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# LONG-TERM CARE

## Baby Boom Generation Presents Financing Challenges

Statement of William J. Scanlon, Director  
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# Long-Term Care: Baby Boom Generation Presents Financing Challenges

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Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the challenges the country will face in financing long-term care for the baby boom generation.<sup>1</sup> Long-term care presents a significant burden for many individuals and for public programs. Long-term care in nursing homes currently costs an individual more than \$40,000 per year, with a substantial share of nursing home residents paying that out of their own pockets. In addition to this out-of-pocket spending, Medicaid and Medicare expenditures for long-term care for the elderly—those aged 65 and older—exceeded \$51 billion in 1995. More than a million elderly with extensive disabilities live at home, relying heavily on their families for assistance. The aging of the baby boom generation, particularly as members become age 85 and older, will have a dramatic impact on the numbers of people needing long-term care services and will challenge individuals, families, and public programs to finance and furnish that care.

My remarks today focus on four areas: (1) an overview of current spending for long-term care for the elderly, (2) the increased demand that the baby boom generation will likely create for long-term care, (3) recent shifts in Medicaid and Medicare financing of long-term care, and (4) the potential role of private long-term care insurance in helping to finance this care. My comments are based on our previous work and on other published and ongoing research. (See the list of related GAO products at the end of this statement.)

In summary, spending for long-term care for the elderly totaled almost \$91 billion in 1995, the most recent year for which expenditures from all sources were available. Almost 40 percent of these dollars were paid for by the elderly and their families and almost 60 percent by Medicaid and Medicare. These amounts, however, do not include many hidden costs of long-term care, since an estimated two-thirds of the disabled elderly living in the community rely exclusively on their families and other unpaid sources for their care.

According to current estimates by the Congressional Research Service (CRS), nearly a quarter of the nation's elderly population—over 7 million elderly people—have some form of disability for which they require assistance, such as help with bathing, dressing, eating, preparing meals, or

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<sup>1</sup>Long-term care, which includes an array of health, personal care, and social and supportive services, is provided to individuals who are at least partially unable to care for themselves because of a disability or impairment resulting from a chronic illness or condition—such as heart disease or diabetes.

taking medicine. As the 76-million-strong baby boom generation ages, so too will its demand for long-term care increase. Long-range predictions of the magnitude of the baby boomers' long-term care needs, however, vary, with estimates of disabled elderly ranging from 2 to 4 times the current disabled elderly. Estimates of cost are even more imprecise due to the uncertain impact of several important factors, including who will be needing care, the types of care they will need, and who will fund it.

Medicaid and Medicare, which currently finance almost two-thirds of long-term care, have undergone some significant changes in recent years. While historically the majority of Medicaid long-term care expenditures were for nursing home care, in recent years there has been a shift toward more financing of home and community-based care. At the same time, Medicare, the largest public payer for home-based care, has been paying for care that more and more resembles long-term care.<sup>2</sup> Both the number of beneficiaries receiving home health care and the number of visits per user more than doubled from 1989 to 1996, with a small but significant proportion of users receiving extensive long-term support from home health aides. Medicare's financing role for this care could, however, again significantly shift as a result of the requirement in the Balanced Budget Act of 1997 to move away from a cost-based per-visit payment system to a case-mix-adjusted prospective payment system in 1999.

Private long-term care insurance, seen as a means of helping reduce the catastrophic financial risk for people needing long-term care and some of the financing burden that falls to public programs, has contributed little to date. It is a relatively new form of insurance with a growing market. Nevertheless, after 10 years, a very small proportion of elderly or near-elderly have coverage. For example, in 1995, private long-term care insurance covered less than 1 percent of total long-term care expenditures. Consumers' reluctance to purchase long-term care insurance is attributed to their limited knowledge about the risk of needing long-term care and the limitations on Medicare and Medicaid long-term care coverage, as well as concerns about the affordability of policies.

What we know today with some certainty is that the aging of the baby boomers will lead to a tremendous increase in the elderly population in the next 3 decades, with an even larger increase in individuals aged 85 and over, who are more likely to use long-term care services. What is less certain, however, is the nature, magnitude, and funding sources for those

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<sup>2</sup>Medicare home health includes skilled nursing and therapy services, which are shorter term, and a significant proportion of services that can be used for long-term support.

services. Financing these services—within the context of evolving service needs and alternatives—will be a challenge for the baby boomers, their families, and federal and state governments.

