U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

February 26, 2016

TO: Members, Subcommittee on Health

FROM: Committee Majority Staff

RE: Hearing: "Examining the Financing and Delivery of Long-Term Care in the U.S."

I. INTRODUCTION

On Tuesday, March 1, at 10:15 a.m. in 2322 Rayburn House Office Building, the Subcommittee on Health will hold a hearing, "Examining the Financing and Delivery of Long-Term Care in the U.S."

II. WITNESS

- Alice Rivlin, PhD, Co-Chair, Long-Term Care Initiative, Bipartisan Policy Center; Senior Fellow, Economic Studies Program, The Brookings Institution;
- William J. Scanlon, PhD, Consultant, West Health Institute and National Health Policy Forum; and,
- Anne Tumlinson, CEO, Anne Tumlinson Innovations; Founder, Daughterhood.org.

III. BACKGROUND

General Overview

Long-term care (LTC), also known as long-term services and supports (LTSS),[1] refers to a broad range of services and supports that are needed by individuals over an extended period of time. Long-term care may include some health care services, but also non-health care services. The need for LTC is generally measured by limitations in an individual's ability to perform daily personal care activities (i.e., eating, bathing, dressing, and walking), or activities that allow individuals to live independently in the community (i.e., shopping, housework, and meal preparation).[2] The probability of needing LTC increases with age. As the nation's population aged 65 and older continues to increase in size, the demand for LTC is also expected to increase. However, younger persons with disabilities may also find themselves in need of medical and supportive care offered through LTC, which can allow them to live longer, more productive lives.

[1] Generally, long-term care in Medicaid is referred to as "long-term services and supports." However, for purposes of simplification, this memo will use the terms interchangeably.
[2] Often referred to as activities of daily living and instrumental activities of daily living.

In 2014, roughly $340 billion was spent on long-term care, representing more than 13 percent of the almost $2.6 trillion spent on personal health expenditures. This total includes payments for services in nursing facilities and in residential care facilities for individuals with intellectual and developmental disabilities, mental health conditions, and substance abuse issues.[3] Spending also includes LTC provided in an individual's own home, such as home health, personal care, and homemaker or chore services (e.g., housework or meal preparation), as well as a wide range of home and community-based services (HCBS), such as adult day health services.[4] Because a substantial amount of LTC is also provided by caregivers who, as the family or friends of the person receiving LTC friends, provide care without compensation, the official estimates of LTC spending likely significantly underestimate total expenditures.

The Bipartisan Policy Center (BPC) noted that there is significant variation in LTC spending among individuals. BPC noted that:

> [W]hile roughly half of individuals turning 65 today will not have any LTSS expenditures, others will have very high spending. Approximately 6 percent will have expenditures greater than zero but under $10,000. On the other hand, about 27 percent will have LTSS costs of at least $100,000 over the course of their lifetimes, and costs will exceed $250,000 for about 15 percent.[5]

<u>Private Long-Term Care Insurance</u>

Private long-term care insurance (LTCI) is available to provide some financial protection for persons against the risk of the potentially high cost of LTSS. In 2010, about 6 percent of LTSS spending was paid by LTCI. That same year, between 7 million to 9 million Americans owned a private LTCI policy, with about 11 percent of the population aged 55 and older covered by a policy.[6]

A number of factors have adversely affected the demand for LTCI. The cost and complexity of LTCI policies have been cited as major deterrents to purchasing LTCI. In addition, increased concerns have arisen about the adequacy of consumer protections for LTCI as a result of inconsistencies in LTCI laws and regulations across the States. More recently, adverse publicity about premium increases and heightened concerns about the future solvency of LTCI insurers in the current economic environment have further dampened demand, prompting State regulators to re-evaluate current regulations and laws governing LTCI.

The private LTCI market has undergone significant changes in the past three decades. The employer-sponsored market has grown as a share of total LTCI sales and the overall market has become more concentrated in terms of the number of companies selling the product. A number of newer product lines have been introduced that combine LTCI with other products, such as retirement annuities and life-insurance products.

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[3] Congressional Research Service, "Who Pays for Long-Term Services and Supports?," January 5, 2016.
[4] Congressional Research Service, "Who Pays for Long-Term Services and Supports?," January 5, 2016.
[5] http://bipartisanpolicy.org/library/long-term-care-financing-recommendations/?_cldee=YXJpZGxvbkBiaXBhcnRpc2FucG9saWN5Lm9yZw%3d%3d
[6] Congressional Research Service, "Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress," January 16, 2013.

One of the key questions for policymakers is what policies may be available to help create more engaged consumers in a more robust private market for long-term care. Policy ideas in this area could be particularly important over the longer-term to avoid shifting costs to public payers.

