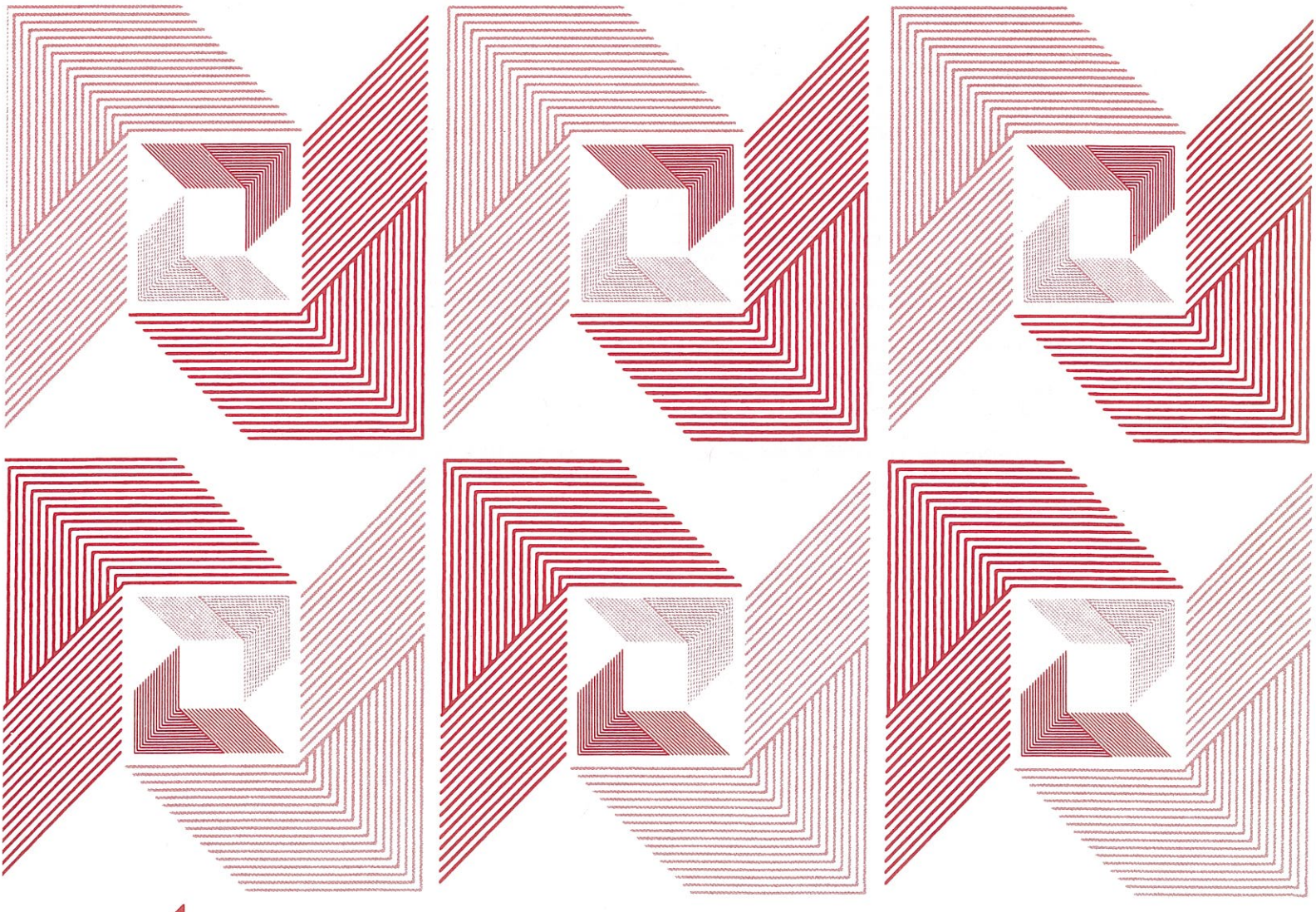
Report No. 90-1
January 1990

FEASIBILITY STUDY OF EARMARKING TAX REVENUES FOR A LONG-TERM CARE INSURANCE PROGRAM

A REPORT TO THE GOVERNOR AND THE LEGISLATURE OF THE STATE OF HAWAII



SUBMITTED BY THE LEGISLATIVE AUDITOR OF THE STATE OF HAWAII

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OVERVIEW

FEASIBILITY STUDY OF EARMARKING TAX REVENUES FOR A LONG-TERM CARE INSURANCE PROGRAM

Honolulu, Hawaii

January 1990

Summary

The financing of long-term care is a challenge facing state governments throughout the United States. The catastrophic expenses of long-term care quickly deplete personal assets so that many people have no recourse but to turn to Medicaid for help. Concern for the growing burden placed on the Medicaid budget led the Legislature to consider different ways to finance long-term care. One alternative is an insurance program financed by the state and supported by earmarking the excise taxes collected on health care services. The auditor was asked to examine the feasibility of this proposal.

The underlying principle of earmarking tax revenues, called the benefit theory, says that those who benefit from a program should support it. The motor fuels tax, for example, is earmarked to support highway construction and maintenance. Earmarking for human service programs has become more prevalent, particularly in states hoping to obtain additional revenues from lotteries or casinos. Only two states, Hawaii and New Mexico, tax almost all health care services.

Long-term care insurance was intended to protect people's personal assets against the catastrophic expenses of long-term care. Most policies are based upon a "medical model" and cover only the skilled care provided in institutional settings. Studies have shown, however, that patients today do not need expensive institutional care. They require help with the activities of daily living that enable them to main independent lifestyles. These personal and social services are not covered in most long-term care policies. Therefore, the actual use of insurance to cover long-term expenses has been minimal--less than one percent of these expenses has been paid for by private insurance.

FINDINGS

Earmarking the tax revenues collected on health care services to support a program for long-term care insurance is not justifiable.

The proposal does not meet the primary principle of earmarking--that a clear relationship should exist between those who pay taxes on health care and those who would receive the benefits of long-term care insurance. Many tax policy analysts consider the tax on health care regressive because it burdens those who need these services and does not take into account their ability to pay. To many, the tax is onerous because it is imposed upon services essential to individual well-being. Finally, long-term care insurance has not yet been shown to be an effective financing mechanism.

