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Filling in the Gaps in Long-Term Care Insurance: Policy Implications for Care Workers

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Edited by | *Madonna Harrington Meyer*

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Filling in the Gaps in Long Term Care Insurance

Policy Implications for Informal Care Workers

Informal care, defined as unpaid care or care that is provided outside of the market, comprises a significant portion of all long term care of the elderly. Most informal care is provided by family members, and among family members, daughters are the largest source of this care. Daughters are more likely than sons to be the primary source of care, and on average provide more hours of care than do sons. In addition, the wives of frail elders provide a substantial portion of informal care. These facts imply that women, to a greater extent than men, play an important role in the long term care of elderly family members. Research findings suggest that more than half of all women will provide care for an ill or disabled person at some point in their lives (Robinson, Moen, and Dempster-McClain 1995). Over time, women's participation in elder care has remained significant, despite increasing pressures on women's time from career and family obligations.

This chapter examines the connections among women's roles in the provision of long term care, the structure of the health insurance system for the elderly in the United States, and the policy options for reducing the burden of long term care. The first part of the chapter deals with the characteristics of the provision of long term care in the United States. In particular, I discuss how existing public and private insurance options fall short of covering all long term care needs, and the degree to which women participate in the provision of informal care. I use the term *caregiver* when citing previous research studies that employ this term to refer to those who provide informal care. Because many providers of informal

care do so at a serious cost of their time and well-being, I use the term *care worker* elsewhere.

I next turn to the question of how current policy solutions may alter the dynamics of informal care. Policy solutions to the burden of long term care have the potential for serious changes for care workers. Of the leading policy options, private insurance is seen by many as the best way to shift the burden of care from families and Medicaid to the paid private sector. Current attempts to increase private insurance include tax incentives for long term care insurance and public-private partnerships for long term care. Despite the focus on private insurance, there is much evidence that private insurance lacks the potential to alter long term care coverage on a large scale. For this reason, policies to increase private insurance coverage are unlikely to significantly reduce the burden of care work on family members.

A second policy option for long term care is social insurance. Social insurance for long term care is subject to many criticisms. One such criticism is that compulsory social insurance programs may actually make individuals worse off, if they would prefer that family members serve as a form of "insurance" for long term care. The evidence, however, fails to support this criticism of social insurance for long term care. The cost of social insurance for long term care is also thought to be prohibitive, but the high cost of informal care work for those who provide it must also be considered. If the United States considers reducing the burden on care providers to be a policy goal, then these types of evidence suggest that the current form of market-based policies aimed at increasing private insurance will have limited effectiveness. Other forms of market-based policies or social insurance options need to be explored.

Insurance for long term care in the United States

Despite the presence of an entitlement program for acute care, the United States health insurance system is characterized by serious gaps in the coverage of long-term care for the elderly. The gap begins with the Medicare program, which is the major source of health insurance for nearly 40 million Americans over age 65. Medicare covers most acute care needs, but does not include coverage for chronic care such as nursing home care. The exception is when an elderly person is released to a skilled nursing facility (SNF) directly from an inpatient hospital stay and under physicians' orders. In this case, only the first 20 days of care in the skilled nursing facility are covered. With the purchase of supplemental insurance for Medicare — or Medigap — individuals have the option of additional coverage for SNF care. Three-fourths of all Medicare recipients own Medigap policies, and three-fourths of those policies include an option for additional coverage for skilled nursing home facility care (Rice, Graham, and Fox 1997). Although these

statistics suggest that Medigap coverage for nursing care is widespread, this type of coverage is inadequate. It covers a maximum of 100 days of care in a skilled nursing facility, and then only when preceded by a Medicare-covered hospital stay. Most important, the care provided in skilled nursing facilities is distinct from the custodial or personal care provided in nursing homes, which includes the kind of assistance with eating, dressing, and bathing that is often required by those in need of long term care. It is expected that many elderly are unaware that Medicare and Medigap fail to cover nursing home costs and other long term care expenses. In the absence of these types of coverage for long term care, many must choose between "spending down" their assets to become recipients of Medicaid or purchasing expensive private insurance.