## Spending for the Elderly’s Long-Term Care Exceeded \$90 Billion in 1995

Spending for the elderly’s long-term care was \$91 billion, or about \$12,000 per disabled elderly person, in 1995, the last year for which data on expenditures from all sources are available. The elderly and their families represent the largest single group of purchasers of long-term care, spending almost \$36 billion dollars out of pocket, or almost 40 percent of the total \$91 billion expenditures for long-term care. (See table 1 for expenditures and fig. 1 for percentages by funding source.) This spending does not include the substantial unpaid support provided to the elderly by family and friends. Studies have found that about 65 percent of disabled elderly living in the community rely exclusively on unpaid sources for their care. Public funding for long-term care comes primarily from Medicaid, which finances almost one-third of long-term care—\$28.5 billion in 1995—and Medicare, which funds one-fourth—\$22.7 billion.<sup>3</sup> Long-term care expenditures for the elderly are disproportionately used to purchase nursing home care; about 70 percent of total elderly long-term care expenditures are for nursing homes.

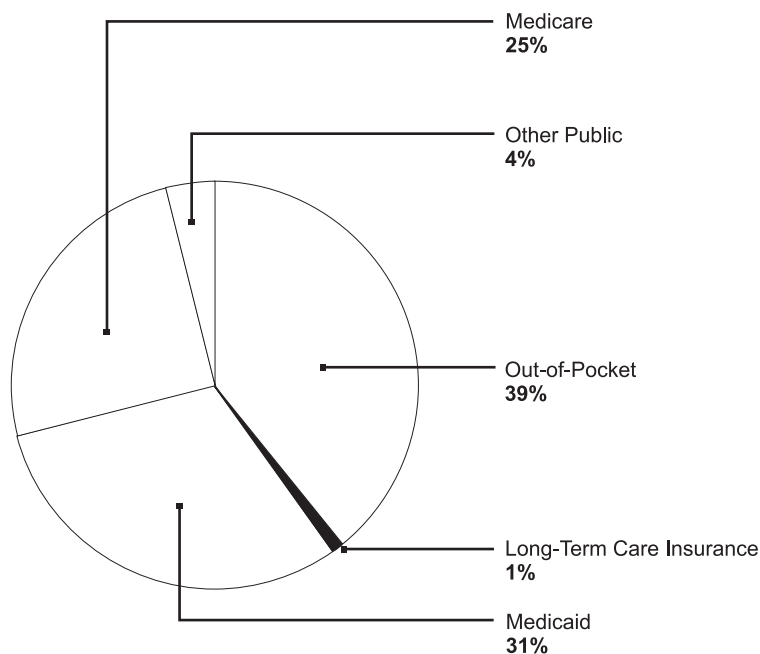
**Table 1: 1995 Expenditures for Long-Term Care for the Elderly**

Dollars in Billions			
<b>Funding source</b>	<b>Nursing home</b>	<b>Home care</b>	<b>Total</b>
Out-of-pocket	\$30.0	\$5.5	\$35.5
Medicaid	24.2	4.3	28.5
Medicare	8.4	14.3	22.7
Other public sources	1.3	2.2	3.5
Private insurance	0.4	0.3	0.7
<b>Total</b>	<b>\$64.3</b>	<b>\$26.6</b>	<b>\$90.9</b>

Source: CRS.

<sup>3</sup>Medicaid, a joint federal-state health financing program for low-income families and blind, disabled, and elderly people, is authorized under title XIX of the Social Security Act and is administered by the states under the general oversight of the Health Care Financing Administration (HCFA). Medicare is a health insurance program that covers virtually all the elderly, authorized by title XVIII of the Social Security Act. The federal share of a state’s total Medicaid expenditures can range from 50 to 83 percent; Medicare home health care is almost totally financed by federal funds.

**Figure 1: Distribution of 1995 Expenditures for Long-Term Care for the Elderly, by Funding Source**



Source: GAO analysis of CRS data.

