Testimony of

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On

The Financing and Delivery of Long-Term Care in the U.S.

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I am pleased to be here as you review the financing and delivery of long-term care. I am an economist who has been involved in health policy research for 40 years. Until 2004, I was the managing director of Health Care Issues as the US General Accounting Office. I also have been a member of the Medicare Payment Advisory Commission and the National Commission for Quality Long-Term Care. Currently, At present, I am a consultant on health policy issues, principally with the West Health Institute and the National Health Policy Forum. My views today are my own and do not reflect those of any organization with which I have been affiliated.

I am going to present a brief overview of long-term care services and current arrangements for financing them and then discuss some of the implications of the aging Baby Boom generation and the growing demand for long-term care for the future. I will

conclude with some factors you may consider as you examine long-term care policy options.

The Present

Long-term care (LTC) or a more recently described as long-term services and support (LTSS) is distinct from other health care both in the nature and provision of the services and its financing[1]. LTC involves assistance with usual activities of daily living, such as dressing bathing, moving around, toileting, or eating, or maintaining a household, or supervision to avoid harm. The presence of different types of disabilities creates the need for these services that individuals would otherwise perform themselves. LTC is not provided only by health professionals. In fact, families and friends are a principal source of LTC support. CBO has estimated that the family of such informal care exceeds the spending on paid services[2].

We generally hope medical care involves treatments proven to be effective for given conditions and are willing to experience inconvenience, sometimes pain, and expense to obtain that benefit. LTC services provide needed assistance for survival, but they also determine how one lives one's life in the presence of a disability. How LTC services are delivered—by whom, with what frequency, in what location, are critical factors affecting an individual's quality of life and satisfaction. In other words, individual preferences play a more significant role in LTC than they do for medical services.

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[1] For simplicity, I will refer to long-term care throughout as it is the term applied to private insurance and this testimony focuses on financing.

[2] Congressional Budget Office, Rising Demand for Long-Term Services and Supports for Elderly People, June 2013, Accessed February 2016 at: https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44363-LTC.pdf

LTC is also distinct in terms of financing. There is little insurance for paid LTC services. The predominant payer is state Medicaid programs which accounted for 61 percent of the $220 billion spent in 2012[3]. Out-of-pocket payments, at 22 percent, constitute the second largest source. Private LTC insurance policies only accounted for 12 percent. Medicaid as the primary source of payment is problematic for both individuals and the programs. Only individuals with limited resources are eligible for Medicaid. Some Medicaid beneficiaries may not have been poor most of their lives. However, they may have limited resources when the need for LTC arises. Disabilities can often develop 20 to 30 years post retirement and savings and other resources may have been depleted. Other individuals may spend down to Medicaid eligibility exhausting their resources after becoming disabled paying for LTC services before becoming Medicaid eligible.

What services a Medicaid eligible receives depends greatly on where one resides. State programs vary widely in the share of spending for home and community based services versus spending for nursing home. Programs also vary in terms of the levels of spending that affects the numbers of persons with disabilities served and the services each receive. An individual's preferences may not be a significant factor in what services are received as state programs can be quite prescriptive regarding what services will be covered for each recipient.[4]

[3] Carol V. O'Shaughnessy, *National Spending for Long-Term Services and Supports (LTSS), 2012*, March 2014 Accessed February 2016 at: http://www.nhpf.org/library/the-basics/Basics_LTSS_03-27-14.pdf

[4] US GAO, *Long-Term Care: Availability of Medicaid Home and Community Based Services for Elderly Individuals Varies Considerably,* Sept. 2002, GAO-02-1121. Accessed February 2016 at: http://www.gao.gov/assets/240/235824.pdf