Medicaid

The cost of a year of nursing home care averages around \$40,000 in the U.S., and varies significantly by region. Paying for this type of care out of pocket can quickly exhaust the savings of many elderly persons. When their assets are near depletion, many recipients of long term care become eligible for the Medicaid program, the means-tested public health insurance program for the poor, disabled, and medically needy. Under the eligibility criteria of the program, assets can be no greater than roughly \$2,000, excluding the value of the individual's home. Any monthly income in excess of a small nursing home allowance — typically \$30 a month — is transferred to the state to compensate for part of the cost of nursing home care. For many of the elderly, public programs such as Medicaid are the primary means of financing long term care needs. Of the \$115.1 billion spent on long term care in 1997, 60 percent was financed by the federal government and states (Health Care Financing Administration 1999a). In 1997, 14 percent of all public medical expenditures on health care went toward nursing home care or home healthcare (Health Care Financing Administration 1999a).

While Medicaid pays a substantial share of the costs of long term care, there are many concerns about the quality of care received in Medicaid-affiliated institutions. The low reimbursement rates set for nursing homes by Medicaid have led to concern about uneven care and inadequate medical attention (Institute of Medicine 1986). In addition to concerns about quality, the elderly and their families may also be concerned about the stigma attached to participation in Medicaid, known as a welfare-related insurance program for the poor. Medicaid is also biased toward institutional care. Almost three-fourths of Medicaid spending on long term care in 1996 was directed toward institutional care, with the remainder going for community-based care (Health Care Financing Administration 1998).

Private Insurance for long term care

Privately purchased insurance policies can cover long term care costs without requiring the insured to deplete private assets or to enter a Medicaid-affiliated institution. These types of policies are relatively new products and are still not widely held. The market for private long term care insurance came into existence in the mid-1980s, and it is estimated that about 4 to 5 percent of the elderly hold such policies. There is a great deal of variation in the features of private long term care insurance policies. Policies usually cover stays in nursing homes, and sometimes cover home care, community care, or adult day care. Benefits usually become payable when the insured person is unable to perform certain activities of daily living, such as bathing, dressing, and eating, although some policies require medical certification or prior hospitalization before benefits are triggered. Policies also vary in the length of the elimination (waiting) period, which may mean that benefits begin between 20 and 100 days after the insured enters a nursing home. Once the insurance company begins making payments, payments may cover only the services specifically defined by the policy, or the insurer may pay benefits to the insured regardless of the specific services received. In most cases benefits are paid out daily or weekly (to coincide with the daily or weekly rates of nursing home care) and up to some lifetime maximum amount. Some policies are sold with inflation protection, which allows benefits to increase with inflation.

One suggested explanation for the low coverage levels of private insurance is the size of the premiums. In 1995, the average annual premium for a standardized individual long term care insurance policy, including inflation protection and other options, was \$2,560 for a 65-year-old; the annual premium for the same policy purchased by a 75-year-old individual was \$8,146 (Coronel and Kitchman 1997). Many elderly may forgo the purchase of insurance because they lack information about insurance policies or about their own future needs. In addition, the availability of insurance policies for long term care may be limited. Insurance companies may be wary of the costs of offering this type of insurance since it holds greater appeal to those already in need to care.

In summary, while the Medicare program addresses the acute-care needs of the elderly, it does not provide the long term care that an estimated 7.3 million Americans over age 65 need. Medicare supplemental insurance does not provide coverage for chronic care either. Private long term care insurance is available; however, it is not very common, and the policies can be very expensive. Private insurance is often unavailable to individuals who are already in poor health and appear to need care in the near future. Companies will inquire about previous hospitalization or wheelchair use before issuing a policy; they may also review medical records and physician assessments of the individual's health. Coverage is

often refused for persons with serious conditions that indicate nursing home use in the near future; individuals with other pre-existing conditions may have difficulty finding coverage or receiving benefits. The high cost of private insurance options, in conjunction with the quality concerns associated with Medicaid and institutional care in general, could explain in part the prevalence of informal caregiving by family members.

The Prevalence of Informal Caregiving

In contrast to statistics that suggest low levels of formal (market-based) insurance for long term care, many studies have noted the prevalence of informal caregiving. Approximately 80 to 90 percent of the care provided to impaired elderly persons is carried out by family members (Cantor 1989:106–7). Early studies, based on the 1982 National Long Term Care Survey, indicate that daughters and wives are especially involved in the provision of care. Stephens and Christianson (1986) found that daughters spent six hours per day providing care, while sons spent about four hours (46–47). Similarly, Stone, Cafferata, and Sangl (1987) found that caregivers are predominantly female (72 percent) and that daughters were more likely than sons to assume the role of caregiver. A large majority of caregivers (90 percent) provided care without the assistance of formal services. Many caregivers were also employed in market work at the time they provided care; more than 40 percent of daughters and 50 percent of sons had paying jobs. Almost one-third of these caregivers reported family incomes that were below or near the poverty line.