## **Ageing Baby Boomers Will Expand Demand for Long-Term Care**

The baby boom generation, about 76 million people born between 1946 and 1964, will contribute to rapid growth in the number of elderly individuals who need long-term care and the resources required to pay for it. Forecasts of the exact number who will need such care are uncertain because of differing conclusions about the effect of better health care and lifestyles on the subpopulation that may eventually need long-term care. Nevertheless, the number will be very large even if the most rosy scenario prevails.

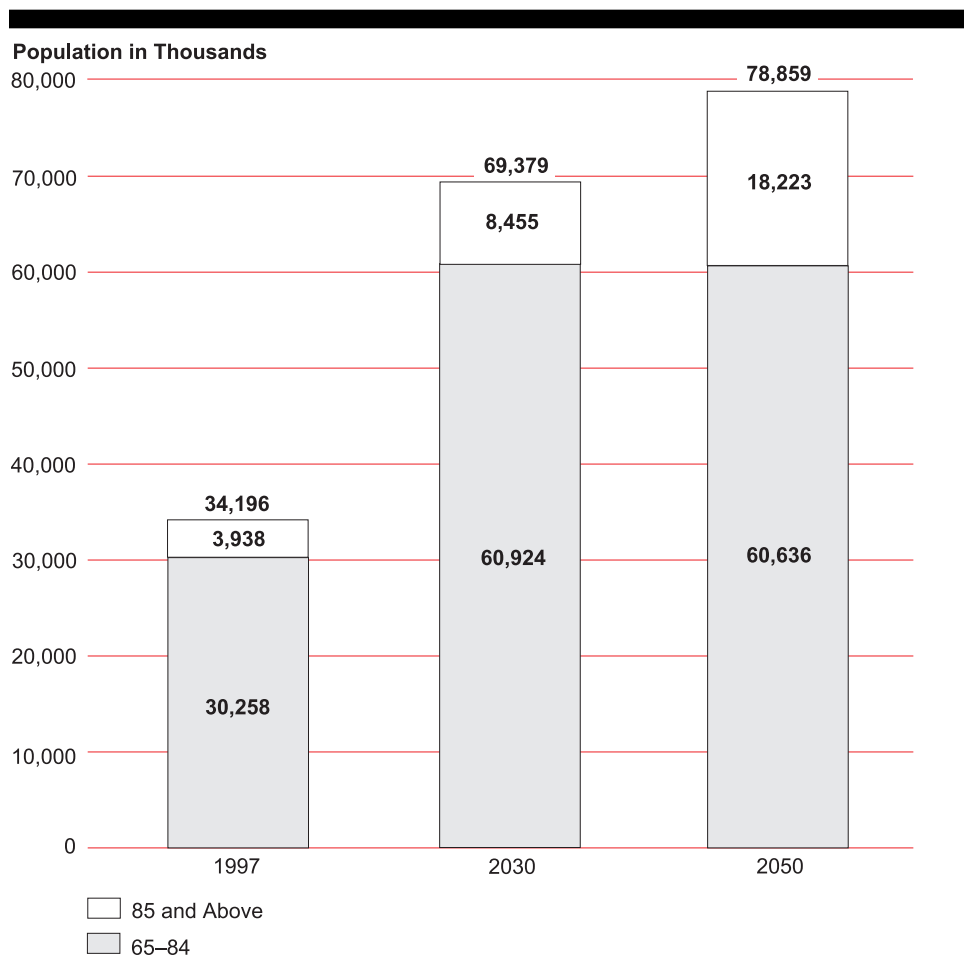
Today's elderly make up about 13 percent of the total population. The number of individuals aged 65 and over will make up about 20 percent of the total population in 2030, when the first of the baby boomers will reach their 85th birthday.<sup>4</sup> From 1997 to 2030, individuals 85 and older, the most rapidly growing age group and the group most likely to require long-term care, will more than double—from about 3.9 million to about 8.5 million individuals—and by 2050 will more than double again—to about 18 million

<sup>4</sup>The prevalence of chronic health conditions increases with age. Disability also increases with age, and the prevalence of disability increases markedly at advanced ages. Those aged 85 and older have almost double the rate of disability of those aged 65 to 74.

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individuals.<sup>5</sup> (See fig. 2 for the distribution of the elderly in 1997, 2030, and 2050.)