LTC is the largest share of Medicaid spending comprising about one third of spending on all beneficiaries and almost two-thirds of spending on aged beneficiaries. [5] Considerable attention has been focused on the large expenditures for beneficiaries eligible for both Medicare and Medicaid (duals). In terms of Medicaid spending, LTC is the principal reason. It comprised 70 some percent of total Medicaid duals spending. Less than one-third of duals receive LTC services. Spending on those duals receiving LTC was about $37,000 per beneficiary in 2011 or more than 15 times that spent on duals not receiving LTC. [6]

Medicaid LTC spending growth has moderated some as states have transformed their programs. In the early days of the Medicaid, LTC benefits were limited to nursing home care in almost all states. Following the enactment of the Medicaid waiver authority for home and community based services in 1981, state programs began to use these services in lieu of nursing home care. Other state policies, such as moratoria on new nursing home construction and stricter certificate of need, constrained growth in the supply of nursing homes to facilitate the shift away from institutional care to home and community based care. A related development was the growth of assisted living facilities. These facilities generally serve individuals with lesser degrees of disability than nursing homes and provide a less institutional-like setting. While Medicaid programs do not finance room and board in these facilities, some states have used

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[5] Medicaid and CHIP Payment and Access Commission, D*istribution of Medicaid Benefit Spending by Eligibility Group and Service Category,* Accessed February 2016 at: https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-18.-Distribution-of-Medicaid-Benefit-Spending-by-Eligibility-Group-and-Service-Category-FY-2012.pdf

[6] Sally Coberly, *Background on the Heterogeneity of Dual Eligibles*, National Health Policy Forum Briefing, January 27, 2012. Accessed February 2016 at: http://www.nhpf.org/uploads/Handouts/Coberly-slides_01-27-12.pdf

waivers to provide LTC services to assisted living facility residents as a cost effective substitute for nursing home care.

Currently, states are moving to managed LTC as a means of obtaining more control over Medicaid LTC spending. About half the states have already engaged or are in the process of engaging managed care plans to administer LTC benefits as either a stand-alone package or combined with other Medicaid medical benefits. What this shift to managed care will mean for either the delivery of LTC services or spending growth is uncertain. Medicaid LTC has not been an unmanaged fee for service benefit where beneficiaries and providers determine what services are used and then submit claims. Because of the costliness of nursing home care and the fear that there would be too much demand for home and community based care, state programs attempted to aggressively manage LTC benefits. For example, pre-admission screening programs for nursing homes established levels of disability required to qualify for nursing home coverage. For home and community based services, case managers determined the types and numbers of services an eligible beneficiary could receive.

The Future

Two major questions for the future would seem to be: whether and how the well-being of persons with disabilities and their care-givers might be improved and how to finance LTC in an affordable and sustainable way. The backdrop for this is demographics—the aging of the Baby Boom generation that will result in large increases in the LTC population within the next few decades. The demographics are critical because they strongly imply that a new means of financing must be found. A solution built on finding

efficiencies in the delivery of or payment for services is unlikely. That might be a possibility with respect to medical care where the perception of substantial inefficiency exists. The same would not seem to be true for LTC. The biggest payers, state Medicaid programs and individuals paying out of pocket, have likely prevented considerable inefficiency from developing especially in terms of excess utilization and somewhat in terms of excessive pricing.

The need to find another way to finance LTC is not a new idea. Serious discussions about alternatives to the current system began in the early 1980s. The primary focus was on expanding private LTC insurance which was starting to be marketed at that time. That focus made sense from two perspectives. First, individuals with insurance that develop a disability would have more resources or purchasing power to obtain services more in line with their and their family or other informal caregivers' preferences. Second, there would be a reduction in Medicaid LTC expenditures as insurance would result in fewer people spending down to become Medicaid eligible.

Having LTC insurance would seem reasonable from an individual perspective. Using paid LTC is an insurable event. Such use is a risk not a certainty. For persons turning 65 between 2015 and 2019, almost half (48 percent) will have zero LTC expenses before they die.[7] Another 15 percent will have expenses less than $50,000. And 15 percent are at risk for catastrophic expenses of more than $250,000. While insurance will change the likelihood of using paid services, the wide distribution of spending will undoubtedly remain.