Analysis of more recent data has been consistent with earlier evidence of a greater level of involvement by women and daughters in caregiving activities. Three-quarters of primary caregivers sampled in the 1989 National Long Term Care Survey were female (Doty, Jackson, and Crown 1998). The care recipients in this survey were predominantly low income. Nearly 73 percent had incomes under \$15,000 a year, which suggests serious financial constraints for the 40 percent of primary caregivers who are spouses, as well as other family members. Analysis of data from the 1993 Study of Asset and Health Dynamics of the Oldest Old showed that daughters were 9 percentage points more likely than sons to provide care, controlling for characteristics of the care recipient and the caregiver (Wolf, Freedman, and Soldo 1997). When care was provided by both sons and daughters, daughters provided between 10 and 18 more hours of care per month than sons. Even when differences in past receipt of financial support from parents are taken into account, daughters remain more likely to provide care to parents than sons (Henretta, Hill, Li, Soldo, and Wolf 1997).

Spitze and Logan (1990) summarize several explanations for the difference in caregiving efforts between daughters and sons. Leading explanations include so-

ciety's assignment of gender roles, which designate nurturing activities to women more than men, and the stronger emotional bonds between daughters and their parents. Economic factors may also explain the larger role of women in the caregiving process. Women face a lower opportunity cost of providing care because fewer women than men work outside the home, and their wages tend to be lower. Differences in caregiving efforts remain, however, when labor market status is held constant (Stoller 1983).

The burden of informal caregiving may be even greater among women of color. Previous research has found that blacks use fewer days of nursing home care than whites, either because of discrimination by nursing homes (Falcone and Broyles 1994) or because blacks have been shown to have a greater availability of unpaid caregivers among family members (Burton, Kasper, Shore, Cagney, LaVeist, Cubbin, and German 1995). A survey of caregivers conducted by the National Alliance for Caregiving and the American Association of Retired Persons (AARP) reported that caregiving was slightly more prevalent among Asian, African-American, and Latino families than white families (National Alliance for Caregiving and the AARP 1997).

The persistent finding of women's significant role in the provision of long term care has motivated much research on the effects of caregiving on women's work patterns and well-being. The causal relationship between care work and employment has been difficult to identify empirically because of the possible existence of reverse causality (that is, employment status may shape one's decision to engage in care work), and the inability to control for certain factors that may affect both employment and care work decisions simultaneously. As a result, the research in this area often reports mixed results, depending on the choice of econometric techniques and other differences in data sets and time periods. Of the many studies on the linkage between care work and employment, only a subset specifically address the problems of causality or simultaneity. Wolf and Soldo (1994) reported that among married women, caring for an elderly parent was not associated with reduced employment or hours of work. In a similar study using different data, Ettner (1995) found that for women ages 35 to 64, living with a disabled parent led to a significant reduction in hours worked. Using three years of data on caregiving and labor force participation, Pavalko and Artis (1997) found that caregivers experienced a reduction in the number of hours in paid employment when care work began, and that when care work ceased, there was no increase in hours of paid employment.

Studies of caregivers also reveal serious behavioral health consequences. Gallagher, Rose, Rivera, Lovett, and Thompson (1989) reported that 49 percent of female caregivers were clinically depressed, and George and Gwyther (1986) found that caregivers of demented adults used prescription drugs for depression, anxiety, and insomnia at two to three times the rate of the rest of the population. In economic terms, the cost of the time spent providing informal care is substantial.

Estimates of the opportunity cost of informal care services based on the minimum wage suggest that providing informal care for an elderly person with a problem in at least one activity of daily living can cost between \$7,280 and \$10,403 a year (Robinson 1997:245). Estimates based on the market value of informal care services (the cost of informal care were it purchased in the market) are similar, and are as much as \$7,680 a year (Harrow, Tennstedt, and McKinlay 1995). As would be expected, the value of informal care for persons with Alzheimer's disease is much greater, and has been estimated to be \$34,000 a year (Max, Webber, and Fox 1995). Ward (1990) estimated that the total value of uncompensated care provided by family members, in terms of forgone wages, may be as much as \$18 billion a year. Thus, in terms of the opportunity cost of time and in terms of psychic costs of illness and stress, informal caregiving places a high cost on those who provide it.