**Figure 2: Census Bureau Estimates of Number of Elderly Individuals in 1997, 2030, and 2050**



Source: U.S. Bureau of the Census, March 1996 and February 1998.

Nearly a quarter of the nation’s elderly population—an estimated 7.3 million in 1994 —require some assistance with either activities of daily

<sup>5</sup>U.S. Bureau of the Census, Resident Population of the United States: Estimates, by Age and Sex, Feb. 6, 1998; Bureau of the Census, Resident Population of the United States: Middle Series Projections, 2015 to 2030, by Age and Sex, Mar. 1996; and Bureau of the Census, Resident Population of the United States: Middle Series Projections, 2035 to 2050, by Age and Sex, Mar. 1996.

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living (ADL) or instrumental activities of daily living (IADL), or both.<sup>6</sup> Almost 80 percent of these 7.3 million elderly live at home or in other community-based settings, and about 30 percent of them are severely disabled, requiring assistance with at least three ADLs or needing substantial supervision because of cognitive impairment or other behavioral problems. About 22 percent—or 1.6 million—live in nursing homes. An estimated 1 million individuals live in residential settings that have services available, such as assisted living facilities. Experts agree that population aging will increase the number of disabled elderly needing long-term care over the next several decades, but no consensus exists on the size of that increase. While the sheer number of baby boomers is expected to drive up demand for long-term care services, projections of the number of elderly needing long-term care in the next century vary because of different assumptions about the future prevalence of disability.

Predicting the magnitude and composition of the growth in the elderly needing long-term care services is complicated by several factors. Some researchers argue that medical advances have increased life expectancy but have not changed the onset of illness. They predict that declining death rates may actually increase the need for long-term care if more people live to develop age-related disabling conditions or live longer with existing disabilities. Others argue that disability is becoming increasingly compressed into a shorter portion of the lifespan, decreasing the number of years long-term care is needed. Improved treatments or prevention of common disabling conditions among the elderly, such as strokes and arthritis, could lessen long-term care need, independent of death rates.

Nonetheless, recent forecasts of the number of disabled baby boomers who will need long-term care have been developed but differ widely, ranging from 2 to 4 times the current number of disabled elderly. How this will translate into the need for long-term care services and actual spending will depend on the public and private resources devoted to purchasing long-term care.

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<sup>6</sup>The need for long-term care is frequently measured by assessing limitations in an individual's ability to manage certain functions or activities that are basic for self-care. ADLs include bathing, dressing, toileting, getting in and out of a chair or bed, and eating; IADLs describe difficulty in performing household chores or social tasks and include taking medicine, preparing meals, cleaning, grocery shopping, and money management.



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## **Shifts in Medicaid and Medicare Funding of Long-Term Care Complicate Projections**

How the increased long-term care needs of the baby boom generation will be met or financed is uncertain. The past 2 decades have seen change in the types of long-term care services used by the elderly and in who paid for these services. The change has occurred in large part because of shifts in Medicare and Medicaid coverage as well as private purchases of long-term care. We still are experiencing considerable change, which makes it extremely difficult to project what type of services the baby boomers will need and who will pay for them.

Historically, the vast majority of long-term care was supplied in nursing homes or at home by family members and friends. Nursing home care was financed almost equally by residents' own resources and state Medicaid programs. Over the past 15 years, there has been a substantial increase in the number of people receiving paid services at home and relying less on nursing homes. A major contributor to this trend has been increased use of Medicaid-financed home care following passage of home and community-based waiver provisions in 1981. In addition, since 1989, Medicare expenditures for home care have grown rapidly.

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## **Medicaid, Largest Public Funder of Long-Term Care, Continues to Expand Home Care**

Medicaid is the largest public funder of long-term care. Most of Medicaid expenditures are for nursing home care, but in the past 15 years there has been a shift to home care. The result is a significant change in the proportion of people with the need for long-term care who are receiving Medicaid-financed services and in the average cost of those services.