CONCLUSION

Earmarking general excise tax revenues collected on health care services to finance a long-term care insurance program is not feasible. Tax policy and principles of earmarking do not support designating a regressive tax to finance a program in which benefits are not directly received by those who support it. The concerns of experts indicate that no one knows whether long-term care insurance will be effective in protecting personal assets and relieving the burden now placed on Medicaid.

Further consideration of financing long-term care through insurance should therefore await more comprehensive study, such as that being conducted by the Executive Office on Aging.

FEASIBILITY STUDY OF EARMARKING TAX REVENUES FOR A LONG-TERM CARE INSURANCE PROGRAM

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A Report to the Governor and the Legislature of the State of Hawaii

Submitted by

Legislative Auditor of the State of Hawaii
Honolulu, Hawaii

Report No. 90-1
January 1990

FOREWORD

The financing of long-term care is a challenge facing state governments throughout the country. The increasing burden placed upon the Medicaid budget by long-term care expenses has caused the Hawaii Legislature to explore alternative financing mechanisms. This report examines current policy issues related to earmarking, taxation of health care, and long-term care financing methods in order to evaluate the feasibility of earmarking tax revenues for a long-term care insurance program.

We wish to acknowledge the assistance extended to our staff by the following state and community agencies: Department of Taxation, Executive Office on Aging, Tax Foundation of Hawaii, the Community Long-Term Care Branch of the Department of Human Services, Healthcare Association of Hawaii, Long Term Care Association, Long Term Care Hawaii, American Association of Retired Persons, and the Legislative Reference Bureau.

Newton Sue
Acting Legislative Auditor

January 1990

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Chapter 1

INTRODUCTION

This is a report on the feasibility of earmarking revenues received from the 4 percent general excise tax on health care services to finance a long-term care insurance program. This study was requested by the 1989 Hawaii Legislature under Senate Concurrent Resolution No. 137.

The request reflected the Legislature's concern that a large portion of long-term care is paid by the Medicaid program, and that the State needs to explore alternative means of financing. The Legislature also expressed its desire that the insurance program provide benefits to all Hawaii residents, regardless of age, for all their long-term care needs.