A variety of demographic trends suggest that the burden of caregiving on women will increase. The population aged 65 and older numbered 34.2 million in 1995 and is projected to be about 60.8 million by the year 2025. Gains in the life expectancy of 65-year-olds, from 14 years in 1980 to a projected 15.6 years in 1999, imply that the duration of caregiving may lengthen. Finally, the trend toward smaller family size, from 3.6 persons in 1970 to 3.2 persons in 1995, implies that there will be fewer caregivers available in the form of family members. These demographic trends together suggest that the demand for long term care will increase in the near future while the supply of informal care providers decreases (U.S. Bureau of the Census 1997; Health Care Financing Administration 1999b).

Policies to Address the Burden of long term care

The low level of private coverage for long term care is associated with high levels of informal caregiving by family members, and also with high levels of public expenditure by the federal government and the states. The costs of long term care borne by the Medicaid program totaled more than \$69.1 billion in 1993, and long term care spending by Medicaid grew at an average rate of 13.2 percent a year between 1989 and 1993 (U.S. General Accounting Office 1995:8, 13). Only a small fraction of total long term care costs (0.2 percent of \$100 billion) was paid by private long term care insurance. In an attempt to keep these costs under control, several policies have been considered or are being evaluated. While the control of formal costs is the primary motivation for these types of policies, increasing coverage for private long term care insurance may provide some relief to care workers themselves. In the United States, current policy initiatives for long term care have focused primarily on using the market for private insurance as a way to reduce public costs. These policies include tax incentives for long term care insurance and public-private partnerships for long term care.

Tax Incentives for Long Term Care Insurance

There have been various attempts to use the tax code to create incentives for the purchase of private long term care insurance, dating back to its emergence on the market. In 1988, the House of Representatives considered legislation to align the tax treatment of long term care insurance with the treatment given to health insurance plans, and to offer tax credits to individuals who purchased long term care insurance. This attempt at legislation failed, as did similar legislation introduced in 1991. In 1994, calls to change the tax treatment of long term care insurance appeared in the Republicans' *Contract with America*. These were followed in 1995 by proposed legislation to exclude employer contributions to long term care from employer and employee gross income and to treat long term care expenses as medical expenses, thus making them tax-deductible. Finally, with the passage of the Health Insurance Portability and Accountability Act of 1996 (the Kassebaum-Kennedy legislation), Congress successfully enacted tax incentives for long term care insurance. Effective January 1, 1997, taxpayers could deduct qualified long term care expenses as itemized medical expenses. The allowable deductions include the premium for long term care insurance coverage. In addition, employer contributions toward the cost of group long term care insurance became a tax-deductible expense for employers.

Proposals to increase long term care insurance through tax incentives have been openly criticized. In their 1994 book *Sharing the Burden*, authors Wiener, Illston, and Hanley include a detailed discussion of the shortcomings of allowing employer contributions and the taxpayer purchase of long term care insurance to be tax-deductible. Taxpayer deductions of the cost of long term care insurance are equivalent to subsidies for long term care insurance premiums, where the size of the subsidy increases with the marginal tax rate. This type of subsidy is regressive, in that it benefits higher-income households more than lower-income households. As a result the benefits of tax incentives are much smaller for the members of low-income families who provide a disproportionate share of unpaid care work and who face the greatest challenge in affording this type of insurance.

Wiener, Illston, and Hanley also state that the effect of deductions for long term care insurance on long term care coverage is limited by the fact that few taxpayers itemize deductions. They cite statistics showing that only 29 percent of tax returns included itemized deductions, and only 4 percent included itemized medical deductions in 1993. The authors also estimate that the costs for each additional person with long term care insurance under tax policies similar to those included in the Kassebaum-Kennedy legislation would be quite high, and would exceed any Medicaid savings. They also suggest that those most likely to benefit from these tax policies are individuals who would have purchased insurance in the absence of subsidies (Wiener, Illston, and Hanley 1994:85–86).

and the care expenses must have been incurred so that the taxpayer could continue working. Proposals to extend the dependent care tax credit during the 105th Congress were unsuccessful.