State Medicaid programs have, by default, become the major form of insurance for long-term care, but only after individuals have become impoverished by "spending down" their assets. Medicaid long-term care spending for many of the elderly results from Medicaid coverage of people who have become poor as the result of depleting assets to pay for nursing home care, the average costs of which exceed \$40,000 per year. In most states, nursing home residents without a spouse cannot have more than \$2,000 in countable assets before becoming eligible for Medicaid coverage of their care.<sup>7</sup>

About two-thirds of nursing home residents in 1994 relied on Medicaid to help pay for their care. Slightly more than 25 percent of Medicaid nursing home residents were admitted as private pay residents. Both multiple nursing home stays and lengths of stay affect whether a private pay

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<sup>7</sup>Countable assets generally refer to liquid assets, excluding such things as a primary residence of any value and an automobile with a market value of \$4,500 or less.

resident spends down to Medicaid eligibility. For example, more than one-half of residents who entered as private pay residents and who have been in the nursing home 3 to 5 years are on Medicaid.

Traditionally, states emphasized nursing home care. In attempts to control their long-term costs, states imposed controls on the number of nursing home beds. They required assessment and screening of prospective residents to ensure that Medicaid financed nursing home care for the people who were most disabled. Some states also implemented payment systems to provide these facilities incentives to admit and care for the more disabled and higher cost residents.

States limited eligibility for home care out of concern about the potential cost of covering services for the large number of disabled who were cared for by their families at home. However, as part of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), the Congress established the home and community-based service waiver program: section 1915(c) of the Social Security Act gave states the option of applying for Medicaid waivers to fund home and community-based services for people who meet Medicaid eligibility requirements. These waivers gave states the ability to restrict the number and costs of eligible individuals. As states have become more experienced with the waivers and confident of their ability to manage these programs, they have expanded their financing of home and community-based care. All states now have home and community-based waivers, and over 200 waiver programs serve more than 250,000 individuals nationwide.<sup>8</sup> Medicaid expenditures for home and community-based waivers have increased an average of 32.7 percent per year from 1987 to 1996, reaching a level of \$5.8 billion in 1996.

States have used home and community-based waiver services not just to serve additional people at home, but to reduce reliance on nursing homes. In an earlier report, we found that three states we reviewed had restricted construction of new nursing home beds as they financed more home care services.<sup>9</sup> According to the National Academy for State Health Policy, 27 states provide waiver services in assisted living or board and care

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<sup>8</sup>Forty-nine of the fifty states have at least one home and community-based waiver. Arizona, the fiftieth state, has a program that functions similarly to such a waiver program.

<sup>9</sup>See Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (GAO/HEHS-94-167, Aug. 11, 1994).

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facilities.<sup>10</sup> Such settings may provide an alternative to nursing homes for someone whose care needs or family resources make it difficult to stay at home.

As they address the challenges identified with providing long-term care, states are expected to increasingly focus on Medicaid-funded care provided in the beneficiary's home or a community-based setting rather than expanding long-term care in nursing homes. Spending on home care in 1996 increased about 24 percent in comparison to the 3-percent increase in the overall program. According to the National Academy for State Health Policy, seven more states plan to expand home care to community-based residential settings, such as assisted living or board and care facilities. In the last 5 years, a number of states also have created forums to consider the direction and financing of long-term care—the National Conference of State Legislatures reports that at least 23 states have formed task forces or study commissions on this issue.

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### **New Payment System May Reduce Medicare's De Facto Long-Term Care Financing**

Since 1989, Medicare has become the largest funder of long-term home care, financing \$14.3 billion in care—or more than half of the home care purchased for the elderly in 1995. A new home health payment system, mandated by the Balanced Budget Act of 1997, however, may reduce the amount of long-term home care financed by Medicare.

Medicare traditionally had focused on acute care and consequently paid very little for long-term care. However, legislative and court decisions and consequent changes in guidelines have essentially transformed the home health benefit from one focused on patients needing short-term care after hospitalization to one that serves chronic, long-term care patients as well.<sup>11</sup> As a result, Medicare, on a de facto basis, has financed an increasing amount of long-term care through its home health care benefit.

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<sup>10</sup>Assisted living facilities are similar to other residential facilities, such as board and care facilities, that offer housing, meals, protective oversight, and personal care to people with physical or cognitive disabilities. Unlike nursing homes or many board and care settings, however, assisted living facilities attempt to provide residents with greater autonomy and control over their living and service arrangements.