Objectives of the Study

The objectives of this study were:

1. To provide background information on tax policy, long-term care, and long-term care insurance concepts.

2. To assess the feasibility of earmarking the tax on health care services to finance a long-term care insurance program for all Hawaii residents.

Scope and Methodology

The study was limited to the issue of whether to earmark general excise tax revenues for a state-financed long-term care insurance program. We note that related studies are being conducted by the Legislative Reference Bureau (LRB) and the Executive Office on Aging (EOA). The LRB report evaluates the use of tax credits to encourage the purchase of private long-term care insurance. The EOA has hired a consultant to evaluate the future impact of long-term care insurance in Hawaii.

In order to conduct this analysis, we collected information on state tax policy related to earmarking and on services, programs, financing, and insurance related to long-term care. Our information sources included textbooks, journals, periodicals, and studies. We interviewed state program administrators and individuals in the community who have knowledge in the areas of tax policy, long-term care, or insurance.

Organization of the Report

This report consists of three chapters. Chapter 1 is this introduction. Chapter 2 provides background information on tax policy, long-term care financing sources, and long-term care insurance concepts. Our findings and conclusion are presented in Chapter 3.

Chapter 2

ISSUES OF EARMARKING, TAXATION, AND LONG-TERM CARE

In this chapter, we present the principles and practices of earmarking, and the policy relating to taxation of health care. We also provide some background on the evolution of long-term care and a discussion of long-term care financing sources, particularly the development of long-term care insurance.

Earmarking of Tax Revenues

Earmarking is defined as "the designation of certain revenue for specific purposes on a continuing basis."[1] The underlying principle of earmarking is that revenue will be sufficient to meet program demands. This principle is based upon the benefit theory that "those who benefit from the program should pay for the program."[2]

Justifications and criticisms of earmarking. The primary justification for earmarking is that it requires those who receive the benefits of government service to pay for it. The case for earmarking is strongest when the taxes that support a program are paid primarily by those who benefit from the program. Earmarking a particular revenue source can also ensure continuity in funding for a program and guarantee a minimum level of expenditures. Finally, earmarking can be used to justify new or increased taxation by guaranteeing that the revenues will support a popular program.[3]

Criticisms of earmarking center on one fundamental point--that it interferes with the ability of policymakers to compare the relative benefits and needs of various government programs. Earmarking thus weakens the budgeting process. It can lead to misallocation of resources if more revenue than necessary is earmarked or if revenues are inadequate to meet program demands. Further, earmarking tends to be inflexible in the face of changing conditions and may remain in force long after the need for it has passed.[4]

Earmarking practices. Historically, earmarking was applied to taxes or fees collected on specific goods or services. Among the states, including Hawaii, the most prevalent form of earmarking is the motor fuels tax collected on sales of gasoline and designated for highway construction and maintenance. Recently, the earmarking of unrelated revenue sources for human service programs has become more popular, particularly in states wishing to raise additional revenue from lotteries or casinos. Earmarking is also used to support other public policy goals by increasing taxes on goods such as alcohol and tobacco, which are proven threats to public health.[5]

Hawaii is among a small group of states that earmark five percent or less of their tax revenues.[6] During the past few years, Hawaii has increased its earmarking through the creation of special funds that receive portions of general revenues. During the 1989 session the Legislature approved several special funds, the most prominent being the State Educational Facilities Improvement Fund, which will earmark a certain amount of general revenues to be used specifically for capital improvements to public schools.

Hawaii's General Excise Tax

Current state policy provides for taxation of goods and services. Hawaii is one of only three states, including New Mexico and South Dakota, that tax almost all consumer services as well as goods.[7] Pursuant to Chapter 237,

Hawaii Revised Statutes, a general excise tax is imposed on all retail sales of goods and services sold within the state, with certain exemptions. The tax imposed is 4 percent of the gross income of the business.[8] Nonprofit corporations including nonprofit health care facilities are exempt. All other health care services are subject to the 4 percent general excise tax.

