partially dependent on the beneficiary's income (Colombo et al. 2011). In Austria, for instance, those eligible but whom have earned above a certain income ceiling (based on last salary) may receive a limited allowance (Zagorskis 2017). Countries also vary in the tax treatment of the cash benefit. In Germany, it is tax-free (Colombo et al. 2011).

3.3.2 Canada's Policy Objectives

The idea of providing cash benefits to those with LTC needs is not new. The Canadian War Veterans Allowance, for example, has for decades provided cash allowances based on the extent of a veteran's disablement (Keigher 1999). Thus, as far as both international experience and path dependency goes, Canadian policymakers are not at a disadvantage. As Canadians wrestle with next steps, however, the German experience helps inform key objectives, namely improved user direction, cost control, and increased informal caregiving.

Improved User Direction

Two drivers lie behind the introduction of a cash benefit system in Germany. First, there has been demand for greater user independence on the basis that in-kind service delivery alone provides little opportunity for disabled people to make decisions and to improve their quality of life. Second, it is argued that the delivery of in-kind services has "been producer rather than [user]-focused – paying more attention to the needs of those who provide home care than those who receive it – as well as being bureaucratic, inflexible and paternalistic" (Arksey & Kemp 2008). It is held that user choice and empowerment will improve both the competition and quality of care amongst providers (Wiener, Tilly & Cuellar 2003).

In regard to user independence, the ability to control the type of care that one would like to receive "is considered a good-in-itself, because the freedom offered by greater choice has the potential to result in increased satisfaction both personally and with service provision" (Arksey & Glendinning 2007). Whether this potential is borne in reality varies considerably. A crucial assumption underlying user-directed care is user sovereignty. The former presumes that care

dependents arrange the services that best accommodate their needs. Yet frail older people – the majority of LTCI recipients - might not be able to organize service arrangements on their own. Many beneficiaries likely rely on family members to help them choose care arrangements and manage entitlements. Even with such family support, rational decision-making is hard to achieve during a period of physical and emotional stress (Schneider 2002).[18] In such cases, "choice is not good and can indeed be problematic rather than beneficial" (Arksey & Glendinning 2007).[19]

Moreover, user-directed care assumes that the power of suppliers will lessen as a result of competition. The logic behind this assumption is that if a vendor's services are priced high and its quality of care is low, it would need to reconsider its prices or offerings given that beneficiaries can instead opt for a cash benefit. However, while competition has likely increased in urban areas, market entry for small and/or specialized providers may not have in rural areas, where demand is lower. In this case, "consumer empowerment would be of little use, given oligopolistic or monopolistic supply of professional care services that prevail in rural areas or small municipalities" (Schneider 2002). Arguably, this has helped contribute to not only a greater reliance on family caregivers in some communities versus others, but also to the creation of grey markets of migrantcare providers from Central and Eastern Europe. As per Rodrigues and Schmidt (2010), "due to wage differentials, it is sometimes affordable to employ persons providing 24-hours care within the family to replace adult children who cannot afford to quit their job in order to care for their older kin."

[18] People who have access to resources such as children or professional networks are advantaged when making choices and, in consequence, may attain better outcomes than those who do not.
[19] By extension, one can also argue that the "practices developed in the context of the private consumption of goods and services [i.e. exercising choice] are not necessarily applicable to collectively-funded welfare goods and services" (Arksey & Glendinning 2007).

All in all, the German experience should remind Canadian policymakers that "the greater the diversity of provision, the greater the chances of [caregivers] and LTC beneficiaries to obtain help tailored to both their individual or joint preferences" (Arksey & Glendinning 2007). However, exercising choice is only beneficial if, for example, the care recipient can think rationally, has access to good quality information and/or sufficient time to make complex decisions. As such, some people may be in a better position than others to benefit from a cash-for-care scheme. Therefore, choice can lead to increased inequities, especially if some groups are already disadvantaged; for example, in terms of social class, race or gender (Arksey & Glendinning 2007). Moreover, given that Canada is more rural than Germany, it is unlikely that user-directed care will increase competition of in-kind service vendors in some communities. However, the cash benefit may be appreciated by people living in areas with little or no access to in-kind services, or where the value of capped in-kind benefits do not "go far" relative to in other areas.