<sup>11</sup>To qualify for Medicare home health care, a beneficiary must be confined to his or her residence (that is, "homebound"); require intermittent skilled care from a qualifying service—skilled nursing, physical therapy, or speech therapy; and be under the care of a physician, with the services furnished under a plan of care prescribed and periodically reviewed by a physician. If these conditions are met, Medicare will pay for additional qualifying services and home health aide, occupational therapy, and medical social service visits. Beneficiaries are not liable for any coinsurance or deductibles for home health services, and there is no limit on the number of visits for which Medicare will pay.

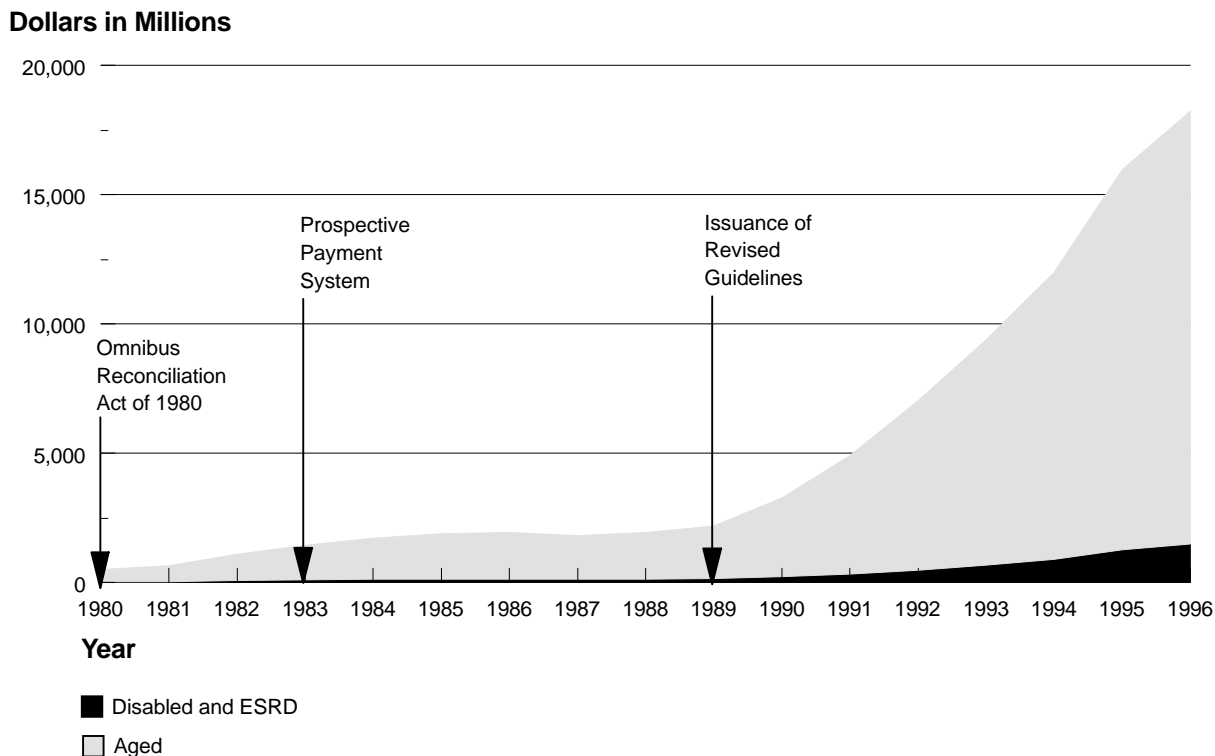
The increase in Medicare home health care use has been dramatic. Emerging trends in home health use suggest that Medicare is covering long-term care for increasing numbers of beneficiaries, rather than just skilled home health care. Both the number of beneficiaries receiving home health care and the number of visits per user more than doubled from 1989 to 1996.<sup>12</sup> A small but significant proportion of users receive extensive long-term support primarily from home health aides. The share of visits supplied by home health aides increased from about 25 percent of all home health visits in 1988 to almost 50 percent in 1995. At the same time, home health users without a prior hospitalization accounted for about one-third of all users in 1993. Figure 3 shows the growth of Medicare home health care expenditures and highlights major policy changes.

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<sup>12</sup>Medicare: Home Health Utilization Expands While Program Controls Deteriorate ([GAO/HEHS-96-16](#), Mar. 27, 1996).