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[7] Melissa Favreault and Judith Dey, *Long Term Services and Supports for Older Americans: Risks and Financing* Research Brief, Assistant Secretary for Planning and Evaluation DHHS, July 2015. Accessed February 2016 at: https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief#table1

Even if one could save to pay for likely LTC expenses, there is more than a 50 percent chance that all or most of those savings would remain unused when one died. Saving would help prepare one for LTC needs, but also prevent the monies saved from being used for other purposes. Insurance is a superior alternative. Insured individuals would have more funding available to deal with their LTC needs if a disability arose. They would presumably spend on premiums than what would have been saved. The difference would be available to spend as they wish.

Considerable efforts have been made to increase coverage with LTC insurance. The National Association of Insurance Commissioners (NAIC) created model laws and regulations to create standards for insurance policies being marketed to increase consumer confidence. This was an important undertaking as some early LTC policy offerings had restrictive coverage provisions that compromised their value. NAIC has also attempted over the years to deal with issue of premium stability which has been a source of considerable concern to potential purchasers. The Health Insurance Portability and Accountability Act of 1996 created a tax incentive for qualified LTC policies. The Act allowed the deduction of premiums as a medical expense. Qualified policies were those that met the NAIC standards at the time of passage. A Partnership Program was created, first as a demonstration in 4 states and then the Deficit Reduction Act of 2005 made it an option for all states. The Partnership Program allowed persons receiving benefits under policies meeting certain standards to retain some of their assets and still qualify for Medicaid. About 40 states have initiated a program. An

education campaign, ‘Own Your Future” was funded by HHS in 2005.[8] The campaign’s main component was a letter from a state’s governor to households with someone over 45 years of age to make them aware of LTC risks and offer an opportunity to receive more information. Letters from the governor were sent in 25 states to more than 18 million households.

Despite the potential advantages and the promotion efforts, the market for private LTC insurance never developed much momentum. Today only 3 percent of adults and 11 percent of adults over 65 have a private LTC insurance policy[9]. Moreover, growth in the number of covered lives has declined dramatically. That growth was 12 percent a year between 1998 and 2005, but only 1.5 percent a year between 2005 and 2011.

While the limited growth in LTC insurance has generally been seen as a problem of demand, today there is a need to consider the potential for a supply side problem. In 2002, 102 companies were selling LTC insurance. By 2014, the number had declined to 20 and additional companies have since exited the market.[10]

LTC insurance has always been a difficult product for insurers. When policies were first offered in the 1980s, there were very little data on disability prevalence and LTC utilization. There was absolutely no experience with how utilization would respond to the presence of insurance. Companies protected themselves by offering limited benefits and setting premiums at higher levels to avoid losses. Both naturally dampened

[8] Tell E J, Cutler J A. *A National Long-Term Care Awareness Campaign: A Case Study in Social Marketing. Cases in Public Health Communication & Marketing*. 2011;5:75-110. Accessed February 2016 at: http://publichealth.gwu.edu/departments/pch/phcm/casesjournal/volume5winter/peer-reviewed/V5w_Case4PR.pdf

[9] Congressional Budget Office, op.cit.

[10] Marc Cohen, *The Current State of the Long-Term Care Insurance Market*, Presentation for the 14th Annual Intercompany Long-Term Care Insurance Conference, March 2014 Accessed February 2016 at: http://iltciconf.org/2014/index_htm_files/44-Cohen.pdf

demand. While there is much more information available to insurers today, there is still considerable uncertainty. In the 30 plus years LTC insurance policies have been marketed, the provision of LTC services has shifted dramatically. As noted, there has been a major reduction in nursing home care and substantial growth in assisted living and home and community based care. There have also been debates about future disability prevalence; whether future cohorts of elderly will be more or less likely to suffer a disability. At one point, it was hypothesized baby boomers might experience less disability as they did not have the disadvantages of being raised during the Depression or World War II. The increasing prevalence of obesity and its correlation with disability might question that hypothesis.