We requested from the Department of Taxation, figures on the amount of revenue collected from the excise tax on health care services. However, the department does not maintain a separate accounting of revenues collected on health care services. Thus, there is no way to determine precisely how much of the tax base would be involved in earmarking. The department was able to provide us rough estimates of general excise taxes collected on medical services. These estimates are based upon unpublished studies of itemized deductions taken for medical expenses on individual tax returns and the gross receipts reported by physicians, dentists and other health professionals. The estimated collections for the 1989 tax year range from a low of $14.6 million to a high of $25.9 million.[9]

The Evolution and Financing of Long-Term Care

The phenomenon of long-term care is a result of medical technology and changing demographics in our society. Today, many advanced medical techniques can treat once-fatal illnesses and extend life. As life expectancies increase, the result is an expanding elder population for which society has not developed adequate services. More important, the fastest growing segment of the expanding elder population are those 85 years and older, who are most likely to need long-term care.[10]

While discussion of long-term care is most often focused on the elderly, other populations such as the developmentally disabled, mentally or emotionally impaired, and chronically ill also need assistance. All of these individuals are long-term care consumers due to the permanent nature of their functional disabilities. Two groups of the chronically ill that are most in need of long-term care services are those with Alzheimer's disease and AIDS. Although an estimated 50 percent of nursing home patients have Alzheimer's disease, many victims of the disease are cared for at home and in community-based settings.[11] AIDS patients also need care at home for extended periods during the chronic phases of their illness.

Defining long-term care: from medical to social model. Long-term care has roots in the health care industry, and so initial efforts to define the phenomenon centered on providing medical care. Early development of long-term care services followed the medical model, which focuses on treatment of illness by a physician or other skilled professional, usually in an institutional setting such as a hospital.

However, the medical model does not address the social services and personal care that a long-term care patient may need after medical treatment is completed.[12] Once an illness is treated, many individuals do not require skilled medical care, but rather assistance with "activities of daily living" (ADLs) such as bathing, dressing, eating, toileting, and mobility. In order to maintain minimal independence, many disabled individuals need help with what are termed "instrumental activities of daily living" (IADLs) such as cooking, cleaning, laundry, shopping, household maintenance, and transportation.[13]

Long-term care thus goes beyond medical care and is more appropriately defined as "a set of health, personal care, and social services delivered over a sustained period of time to persons who have lost or never acquired some degree of functional capacity."[14] In ordinary terms, it is the help a person needs in order to get along as independently as possible when incapacitated by disabilities.

Long-term care services. Within the broad spectrum of services now recognized as long-term care, various levels of care are provided. The most prevalent is *personal care*, which includes assistance with the regular and instrumental activities of daily living (ADLs and IADLs). *Intermediate care* includes nursing care on an occasional basis, as well as assistance with ADLs and IADLs. *Skilled care* includes daily nursing care and assistance with ADLs and IADLs.

Long-term care settings. Long-term care services are provided within home, community-based, and institutional settings. An individual may receive any level of care within each setting. *Home care* is provided by either paid staff or family and friends. The Executive Office on Aging estimates that 80 to 85 percent of long-term care is provided at home through family and friends.[15] *Community-based care* is provided through programs developed as alternatives to institutionalization such as adult day care. Adult day care includes services such as recreation, education, and medication monitoring. *Institutional care* is mainly provided by skilled nursing or intermediate care facilities (nursing homes). It is the most costly form of care and is only needed by a small percent of the population.

Long-term care financing. The demand for and expansion of long-term care services has left our nation facing a crisis in financing long-term care. For the 1989 federal fiscal year, national expenditures for long-term institutional and home care will exceed $60 billion.[16] Personal assets will pay for 51 percent of these expenditures, Medicaid will contribute 36 percent, Medicare will pay 7 percent, other government programs will pay 5 percent, and private insurance will pay 1 percent of these expenditures.[17]

As they are in the rest of the nation, long-term care expenses in Hawaii are paid by personal assets or Medicaid. Estimates indicate that 50 percent of all institutional care and 60 to 70 percent of home care is paid by the patient or their family.[18] Further, 90 percent of all government-financed long-term care in Hawaii is supported through Medicaid.[19]

The current reliance upon personal assets and Medicaid has had adverse impacts upon consumers and long-term care programs. First, the catastrophic expenses of long-term care quickly deplete personal assets. Once personal assets are gone, individuals are forced to do without services, depend upon family members, or become eligible for Medicaid.