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**Figure 3: Medicare Home Health Expenditures, 1980-96**



Notes: ESRD = end-stage renal disease.

The Omnibus Budget Reconciliation Act of 1980 removed both the requirement that a beneficiary be hospitalized for 3 days in the year prior to receiving home health care and the 100-visits-per-year limitation.

Source: HCFA's Office of the Actuary.

Medicare's role could shift significantly as a result of the Balanced Budget Act. The Balanced Budget Act will change the way that Medicare home health care is reimbursed from a cost-based per-visit payment system to a case-mix-adjusted prospective payment system in 1999. How this system will be designed to reflect differences in home health care needed by individuals with various disabilities and what incentives the system creates will have major implications for the amount of future Medicare funding for long-term care.

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## **Slow Growth of Long-Term Care Insurance Raises Questions About the Extent of Private Support**

The baby boomers, in general, are expected to be wealthier in retirement than their parents.<sup>13</sup> Those who are single or less educated, or who do not own homes, however, may not do as well. At the same time that many baby boomers will have greater financial resources, they will have fewer social resources, since this generation has remained single longer and had fewer children. As a result, a smaller proportion of this generation will have a spouse or adult children to provide unpaid caregiving. Geographic dispersion of families and the large percentage of women who work outside the home also may reduce the number of unpaid caregivers available to elderly baby boomers, creating more need for purchased services.

While many baby boomers will have more financial resources in retirement than their parents, what might be more important is whether they have insurance. Private long-term care insurance has been seen as a means of reducing the catastrophic financial risk for people needing long-term care, and relieving some of the financing burden currently falling on public programs. Some observers also believe private long-term care insurance could provide individuals greater choice in selecting services to satisfy their long-term care needs. Nevertheless, a very small proportion of the elderly or near-elderly have purchased long-term care insurance during the past 10 years. Concern exists that consumers are not knowledgeable about their risk for needing long-term care and about the limitations on Medicare and Medicaid long-term care coverage, and that this lack of awareness decreases demand for long-term care insurance. Questions also remain about the affordability of policies for the majority of elderly people and the value of the coverage relative to the premiums being charged.

Private long-term care insurance is a relatively new product with a growing market. In 1986, approximately 30 insurers were selling long-term care insurance policies of some type, and an estimated 200,000 people had purchased these policies. The Health Insurance Association of America (HIAA) has found that by 1995 125 insurers were offering long-term care insurance policies, and more than 4 million policies had been sold. Many fewer individuals had coverage, since many policies sold did not remain in force as individuals stopped paying premiums or dropped one policy to

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<sup>13</sup>This prediction depends on the assumption that real wages will continue to grow and that Social Security, private pensions, and health expenditures will remain stable.

purchase another.<sup>14</sup> Long-term care insurance financed less than 1 percent of long-term care in 1995.

Long-term care insurance is still struggling to gain a greater market share. A recent survey of the elderly and near-elderly found that only about 40 percent believe that they or their family will be responsible for paying for their long-term care.<sup>15</sup> HIAA reports that the industry expects continued growth, however, and that the “tax deductibility” of qualified policies will help accelerate that growth.<sup>16</sup>

The affordability of long-term care insurance will have a large impact on its market share. Assessments of the ability of private long-term care insurance to provide coverage to a majority of people who will need long-term care are pessimistic. HIAA reports that in 1995 policies paying \$100 a day for nursing home care and \$50 a day for home health care averaged annual premiums of \$1,881 when purchased at the age of 65 and \$5,889 when purchased at the age of 79.<sup>17</sup> Long-term care insurance, then, is most affordable for middle- and upper-income individuals. One recent study estimates that the proportion of elderly who can afford long-term care insurance ranges from 10 to 20 percent.<sup>18</sup>

Not only is the cost of long-term care insurance a problem for the elderly and near-elderly, but questions also remain about the value of the coverage relative to the premiums being charged. Individuals who consider and decide against purchasing long-term care insurance indicate

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<sup>14</sup>We found that insurance companies we reviewed expected about 20 percent of long-term care insurance policies to lapse during the first year of ownership and about half of all policies to lapse within 5 years. See *Health Care Reform: Supplemental and Long-Term Care Insurance* (GAO/T-HRD-94-58, Nov. 9, 1993).