The additional factor that has impacted LTC insurers is the economic downturn that began in 2007-8 and the low interest rates that have persisted since then. The model for LTC insurance is to charge premiums for policies; invest those premiums; and pay benefits to policyholders 25-35 years later. The limited returns on investments that have been available in recent years conflict with the assumptions insurers used to set premiums on previously sold policies. While raising premiums to cover anticipated losses may be an option, adjustments to premiums on existing policies have generated considerable negative publicity and likely reduced demand among potential purchasers. Similarly, a strategy for future policies of charging higher premiums to compensate for smaller returns on investment is likely to dampen demand.

Conclusion

I wish to conclude with some considerations that might be taken into account as you examine LTC financing. They are not specific recommendations for two reasons. First,

specific proposals will almost always involve decisions about the roles of the private and public sector. Those are decisions for elected officials not for an analyst such as myself. An analyst can tell you the implications of any decision in terms of achieving different goals. Second, I have not done that type of analysis for any proposal. Such analyses will be quite challenging. There are multiple outcomes to consider (e.g., satisfaction of individuals' with disabilities needs and preferences, impacts on families and other caregivers, impacts on the workforce, and spending). As all outcomes will be dependent on the responses of individuals, providers and insurers, strong effort should be made to minimize uncertainty in estimating projected outcomes.

Encouraging personal preparedness should be a priority. While that may be perceived by some as a means of limiting public expenditures, I see it as essential to providing individuals with more choice in how they live their lives when they have a disability and in how their families will be impacted by the disability. Both increasing awareness of the importance of preparedness and its affordability should be considered. While there have been attempts to increase awareness about the realities of LTC and its financing, they have had limited success. To give you an example of our limited progress, 30 years ago about 80 percent of seniors believed Medicare would cover their LTC needs. Our education efforts may have reduced that percentage to around 50. Our education efforts simply have not been good enough. Today reports from multiple federal agencies indicate the percent of LTC spending paid by Medicare with footnotes indicating this is for short term LTC services. This is simply wrong. Medicare pays for services delivered by providers that also deliver LTC services paid by others. The message to the public needs to be clear and straightforward: Medicare pays for NO LTC.

Making personal preparedness more feasible or affordable also must be considered. Insurance, as mentioned, is preferable to savings as the primary means of preparation. Yet we now have concerns about insurer participation. What actions can be taken to assure insurers will be interested and able to market LTC policies with reasonable benefits and premiums. Some proposals have suggested that there be a public sector assumption of some of the risk for LTC. What might be seen as ironic is that depending on how a public sector initiative is structured, the private insurance market may be strengthened. In addition to relieving insurers of covering a segment of the risk, a public initiative that clearly delineated what would and would not be covered could enable consumers to understand the importance of supplementary coverage. Those possibilities should be explored.

Informal or unpaid care provided by family members and other caregivers is another important consideration. These caregivers are the primary source of care for persons living in the community. That care can involve physical, emotional, and economic costs to those care givers. Assuring that the burden on individual caregivers is not excessive is one consideration. The social costs of lost productivity as caregivers reduce their participation in the labor market is another, particularly as the share of the population that is working-age declines in future decades.

The Medicaid program represents a commitment to maintaining a safety net to assist people unable to do so on their own. State Medicaid programs vary considerably in the

levels of assistance and the persons served. Part of this relates to differences in states' capacities to fund services. There is variation in the proportions of a state's population likely to need services and the costs of delivering services. Today federal assistance to states is determined by the Federal Medical Assistance Percentage (FMAP). Per-capita income, the FMAP's basis for distributing federal funds, does not capture the differences in either the relative need for services or cost differences among states. As the numbers of persons needing LTC increases and as economic activity shifts geographically, some states may be significantly affected and what assistance they may need should be considered.