President Clinton's initiative differs significantly in that the proposed \$1,000 credit would apply to informal care costs in addition to out-of-pocket expenses. This proposal takes an unprecedented step to recognize the value of informal costs, and builds on efforts to lessen the burden of providing care for families through the Family and Medical Leave Act of 1993. The initiative nonetheless has its limitations. A \$1,000 tax credit is only a fraction of the total cost borne by those who provide informal long term care. Estimates place the informal care anywhere from seven to ten times that amount, and as much as 34 times that amount in the case of caregiving for persons with Alzheimer's disease. Another limitation is the use of tax credits to recognize the costs of long term care. Kuttner states in the *Post* editorial that the income of 40 percent of the elderly is so low that no income taxes are owed; these needy elderly would receive no benefit from a tax credit. Finally, similar to the dependent care tax credit, the proposed program requires that the caregiver reside with the recipient of long term care. So, for approximately 32 percent of all providers of informal care who live apart from the care recipient, the tax credit would not apply (Doty, Jackson, and Crown 1998).

Compulsory Social Insurance: The Case of Germany

While the United States has focused primarily on reforms in the private insurance market for long term care, other countries are taking bolder initiatives to control long term care costs. In 1994, Germany passed legislation to enact a compulsory social insurance policy for long term care. Prior to the enactment of this law, Germany addressed such needs with a combination of short-term nursing home coverage for those covered by national health insurance, long term care insurance benefits for public servants, and a means-tested program that paid for long term care if individuals became impoverished paying for home care or nursing home expenses. The Statutory Long Term Care Insurance Act, which went into effect in 1995, established a new branch of the social insurance system specifically for long term care insurance. All German citizens must enter into the program, unless they can provide evidence of a private policy that provides benefits similar to the social insurance program. The program is financed by employer and employee contributions of 1.7 percent of payroll.

Germany's social insurance for long term care places special importance on allowing persons in need to remain in the community as long as possible. To that end, monthly cash benefits or in-kind benefits provide coverage for home care up to set limits. Professional caregivers are offered relief nurses for up to four weeks a year. In order to provide incentives for caregiving from family members, nonprofessional caregiving is treated as market-based employment by the pension pro-

gram. When institutional care becomes necessary, the social insurance scheme allows for a monthly payment to cover nursing home stays (Schulte 1996).

Potential Impacts of Policies on Care Workers

Attempts to increase private insurance coverage for long term care have been greeted with skepticism. A subsidy for long term care insurance would be regressive, may benefit individuals who would have bought insurance anyway, and would be of value only to the minority of taxpayers who itemize deductions. The public-private partnerships for long term care would make Medicaid-provided nursing home care easier to access, when many of those interested in private insurance wish to avoid Medicaid. Preliminary statistics on the number of new policies purchased through the partnership programs have been referred to as "disappointing" (Wiener 1998).

The partnerships rely on asset-protection motives to entice people to buy long term care insurance policies. As stated earlier, some have questioned how important these motives are in the decision to buy insurance. In my own work, I find that assets do have a strong association with owning insurance for long term care, but only when assets are above \$200,000 (Mellor 1999a). This finding suggests that private long term care insurance is considered an option for those with substantial resources, and that the partnership program is potentially a vehicle to provide the well-to-do with Medicaid coverage.

The many criticisms and limitations of private insurance options to reduce the financial burden of long term care can be extended to their ability to reduce informal care burden. If tax incentives for long term care insurance are severely limited in their ability to increase long term care insurance coverage, then it follows that they are limited in their ability to alleviate costs to the public through Medicaid programs, and also to reduce the burden of care workers providing informal care to those without insurance.

Substitutes for Insurance

Social insurance programs, such as the one enacted in Germany, appear to hold greater promise for alleviating care worker burden than do market-based policies aimed at increasing private insurance for long term care. The German program provides comprehensive coverage for long term care to all citizens, and provides relief for professional caregivers and pension benefits for nonprofessional (informal) caregivers. Not surprisingly, however, social insurance for long term care does not appear to be a politically viable option in the United States in the wake of the failed proposal for universal health care in the early part of the Clinton administration.

The concept of compulsory social insurance has among its critics those who believe that social insurance can actually make an individual less well-off from an efficiency standpoint. Economists Peter Zweifel and Wolfram Strüwe (1998) offer such a criticism of Germany's social insurance program. Their theoretical model of a parent's propensity to purchase long term care insurance suggests that when children with low wages are available as potential care providers, the purchase of insurance will result in welfare loss for the parent. Zweifel and Strüwe's interpretation of their theoretical results leads them to suggest that compulsory social long term care insurance programs will have adverse consequences for welfare.