Second, because Medicaid was developed to cover *medical* care, benefits are paid primarily for the more expensive long-term care provided in institutional settings by skilled caregivers. If people are forced to become dependent on Medicaid, they are usually institutionalized. Institutional care conflicts with the current philosophy of functional independence and is not in keeping with the desires of those individuals who prefer community-based and home care.[20]

Finally, the use of Medicaid financing for long-term care has reinforced the development of more costly institutional care. During the 1986 federal fiscal year, 81 percent of the Medicaid expenditures for long-term care were spent on institutional care and only 9 percent were for home and community-based services.[21]

Development of long-term care insurance. The crisis created by the catastrophic expense of long-term care has led private insurance companies to develop long-term care products. Long-term care insurance was developed with the intention of assuming the catastrophic expenses of long-term care while protecting personal assets and preventing Medicaid dependency. Insurance involves risk-pooling across a large population in order to accumulate resources. These collective resources then pay benefits toward long-term care expenses in lieu of personal assets or government assistance.

Characteristics, benefits, and costs. Long-term care insurance has characteristics of both health insurance and life insurance--prepayments of agreed-upon premiums in anticipation of illness and death. The main difficulty in developing long-term care insurance has been the lack of actuarial data derived from such information as the need for, cost of, and use of long-term care services, and the monitoring of insurance claims for coverage of these services.

Because these data bases are not yet developed, insurers are offering conservative products under two premises, *adverse selection* and *induced demand.* Adverse selection assumes that only those that need the product will buy it, and induced demand assumes that more services will be consumed because they are covered by insurance.[22] The result is that these products tend to have major limitations.

The coverage most commonly offered by long-term care insurance is for institutional and skilled-nursing care. Early long-term care policies were marketed as "nursing home policies" because they were limited to coverage of services linked to the medical model of long-term care, which focuses on treatment by a skilled health professional in an institutional setting. These policies offered fixed benefits that were not adjusted for inflation and therefore not linked to the actual cost of services. Other restrictions included lengthy deductible periods for preexisting conditions, clauses requiring prior hospitalization before benefits could be paid, and renewability clauses that allowed insurers to cancel the benefit package at any time.

These restrictions were put in place to limit the liability of insurance companies in the face of the expanding long-term care service environment. More recently, some insurance companies have expanded benefits to include coverage of some types of home care. However, most products restrict coverage to home care that is linked to prior skilled care or based upon a physician's orders.[23]

Premiums for long-term care insurance are based upon the policyholder's age and individual health status and on the type of coverage selected. With the recent inclusion of home care as a benefit, premiums have been increased. Annual individual premiums can range from $400 to $1,000 at age 60, and $1,100 to $2,100 at age 70. Over age 75, coverage is either not provided or premiums are increased every year.[24]

Actual use of long-term care insurance. Even though the phenomenon of long-term care has resulted in catastrophic expenses, only a small percent of the population has purchased protection. Three factors account for this. First, people tend to deny that they will experience a loss of independence that will require extended care prior to death. Second, many people, especially the elderly, mistakenly believe that Medicare or supplemental "Medigap" insurance policies, which primarily cover hospitalization, will also cover long-term care. Finally, the costs of long-term care insurance premiums are high relative to the benefits offered.[25]

Chapter 3

FINDINGS AND CONCLUSION

In this final chapter, we present our findings and conclusion on the feasibility of earmarking tax revenues for a long-term care insurance program.

Summary of Findings

1. *Earmarking the tax revenues collected on health care services to support a long-term care insurance program is not justifiable. The proposal does not meet the primary principle of earmarking, which is that a clear relationship should exist between those who pay taxes on health care and those who would receive benefits from long-term care insurance.*

2. *Taxation of health care services is regressive, and to many persons, it is an onerous tax.*

3. *The effectiveness of long-term care insurance as an alternative financing mechanism has yet to be established.*

Earmarking Not Justified

The proposal to earmark the general excise tax revenues collected on health care services does not meet the primary justification for earmarking. The proposal is not supported by the benefit principle that establishes a clear relationship between those who pay the taxes and those who ultimately benefit from the services receiving earmarked funds.

The tax on health care services is collected from health care providers but passed on to (and therefore supported by) the consumers. It is not clear that earmarking these tax revenues to support an insurance program will provide a direct benefit to those who are in fact paying for it. Providing *insurance coverage* is not the same as actually providing a service; it does not guarantee that those supporting the program will actually benefit.

