



The Financing and Delivery of Long-Term Care in the United States

**Submitted to the
House Energy and Commerce Committee
Subcommittee on Health**

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America's Health Insurance Plans (AHIP) is the national association representing health insurance plans. Our members provide health and supplemental benefits to the American people through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

We appreciate this opportunity to provide our perspectives on the financing and delivery of long-term care services. Our membership, which includes companies that offer long-term care insurance and Medicaid health plans, is strongly committed to meeting the long-term care needs of our nation's aging population and individuals with disabilities.

This statement focuses on: (1) the value of private long-term care insurance for individuals, families, and taxpayers; and (2) best practices implemented by Medicaid health plans to promote the delivery of managed long-term services and supports, including programs tailored to meet the needs of individuals with disabilities.

The Value of Private Long-Term Care Insurance

Private long-term care insurance provides valuable financial protection and peace of mind to the approximately 7.4 million Americans who currently carry this coverage. It also reduces stress for family caregivers who often face challenges in navigating and finding services for their loved ones.

A November 2014 report¹, commissioned by AHIP and prepared by LifePlans, found that long-term care insurance offers critical protection and needed flexibility for millions of families managing the significant costs associated with long-term care. This analysis found that long-term care insurance provides a more cost-effective way to pay for health care expenses later in life – such as nursing homes, assisted living, or in-home care – rather than relying on personal savings or depleting assets in order to qualify for Medicaid.

The report's findings demonstrate the important protection consumers receive by purchasing long-term care insurance:

- A 60-year-old would have to put aside \$1,666 a month over 22 years to pay for the same amount of services that would otherwise be covered by long-term care insurance with a monthly premium of \$188.
- Individuals who are covered by long-term care insurance reduce their out-of-pocket costs by \$3,000 to \$5,000 a month (depending on the service setting) compared to those without coverage.
- Individuals with long-term care insurance receive on average 35 percent more hours of care than those without coverage.
- The vast majority of consumers are satisfied with the way their long-term care insurance company has serviced their claims. Ninety-four percent of people filing claims reported either having no disagreements with their insurance company or that any disagreements were resolved to their satisfaction. Only about four percent reported that their claims were denied.
- Most individuals with long-term care insurance said their coverage provided greater access and flexibility as they seek to obtain the services of their choice.

The LifePlans report also discusses the value of long-term care insurance to the Medicaid program, noting that current policyholders are expected to save the Medicaid program about \$50 billion over their lifetimes. At a time when state governments and the federal government are facing significant budget constraints, this is an important point for policymakers to consider when advancing legislation to address the financing and delivery of long-term care services.

¹ *The Benefits of Long-Term Care Insurance and What They Mean for Long-Term Care Financing*, LifePlans, Inc., November 2014

The Role of Medicaid Health Plans in Serving Individuals With Long-Term Care Needs

Medicaid health plans are making important contributions toward helping state Medicaid programs use their limited resources to expand access, improve quality, and better meet the health care needs of beneficiaries. A recent AHIP issue brief² shows that enrollment in Medicaid health plans continues to grow, with approximately 35 million beneficiaries – 56 percent of all Medicaid beneficiaries – enrolled in these plans as of July 2013. Thirty-six states, the District of Columbia, and Puerto Rico had Medicaid health plan programs in place in 2013 and states are increasingly partnering with Medicaid health plans to address the needs of vulnerable populations.

Medicaid health plans have demonstrated strong leadership in offering integrated health care delivery systems, conducting outreach and health education efforts, helping to manage chronic conditions through patient-centric disease management programs, and facilitating access to non-medical services. An increasing number of states are relying on Medicaid health plans to serve beneficiaries with complex needs, including individuals with disabilities and those requiring an institutional level of care in managed long-term services and supports (MLTSS) programs.

Managed Long-Term Services and Supports

Working with the states, Medicaid health plans have developed successful MLTSS models that encourage and provide opportunities for beneficiary self-direction of services and supports, take a holistic approach, apply person-centered care, and employ multiple providers and additional services, including community and social supports, to address the many issues that affect a beneficiary's health, well-being, and ability to live in the community. These models include the active use of care coordinators who have been trained in integrating physical health services with home and community-based services, and work actively with beneficiaries and the provider community to address key needs. MLTSS models also ensure that beneficiary needs and preferences are addressed through in-home assessments, care planning, care and service coordination, and care management that engages the consumer, supports families, and monitors the delivery of services.

MLTSS programs also promote active engagement between Medicaid health plans and community-based partners – such as community-based and faith-based organizations and in-home health and services agencies – that can provide critical, individualized services, including:

² *Issue Brief: Medicaid Health Plan Enrollment and Participation Trends*, AHIP, February 2016

- Personal care/assistant services;
- Homemaker services;
- Respite care (in home or out-of-home);
- Nutritional and home-delivered meals;
- Home maintenance and home modifications;
- Family supports;
- Employment supports;
- Independent living skills;
- Operating expenses for use of Medical Emergency Response Systems;
- Assistive technology; and
- Non-emergency medical transportation.

A key ingredient to the success of MLTSS programs is ensuring transparent communication and providing avenues for feedback from beneficiaries and providers to facilitate a smooth transition from fee-for-service coverage to managed care. Medicaid health plans devote considerable resources to training their staffs on MLTSS benefits and the needs of the beneficiaries these programs serve, which is based on direct input from people with disabilities and older adults.

Tailored Programs for Individuals with Disabilities

To address the unique needs and circumstances of individuals with disabilities, Medicaid health plans develop with beneficiaries and their families, individualized, person-centered approaches that incorporate self-direction and address the specific needs and preferences of each member, to support independent living including housing, transportation, and employment. Research has demonstrated health plans are effective in ensuring individuals enrolled in programs in which beneficiaries self-direct care receive the services they need when they need them and in the most appropriate settings³.

In 2007, AHIP and ADAPT, a national disability rights organization, developed guiding principles for serving individuals with disabilities through Medicaid health plans. These principles continue to provide the foundation for best practices Medicaid health plans have adopted for working closely with each person with disabilities to meet their individual needs. For example:

³ For example see JEN Associates, Incorporated, *MassHealth Senior Care Options Program Evaluation: Pre-SCO Enrollment Period CY 2004 and Post-SCO Enrollment Period CY 2005 Nursing Home Entry Rate and Frailty Level Comparisons* (June 2008)

- Medicaid health plans engage in ongoing dialogue with stakeholders, including individuals with disabilities, in the development of Medicaid health plan contract requirements and program design including eligibility, rates, community integration principles, and program requirements. For example, Medicaid health plans have established advisory committees including individuals with disabilities, advocacy groups, and community-based organizations that serve as key forums to review existing programs and make recommendations for improvement.
- Medicaid health plans have established strategies to ensure all individuals with disabilities, regardless of age, have the information they need to be knowledgeable about the programs and services available to them. These efforts include use of community-based organizations, wherever available, in the development and implementation of outreach activities.
- Medicaid health plans work with individuals with disabilities to promote independence and control of their activities of daily living, instrumental activities of daily living, and health maintenance activities.

AHIP and our member plans continue to build relationships and work closely with the cross-disability community to incorporate these best practices and share experiences about how to implement them as well as to maintain an active dialogue on evolving issues.