Medicare

Medicare is a Federal program that pays for covered health services for the elderly and certain non-elderly individuals with disabilities. Generally speaking, Medicare does not cover most long-term care services as they are traditionally defined. However, Medicare does cover acute and post-acute care, including skilled nursing facility (SNF) services and home health services on a short-term basis.[7] If these services were counted as LTC, they would represent about a fifth of national LTC expenditures in a given year.[8]

Out-of-Pocket Spending

In 2014, out-of-pocket spending was about 16 percent of all LTC spending, costing consumers about $53 billion. These expenditures include deductibles and copayments for services that are primarily paid for by another payment source as well as direct payments for LTSS.[9] In addition, some private health insurance plans may provide limited skilled nursing and home health coverage, which may require copayments. Moreover, private long-term care insurance often has an elimination or waiting period for policyholders, which requires out-of-pocket payments for services for a specified period of time before benefit payments begin.

Once individuals have exhausted their Medicare and/or private insurance benefits, they must pay the full cost of care directly out-of-pocket. With respect to Medicaid LTC, individuals must meet both financial and functional eligibility requirements. Individuals not initially eligible for Medicaid would have to pay for LTC directly out-of-pocket. Eventually, these individuals may spend down their income and assets over a period of time to meet the financial requirements for Medicaid eligibility.

Medicaid

Today, Medicaid is the largest payer for long-term care in the U.S. Individuals applying for Medicaid coverage for long-term care must meet certain financial and functional eligibility criteria. To meet the financial eligibility criteria, individuals must have assets that fall below established standards, which vary by State, but are within standards set by the Federal government.

As the administrators of the Medicaid program, States are responsible for assessing applicants' financial eligibility for Medicaid coverage for long-term care. States determine

[7] While Medicaid SNF and home health benefits are available to eligible beneficiaries for as long as they qualify, Medicare benefits, in general, are limited in their duration. In addition, Medicare SNF and home health benefits include coverage of rehabilitation services that will, presumably, prevent a decline in the beneficiary's physical condition or functional status.
[8] In 2014, Medicare spent $75.2 billion on SNF and home health services combined.
[9] While there are daily copayments for skilled nursing services after a specified number of days under Medicare, there are no copayments for Medicare's home health services.

whether an applicant's countable assets—both income and resources—are below the State-established standards, and whether an applicant transferred assets for less than the fair market value during the look-back period.[10] The processing of Medicaid applications is generally performed by local or county-based eligibility workers.

Many persons needing LTC may be "dual eligible"—that is, enrolled in both Medicare and Medicaid. The Bipartisan Policy Center has noted that:

> [J]ust over half of individuals aged 65 and over will have a high level of LTSS need, meaning that they will need help with two or more activities of daily living for at least 90 days or will have severe cognitive impairment. About 14 percent will have a high level of LTSS that lasts for five years or more.[11]

Medicaid enrollees who use long-term care are a diverse group of individuals, who may be young or old, or face different types of physical, cognitive, and mental disabilities. They include: adults with significant physical disabilities, children who are medically fragile, individuals age 65 and older, people with intellectual and developmental disabilities, and individuals who are severely mentally ill. In fact, there are several pathways in Federal statute by which an individual may become eligible for Medicaid long-term care. These paths include:

- ***Supplemental Security Income (SSI) pathway.*** SSI is a Federal income support program for people with extremely limited income and resources who are age 65 or older, blind, or have disabilities. In 40 States and the District of Columbia, individuals eligible for SSI are automatically eligible for full Medicaid benefits, including LTSS offered under the State plan if they meet specific functional eligibility criteria. They must generally meet SSI's age and disability eligibility standards.[12]

- ***Poverty-related pathway.*** This is an optional pathway allowing the State to cover individuals with incomes up to 100 percent of the Federal Poverty Limit (FPL) who have disabilities or are over age 65.

- ***Medically needy pathway.*** This optional pathway allows States to cover individuals with high medical expenses relative to their income once they have spent down to a State's medically needy income level.

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[10] Not all assets are countable in determining financial eligibility for Medicaid. For example, States generally exclude—within specified limits—the value of an individual's primary residence, car, and prepaid burial arrangements. Additionally, Federal law includes provisions to discourage individuals from reducing their countable assets—for example, by transferring them to family members—in order to establish financial eligibility for Medicaid coverage. Specifically, those who transfer assets for less than fair market value (FMV) during a specified "look-back" period—a period of time before applying for Medicaid in which an individual's or couple's assets are reviewed—may be deemed ineligible for Medicaid coverage for long-term care for a period of time called the penalty period.