A related point is that if the insurance program is to meet all long-term care needs, it will have to go beyond health care services to include services that are personal and social in nature. The person paying the tax on health care, and those who in turn support that tax, are paying for a program with a much broader scope than health care services alone. The relationship between the services taxed and earmarked and those eventually provided is not direct.

Further, earmarking revenues to establish a long-term care insurance program will not necessarily solve the long-term care financing problem. As previously pointed out, the increasing demand for long-term care services has led to a crisis in financing these services. Earmarking for insurance coverage will not adequately address the larger problem of financing to meet increasing demands for a broad range of services that have yet to be defined and developed. A state-funded insurance program could create a false sense of security among consumers and policymakers who may assume that the problem has been solved.

Regressivity of Health Care Tax

Most tax policy analysts object to taxation of health care services because expenditures for these services are unevenly distributed and tend to concentrate among persons least able to support the tax. Since the elderly and disabled are more likely to need health care services, they will more frequently contribute to this part of the tax base.[1] Taxation of health care services is therefore considered "regressive" because it places the burden on persons who require health care and does not take into account their ability to pay the tax. Only two states, Hawaii and New Mexico, tax most health care services.[2] Earmarking these revenues to finance a long-term care insurance program does not remove the inequities of the regressive tax, and would appear to be forcing those who require health care to finance a program from which they may not receive direct benefits.

The tax on health care, to many persons, is an onerous tax because it is imposed upon services which are essential to the well-being of individuals. In Hawaii there have been attempts in recent years to eliminate taxation of health care goods and services. Although the Legislature has chosen not to exempt taxation of all health care goods and services, they have taken some action in that direction. In the past several sessions, numerous bills have been introduced seeking exemption for a variety of health care goods and services. In 1986, the Legislature passed Act 306 which provided a general excise tax exemption for prescription drugs and prosthetic devices. During the 1989 session the Legislature passed Act 321, which created a tax credit for medical services to assist with out-of-pocket costs of medical care.

Effectiveness of Insurance Not Yet Established

An underlying premise of the proposal is that insurance will lessen the burden of financing long-term care from personal assets or Medicaid. However, the ability of insurance to do this cannot be determined. There is no history of its use to show that it will alleviate these burdens. Since insurance products are still linked to the medical model of long-term care, they primarily cover skilled care prescribed by a physician and provided within an institutional setting. But in practice, only a relatively small number of people require institutional care. The increasing need is for the less expensive personal care provided in home or community-based settings, which is not generally covered by insurance. Thus only in a limited number of cases would an insurance program offering benefits based on the medical model be of help in alleviating long-term care costs.

Several recent reviews of long-term care insurance products have had reservations about their effectiveness in assisting with the expenses of long-term care. One source predicted that current policyholders will likely be subjected to rate hikes as more actuarial data on long-term care is collected.[3] These hikes could pose problems for elderly policyholders on fixed incomes, who may purchase insurance near retirement age but become unable to afford the increasing premiums.

Further, the exclusions and qualifications on many current policies mean that insurance will not cover many needed services. A recent study by the United Seniors Health Cooperative estimates that 61 percent of all long-term care policyholders who enter a nursing home will receive no benefits. The study also indicated that of all the policies reviewed, 77 percent required a prior hospital stay as a condition for paying benefits even though 54 percent of the people entering a nursing home did not require hospitalization.[4]

In January 1989, the Hawaii Legislature received a report on the feasibility of providing long-term care insurance to enrollees of the Hawaii Public Employees Health Fund. This study was commissioned to assess whether the health fund should include a long-term care

insurance product as an optional benefit for public employees. The study raised the following concerns: the lack of available long-term care services would probably impede the actual use of accrued benefits; consumers need to be educated about long-term care issues and financing sources; and insurance should be but one component of a larger financing strategy for long-term care. The report also reviewed several long-term care insurance products and concluded they would not adequately meet consumer needs.[5]

Conclusion

Earmarking general excise tax revenues collected on health care services to finance a long-term care insurance program is not feasible.