Cost Control

Although in-kind home care is a crucial element of LTC provision, it has not received much attention in the health economics literature outside the US (Denberg, Brouwer & Koopmanschap 2005). This includes the question of whether user-directed home care provision is having any effects on aggregate LTC spending. Indeed, "the historical institutional bias in LTC coverage relates partially to policymakers' concerns regarding moral hazard (or [the] woodwork effect), whereby publicly financed non-institutional services substitute for informal services previously provided by family and friends" (Grabowski 2006). It is for this reason that program administrators in Germany initially structured the eligibility criteria such that only those eligible

for institutional care can receive in-kind home care and/or cash benefits. Yet this approach did not fare well politically.[20] And while evidence regarding the woodwork effect is inconclusive, the popularity of the cash benefit scheme (see next section for statistics) has led some people to believe that some savings are being made.

However, a cash benefit may strengthen the risk of moral hazard because it provides beneficiaries, instead of LTC agencies, with the resources to arrange the care (VanDenBerg & Hassink 2005). And whether that money is used to reward informal caregiving is unclear. This partially explains why the level of cash payments is set lower than that of in-kind services. In light of the concern that cash benefits may be misused, their lower value was intended to nudge patients toward in-kind home care (Blomqvist & Busby 2012).

Moreover, while the focus on costs is warranted, a better focus may be on how to provide user-directed care in the most cost-effective manner (Grabowski et al. 2010). A great dilemma associated with cash benefit schemes is how to ensure the benefits' proper use while at the same time providing beneficiaries with choice and a chance to improve their quality of life. Take-up of the Direct Payments scheme in England, for example, has been relatively low: 0.2% of the older population in 2006-07. This is believed to be due to the restrictions placed on the use of the cash benefit (Colombo et al. 2011). Therefore, Canadian policymakers are encouraged to carefully consider how to best strike a balance between improving user direction and safeguarding the proper use of resources.

[20] Various reforms in the 2000s revised the eligibility criteria, the latest being in 2015 (see section 3.1).

Incentivizing Informal Caregiving

Largely due to the "historical reliance on care provided especially by female family members," the German social LTCI system introduced a user-directed home care system "as a means of perpetuating the predominance of informal care arrangements" (Doetter & Rothgang 2010). Indeed, the take-up of the cash benefit option is greater than that of the in-kind-benefit: as of 2014, around 1.3 million people received cash benefits, while 181,000 opted for in-kind services and 408,000 for combined services. As such, cash benefits are considered to be an integral component of the German social LTCI system (Doetter & Rothgang 2017).

In Germany, one third of all beneficiaries are cared for by their partners and/or their children. In fact, since 1998, the share of beneficiaries receiving informal care from their children has increased by nine per cent. According to Doetter and Rothgang (2017), this suggests that "cash benefits not only reinforce but also incentivize informal care giving, particularly amongst male children: between the years 1998 and 2010, for instance, the share of persons in receipt of care by a son doubled and has since remained relatively constant, even if still inferior to that of care by daughters." Such observations support the belief that older people prefer to receive a cash benefit because they appreciate care by family members to strangers. However, according to one survey, "half of all family caregivers received a regular payment from an older person in receipt of the cash benefit, but in a third of these cases the payment to the family caregiver was less than the full amount of the benefit" (Glendinning 2006).

This discrepancy points to some of the downsides associated with the cash benefit scheme. First, "all entitlements rest with the older insurance beneficiary and none with the [caregiver], who is

dependent on the discretion of the older person to pay as the latter considers appropriate" (Glendinning 2006). Second, the fact that informal caregivers may or may not get paid by the beneficiary, who's rational decision-making ability is more likely to be impacted by physical and emotional stress, further undermines the status of the caregiver. Third, it could be the case that some cash benefits are being used to hire grey migrant caregivers instead of supporting informal caregivers.