<sup>15</sup>M.A. Cohen and A.K. Nanda Kumar, “The Changing Face of Long-Term Care Insurance in 1994: Profiles and Innovations in a Dynamic Market,” *Inquiry*, Vol. 34 (spring 1997), pp. 50-61.

<sup>16</sup>Section 321 of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, 110 Stat. 2054, amends the tax code to treat private long-term care policy and long-term care expenses the way health insurance policy and other health care expenses are treated under the code. The portion of such expenses that exceeds 7.5 percent of adjusted gross income is deductible. Private long-term care policy and long-term care expenses can now be included in calculating the amount of this deduction. However, aged-based limitations were established on the amount of these policy premiums that may be included in calculating this deduction. For example, individuals aged 51 to 60 are limited to including no more than \$750 of these premiums.

<sup>17</sup>These policies have lifetime 5-percent compounded inflation protection and a 20-day deductible period; adding nonforfeiture benefits increases average annual premiums to \$2,560 for 65-year-olds and \$8,146 for 79-year-olds.

<sup>18</sup>“Long-Term Care Insurance Special Report: How Will You Pay for Your Old Age?” *Consumer Reports* (Oct. 1997), pp. 35-50.

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skepticism about the policies' providing adequate coverage.<sup>19</sup> Also, as insurers have better understood their risks and competition has increased, premiums have decreased. Some potential purchasers may defer purchase of long-term care insurance because they expect a "better buy" in the future—that is, improved coverage at less cost.

We have reported on a number of problems in the long-term care insurance market—including disclosure standards, inflation protection options, clear and uniform definitions of services, eligibility criteria, grievance procedures, nonforfeiture of benefits, options for upgrading coverage, and sales commission structures that reduce incentives for marketing abuses.<sup>20</sup> By the end of 1996, all 50 states had adopted laws and regulations pertaining to long-term care insurance, and 38 states had adopted at least one-half of the provisions of the 1996 National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Act. The Health Insurance Portability and Accountability Act requires that long-term care insurance policies written after December 1996 meet requirements of NAIC Long-Term Care Insurance Model Act to qualify as tax-deductible. This requirement adds to consumers' protection.

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In conclusion, even though we cannot know the exact numbers of the baby boom generation who will require long-term care services, we do know that the aging of the baby boomers will lead to a tremendous increase in the elderly population in the next 3 decades and an even larger increase in the 85-and-over population who are more likely to use long-term care services. Financing these services will be a challenge for the baby boomers, their families, and federal and state governments.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or Members of the Committee might have at this time.

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<sup>19</sup>Cohen and Kumar, "The Changing Face of Long-Term Care Insurance in 1994," 1997.

<sup>20</sup>GAO/T-HRD-94-58, Nov. 9, 1993.



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# Related GAO Products

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Long-Term Care: Consumer Protection and Quality-of-Care Issues in Assisted Living ([GAO/HEHS-97-93](#), May 15, 1997).

Medicare Post-Acute Care: Home Health and Skilled Nursing Facility Cost Growth and Proposals for Prospective Payment ([GAO/T-HEHS-97-90](#), Mar. 4, 1997).

Medicare: Home Health Utilization Expands While Program Controls Deteriorate ([GAO/HEHS-96-16](#), Mar. 27, 1996).

Long-Term Care: Current Issues and Future Directions ([GAO/HEHS-95-109](#), Apr. 13, 1995).

Long-Term Care: Diverse, Growing Population Includes Millions of Americans of All Ages ([GAO/HEHS-95-26](#), Nov. 7, 1994).

Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs ([GAO/HEHS-94-167](#), Aug. 11, 1994).

Health Care Reform: Supplemental and Long-Term Care Insurance ([GAO/T-HRD-94-58](#), Nov. 9, 1993).

Long-Term Care Insurance: High Percentage of Policyholders Drop Policies ([GAO/T-HRD-93-129](#), Aug. 25, 1993).

Long-Term Care Insurance: Risks to Consumers Should Be Reduced ([GAO/T-HRD-91-14](#), Dec. 26, 1991).

Long-Term Care Insurance: Consumers Lack Protection in a Developing Market ([GAO/T-HRD-92-5](#), Oct. 24, 1991).

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