Tax policy and the principles of earmarking do not support designating a regressive tax to finance a program from which benefits are not directly received by those who support it. Moreover, the concerns expressed by many experts about the effectiveness of long-term care insurance indicate that no one knows whether such insurance will relieve the burden of financing long-term care from personal assets or Medicaid. Further consideration of financing long-term care through insurance should therefore await more comprehensive study such as that being conducted by the Executive Office on Aging.

NOTES

Chapter 2

1. Steven Gold, *Earmarking State Taxes*, Denver, Colorado, National Conference of State Legislatures, May 1987, p. 1.

2. Hawaii, Legislative Auditor, *Hawaii Constitutional Convention Studies 1978*, Article VI: Taxation and Finance, p. 26.

3. *Earmarking State Taxes*, pp. 25-26.

4. *Ibid.*, pp. 25-26.

5. *Ibid.*, pp. vii-8.

6. *Ibid.*, p. 4.

7. John F. Due and John L. Mikesell, *Sales Taxation--State and Local Structure and Administration*, Baltimore, Maryland, Johns Hopkins University Press, 1983, p. 88.

8. Sections 237-7 and 237-13, HRS.

9. Letter to Laurel Johnston Mitchum, Legislative Analyst, from Richard F. Kahle, Jr., Director, Department of Taxation, July 25, 1989.

10. Stanley S. Wallack, "Recent Trends in Financing Long-Term Care," *Health Care Financing Review*,. 1988 Supplement, p. 98.

11. U.S. Health Care Financing Administration, Office of Intergovernmental Affairs, *Focus On...Alzheimer's Disease: An Overview of State Activities*, Washington D.C., July 1987, no. 21, p. 2.

12. Vernon K. Smith and Ronald Eggleston, "Long-Term Care: The Medical Versus the Social Model," *Public Welfare*, vol. 47, no. 3, pp. 26-29.

13. Rosalie A. Kane, *Long-Term Care: Principles, Programs, and Policies*, New York, Springer Publishing Company, 1987, p. 4.

14. *Ibid.*, p. 4

15. Hawaii, Executive Office on Aging, *Long Term Care Plan for Hawaii's Older Adults*, Honolulu, July 1988, p. 9.

16. U.S. House of Representative, Subcommittee on Health and Long-Term Care, *Private Long-Term Insurance: Unfit for Sale?*, May 24, 1989, p. i.

17. *Ibid.*, p. 4.

18. *Long-Term Care Plan for Hawaii's Older Adults*, p. 16.

19. Debra J. Lipson and Elizabeth Donohoe, *State Financing of Long-Term Care Services for the Elderly*, Intergovernmental Health Policy Project, Washington D.C., George Washington University, May 1988, p. 8.

20. *Long-Term Care Plan for Hawaii's Older Adults*, p. ix.

21. *State Financing of Long-Term Care Services for the Elderly*, p. 7.

22. David Landes, *What Legislators Need to Know About Long-Term Care Insurance*, Denver, Colorado, National Conference of State Legislatures, May 1987, p. 6.

23. *Private Long-Term Care Insurance: Unfit for Sale?*, pp. 5-13; and U.S. General Accounting Office, Report to the Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives, *Long-Term Care*

Insurance: Coverage Varies Widely in a Developing Market, GAO/HRD-87-80, May 1987, pp. 2-5, 33.

24. "Nursing Home Insurance--Who Needs It?", *Changing Times*, July 1989, pp. 59-62; and "Who can afford a nursing home?", *Consumer Reports*, May 1988, pp. 304-306.

25. *What Legislators Need to Know About Long-Term Care Insurance*, pp. 9-11.

Chapter 3

1. John F. Due and John L. Mikesell, *Sales Taxation--State and Local Structure and Administration*, Baltimore, Maryland, Johns Hopkins University Press, 1983, p. 105.

2. Steven D. Gold, *Reforming State Tax Systems*, Denver, Colorado, National Conference of State Legislatures, December 1986, p. 220.

3. "Nursing Home Insurance--Who Needs It?", *Changing Times*, July 1989, p. 59.

4. "Experiment in Progress", *Financial Planning*, January 1989, p. 62.

5. Mattson & Co., *Report on the Feasibility of Providing Long-Term Care Insurance for the Enrollees of the Hawaii Public Employees Health Fund*, Honolulu, January 1989, pp. 9-19.