This interpretation is based on the notion that children and insurance are interchangeable—that is, children are substitutes for insurance. This concept has been expressed in previous literature, especially with respect to developing countries, but the question of whether the elderly do not buy insurance because of the availability of children (i.e., potential caregivers) had not been tested empirically until recently. In recent work (Mellor 1999b), I found that neither the presence of children, nor the presence of female children specifically, reduced the extent of coverage for long term care insurance. In some cases, the opposite relationship was observed—some parents with children who were potential caregivers were more likely to have private insurance for long term care. These findings are in contrast to the notion that family members serve as substitutes for long term care insurance, and refute the specific criticism that social insurance programs for long term care are inefficient because they require the purchase of unwanted insurance by persons who would rather use children to substitute for insurance. While many concerns about social insurance for long term care remain, notably the costs of such a program, at least one such criticism should be ignored.

Conclusion

The current provision of long term care is characterized by low levels of private insurance, high Medicaid program costs, and a substantial contribution by informal care workers. The United States is currently addressing the financial burden of long term care by opting for market-based policies to increase private insurance. Yet, as presented here, there are a number of reasons why tax incentives and public-private partnerships would have limited effects. Taxpayer deductions of the cost of long term care insurance are equivalent to subsidies that benefit those with higher incomes far more than the poor. Using public-private partnerships for long term care insurance may increase coverage by appealing to those with high levels of assets to protect, but this approach is far less appealing to the poor families who are bearing a sizable burden of unpaid care work. The current market-based policies offer the greatest benefits to those with higher incomes and

asset levels, the same individuals who have options for the provision of long term care other than informal care work. The population in greatest need for better access to long term care insurance—the low-income women and minority family members who are providing care at a significant cost of their time—are offered little relief by the current market-based policies.

The emphasis on market-based approaches is not unique to the problem of long term care; instead, it echoes a larger trend toward using market principles to approach the reform and provision of social programs. Other examples of this trend are exhibited by the emphasis on privatization as a means to save Social Security, and the reform of Medicare through managed care. This trend, documented and critiqued by Jill Quadagno (1999), is based on the idea that the welfare state is an impediment to market performance. The problem with applying market-based approaches to social problems, according to Quadagno, is that since they rely on the tax system and private investment they can create a two-tiered society, where “the welfare state would consist of an investment class and a class of those too poor to invest” (Quadagno 1999:8).

Returning to the case of long term care, the use of social insurance programs, such as that enacted in Germany, is largely overlooked as a viable option in the United States. Some criticize social insurance for long term care on the grounds that it is inefficient when family members prefer to provide care. First, one must challenge the notion that family members are the preferred providers of care, in light of surveys in which elderly people reveal their desire to avoid burdening family members with the responsibility of care work (Life Plans Inc. 1992:28). As is more likely to be the case, children are forced into the position of providing care because other options do not exist: Medicare does not cover long term care, and private insurance is costly and difficult to get for those with pre-existing conditions. Moreover, recent research rejects the criticism that social insurance is inefficient on these grounds, finding that children are not substitutes for insurance.

Social insurance for long term care is also said by some to be at odds with the fiscal realities faced by the United States. Social insurance for long term care in the United States would undoubtedly share some of the same budgetary concerns that are apparent in the current debates over Social Security and Medicare financing. However, an important element of the cost of long term care has been overlooked. When the cost of informal care work to those who provide it is taken into account, social insurance may be less costly than the current approach. Government decisions to save money using policies to encourage private insurance that appeal to the wealthy and those in higher income levels may have been made without considering the value of time contributed by care workers. Finally, consideration must also be given to equity. The current system, which places the burden of long term care largely on women, is far less equitable than a social insurance system that spreads the burden across society.

In the absence of broad federal policies, many state and local agencies have developed programs to assist care workers in a variety of ways. These include attempts to help care workers deal with stress and policies to provide respite care or subsidized paid care. Subsidizing formal care raises questions about whether family members will use formal services as substitutes for the care they provide. A reduction in effort could potentially increase government expenditures dramatically. Substitution is a complex issue; it is difficult to measure empirically, and some degree of substitution is actually intended as respite or relief. While no easy solution to the rising costs of both formal and informal long term care is at hand, evidence points to the limitations of private long term care insurance policies to dramatically improve coverage among the elderly. Current market-based approaches do not offer targeted relief to the low-income providers of informal care, and as a result, other policy options need to be considered.