[11] http://bipartisanpolicy.org/library/long-term-care-financing-recommendations/?_cldee=YXJpZGxvbkBiaXBhcnRpc2FucG9saWN5Lm9yZw%3d%3d

[12] Social Security's eligibility standards include being age 65 or older; or, for adults age 18 to 64, having a significant impairment that impedes their ability to do any gainful work; or, for children under the age of 18, having a significant impairment that results in marked or severe functional limitation. Additionally, ten States—known as 209(b) States—establish more restrictive criteria for LTSS benefits (either income and resource thresholds or functional eligibility criteria) than SSI.

- ***Special income-level pathway.*** Under this optional pathway, States may cover individuals who meet criteria for certain institutions and have incomes up to 300 percent of the SSI benefit rate (which is about 222 percent FPL).

- ***TEFRA/Katie Beckett pathway.*** This pathway provides Medicaid eligibility to children with severe disabilities whose family income would ordinarily be too high to qualify for Medicaid. In 1982, TEFRA (P.L. 97-248) created an exception that allowed severely disabled children (like Katie Beckett, for whom the provision was named), to receive their care at home while retaining their Medicaid coverage. Under this pathway, States may elect to count only the income and financial resources of a child with a disability who needs LTSS. States may provide institutional LTSS or HCBS waiver benefits to individuals eligible under this pathway who meet institutional criteria.[13]

- ***Section 1915(I) State Plan Home And Community-Based Services.*** Section 1915(i) of the Social Security Act allows States to offer HCBS as part of the Medicaid State plan to targeted groups of individuals with incomes up to 150 percent FPL. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) amended this section to create a new eligibility pathway for individuals with disabilities who do not require an institutional level of care and expand the types of services that could be offered, while also prohibiting enrollment caps under the State plan.[14]

- ***Medicaid buy-in pathways.*** There are also several optional pathways for States to cover people with disabilities who work and have incomes too high to qualify for Medicaid. The Medicaid buy-in pathway entitles individuals with disabilities who work and have incomes too high to qualify for Medicaid to pay a premium to receive full Medicaid benefits, including State plan LTSS. States may extend HCBS waiver benefits to individuals eligible under this pathway if they meet level-of-care criteria.[15]

One consideration for policy-makers is that differences in the interoperation and application of existing eligibility standards may lead to notable variation in State Medicaid programs. Previously, the Government Accountability Office (GAO) examined the process States use for reviewing applications for long-term care. GAO noted that some of their findings "raised questions about whether States had sufficient information about applicants' assets to implement Federal requirements."[16] More recently, MACPAC has conducted a review of States' assessment tools as part of ongoing work.[17]

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[13] This pathway was created to address the fact that Medicaid policies originally did not count parental income toward the child's Medicaid eligibility if that child was institutionalized in a hospital, nursing home, or an intermediate care facility for individuals with intellectual or developmental disabilities (ICF/ID) for 30 days or more, but would count such income if the child was at home. Families of such children could get Medicaid coverage only by placing their child in an institution, becoming impoverished, or relinquishing custody.
[14] States may also extend this pathway to individuals with income up to 300 percent of SSI (about 222 percent FPL) who are receiving Section 1915(c) HCBS waiver services (Stone 2011). As of May 2015, 17 States had received approval of Section 1915(i) State plan amendments
[15] For more information, please see MACPAC's summary online, https://www.macpac.gov/subtopic/long-term-services-and-supports-population/
[16] http://www.gao.gov/assets/600/593053.pdf
[17] https://www.macpac.gov/wp-content/uploads/2016/01/Functional-Assessments-for-LTSS-Part-2.pdf

Proposals to Improve Long-Term Care

In the wake of the creation and termination of the CLASS Act,[18] Congress created the Commission on Long-Term Care. The Commission on Long-Term Care was established under Section 643 of American Taxpayer Relief Act of 2012 (P.L. 112-240), signed into law January 2, 2013. With a deadline of September 12, 2013, the statute instructed the Commission to "vote on a comprehensive and detailed report based on the long-term care plan . . . [described above] . . . that contains any recommendations or proposals for legislative or administrative action as the Commission deems appropriate, including proposed legislative language to carry out the recommendations or proposals." The Commission was composed of 15 members appointed by the President and Congress.[19]

More recently, there have been several bipartisan efforts that have examined long-term care and sought to offer proposals to protect consumers, beneficiaries, or taxpayers. A comparison of three of the more recent reports is available online.[20]

- **Bipartisan Policy Center.** In April 2014, the Bipartisan Policy Center released *America's Long-Term Care Crisis: Challenges in Financing and Delivery.*[21] Specifically, that report noted that the demand for long-term care will more than double over the next 35 years and is fiscally unsustainable. As a follow-up, earlier this month BPC released *Initial Recommendations To Improve the Financing of Long-Term Care*.[22] In late 2016 or early 2017, BPC will release additional recommendations for new approaches to finance LTC and also to reform LTC delivery and improve integration of care for persons with multiple chronic conditions and functional limitations.