As Canada wrestles with the question of how much family care is appropriate in the context of public LTC provision, it becomes clear that the use of cash benefits reflects (at least based on the German case) a conflict between equity and efficiency. Germany's cash payments can be justified as a means to "maintain social equity so that those who provide family care are not substantially worse off than those that do not" (Glendinning 2006). On moral grounds, policymakers want to acknowledge and reward informal caregivers for their efforts. However, from an efficiency perspective, a lot of money is being spent to accomplish little behavioral change (Wiener 2016). The potential for moral hazard, as discussed earlier, is considerable. Thus, whether the quality of life of both the caregiver and user will improve as a result of the benefit is debatable. This is problematic as cash benefits with little to show for leaves the LTCI system with less money for other priorities, such as LTC infrastructure development, or financing better ways of both recognizing and incentivizing informal caregiving (Baicker & Chandra 2012).

3.3.3 Key Takeaways

Based on my analysis of Germany's user-directed care experience, the key policy takeaways for Canada are as follows:

Objective 1: ***Improving User Direction***

- While choice between an in-kind service and a cash benefit may empower consumers and improve their quality of life, this is not always the case. A crucial assumption underlying user-directed care is user sovereignty. Frail old persons – the majority of LTCI recipients - might not be able to organize service arrangements on their own. Even with family support, rational decision-making is hard to achieve during a period of physical and emotional stress (Schneider 2012).
- While choice may prove to be effective in improving service standards and introducing new services that better meet users' needs, it may be of little use in rural areas, where an oligopolistic or monopolistic supply of professional care services may prevail Schneider 2012).

Objective 2: ***Cost Control***

- While home care may be less expensive than institutional care on an individual basis, its effects on aggregate LTC costs are unknown. There is potential of moral hazard, or a "woodwork effect" (Grabowski 2006).
- Cash benefits may strengthen the risk of moral hazard because they provide beneficiaries, instead of LTC agencies, with the resources to arrange the care (VanDenBerg & Hassink 2005). And whether that money is used to incentivize or reward informal caregiving is

unclear. One way to address this concern of cash benefits being misused includes lowering their value and nudging patients toward in-kind home care services (Blomqvist & Busby 2012).

Objective 3: ***Incentivizing Informal Caregiving***

- Some trends suggests that cash benefits incentivize informal care giving, particularly amongst male children (Doetter & Rothgang 2010). However, this does not imply that the majority of cash benefits are being transferred to informal caregivers, or that they are being used for their purpose
- From an efficiency perspective, a lot of money is being spent on cash benefits in to accomplish little behavioral change (Wiener 2016). Thus, whether the quality of life of both caregivers and users have improved as a result is debatable. This is problematic as cash benefits with little to show for leaves the LTCI system with less money for other priorities, such as LTC infrastructure development, or financing better ways of both recognizing and incentivizing informal caregiving (Baicker & Chandra 2012).

3.4 Concluding Remarks

As Canada's population ages, an increasing number of people will need LTC services. Ensuring that these services are both adequate and accessible presents a challenge to Canadian governments. Currently, the financing, delivery and organization of LTC provision varies by province and territory, raising considerable equity issues. As Canadian policymakers consider different ideas for LTC reform, my analysis here examines the German social LTCI system's financing scheme as a potential means to ensure universal coverage of LTC. I argue that relying on private savings is not an efficient way for individuals to provide for their potential future care needs. Long-term care thus warrants some form of insurance, either private or public. Private long-term care insurance, by its nature, is subject to market failures. Meanwhile, a tax-financed system would be prone to budget appropriations and underfunding. Ultimately, I argue that mechanisms for pre-payment and risk-pooling – characteristic of a social insurance system – constitute the best solution to the high costs and uncertainty associated with the need for LTC. How such mechanisms can ensure universal coverage of LTC in a politically feasible, financially sustainable, equitable and efficient way is tricky. As is striking an appropriate balance between improving user direction and safeguarding the proper use of resources. While Germany's social LTCI is imperfect, its experience provides a number of lessons for Canadian policy actors wrestling with these issues.

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