- **LeadingAge.** In February 2016, LeadingAge released *Perspectives on the Challenges of Financing Long-Term Services and Supports.* The report noted that LeadingAge "believes America needs a fairer and more rational financing system to ensure access to quality LTSS. Based on research, discussions, and modeling work conducted over the last 12 years, we know that workable solutions can be developed to reach this goal."[23]

- **Long-Term Care Financing Collaborative.** In 2012, a diverse group of policy experts and senior-level decision makers representing a wide range of interests and ideological views created the Long-Term Care Financing Collaborative. The goal was to develop pragmatic, consensus-driven recommendations for a sustainable and affordable, public and private insurance-based financing system that better enables people of all incomes to

[18] The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, enacted March 23, 2010) established the Community Living Assistance Services and Supports (CLASS) program, a new Federally administered voluntary insurance program to help adults age 18 and over with disabilities pay for LTSS. During 2011 the Department of Health and Human Services (HHS) conducted an analysis of possible CLASS implementation options consistent with the statutory requirements that the program be actuarially solvent over a 75-year period and self-funded. After a 19-month period of analysis, HHS officials Stated in testimony before the House Committee on Energy and Commerce on October 26, 2011, that the Department had "not identified a way to make CLASS sustainable, legal and attractive to potential buyers…" and therefore "decided not to move forward with CLASS ….". The CLASS Act was subsequently repealed.
[19] http://ltccommission.org/
[20] http://www.thescanfoundation.org/side-side-review-long-term-care-financing-policy-recommendations
[21] http://bipartisanpolicy.org/wp-content/uploads/2014/03/BPC-Long-Term-Care-Initiative.pdf
[22] http://bipartisanpolicy.org/library/long-term-care-financing-recommendations/?_cldee=YXJpZGxvbkBiaXBhcnRpc2FucG9saWN5Lm9yZw%3d%3d
[23] http://www.leadingage.org/uploadedFiles/Content/Members/Member_Services/Pathways/Pathways_Report_February_2016.pdf

receive high quality long-term services and supports. In February 2016, the Collaborate released *A Consensus Framework for Long-Term Care Financing Reform.*[24]

Considerations for Congress

According to some estimates, the number of Americans expected to need long-term care at some point is excepted to double from 12 million today to 27 million by 2050.[25] By all projections, the demand for LTC is expected to significantly outpace the rate of growth in the U.S. economy over the next decade.

LTC growth is the most significant driver of Medicaid spending. For example, in fiscal year 2012, the 6.2 percent of Medicaid enrollees that used LTSS accounted for 43.4 percent of Medicaid benefit spending.[26] The Office of the Actuary of the Centers for Medicare and Medicaid Services (CMS) estimates that Medicaid spending on LTSS will grow by an average of 6 percent annually from 2012 to 2021, far faster than GDP.[27] The Congressional Budget Office projects that public and private spending on LTSS for the elderly will grow from 1.3 percent of GDP in 2010 to 3 percent of GDP in 2050.[28]

IV. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Josh Trent or Michelle Rosenberg of the Committee staff at (202) 225-2927.

[24] http://www.convergencepolicy.org/wp-content/uploads/2016/02/LTCFC-FINAL-REPORT-Feb-2016.pdf
[25] http://bipartisanpolicy.org/wp-content/uploads/2014/03/BPC-Long-Term-Care-Initiative.pdf
[26] https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-20.-Distribution-of-Medicaid-Enrollment-and-Benefit-Spending-by-Users-and-Non-Users-of-Long-Term-Services-and-Supports-FY-2012.pdf
[27] Office of the Actuary, Centers for Medicare and Medicaid Services (2012) 2012 Actuarial Report on the Financial Outlook for Medicaid, p. 27. Available at: http://medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2012.pdf.
[28] Congressional Budget Office (2013) Rising Demand for Long-Term Services and Supports for Elderly People. June, p. 33. Available at: http://www.cbo.gov/publication/44363. Note: In this analysis, the Congressional Budget Office includes Medicare spending for post-acute care in its LTSS spending statistics. In BPC estimates of LTSS spending elsewhere in the report, we have attempted to exclude spending on post-acute care, to the extent possible.