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Forum Brief

Kansas Health Policy Forums 2002

Financing Long-Term Care Services for Elderly Kansans

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212 SW Eighth Avenue, Topeka, KS • Lower Level Conference Room

A DISCUSSION FEATURING

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KANSAS HEALTH INSTITUTE
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About the Forums

Kansas Health Policy Forums are a series of interactive sessions for policymakers examining a broad array of health issues. Forums present a wide range of national and local expertise on current health policy issues followed by facilitated discussion and dialogue in a non-partisan, off-the-record, setting. Forum Briefs analyze issues, present relevant data and information, and are prepared in advance of each Forum.

Brief Author

This Brief was written by **Susan Kannarr**, Policy Analyst.

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Speaker Biography

Joshua Wiener, Ph.D. is a principal research associate at the Urban Institute's Health Policy Center, where he specializes in research on health care for the elderly, Medicaid, and long-term care. He is the author or editor of seven books and more than 80 articles on these topics.

His recent projects include research on the long-term care work force, the Urban Institute's Assessing the New Federalism project, Medicaid home and community-based services, consumer-directed home care, and Medicaid and end-of-life care. Prior to coming to the Urban Institute, Dr. Wiener did policy analysis and research for the Brookings Institution, the White House, the Health Care Financing Administration, the Massachusetts Department of Public Health, the Congressional Budget Office, the New York State Moreland Act Commission on Nursing Homes and Residential Facilities, and the New York City Department of Health.

Financing Long-Term Care Services for Elderly Kansans

Introduction

Private sources pay for approximately 40 percent of long-term care (LTC) services for the elderly either directly or through private insurance. The federal Medicare program funds only 14 percent of LTC costs for seniors.[1] At more than 40 percent, Medicaid — the shared state and federal program for the poor — is the largest public funder of LTC services for the elderly. In Kansas, budgeted state expenditures for LTC services for the elderly totaled $160 million for fiscal year (FY) 2002. The rate of spending is expected to grow into the foreseeable future due to cost increases and rising numbers of beneficiaries. Funding for long-term care services for younger persons with disabilities, who account for a majority of total public long-term care spending, are not included in the Kansas figures.

POLICY IMPLICATIONS

The public policy importance of long-term care financing is growing for three primary reasons:

• *LTC financing is largely a middle-class problem*. The elderly poor are immediately eligible for Medicaid. Those with higher incomes or greater assets or both likely have the means to pay for LTC services out-of-pocket. Two visits a day from a home health aide can cost in excess of $2,500 per month; assisted living facility costs average over $26,000 per year; and nursing facility care averages $55,000 per year[2] with an average length of stay of about two years. These costs exceed the ability to pay of many middle income elders, driving them into poverty and forcing them into Medicaid.

• *The public burden of LTC financing falls most heavily on Medicaid*. Nationally, Medicaid pays for 43 percent of LTC costs.[1] In 1998, two-thirds of nursing home residents relied on Medicaid to pay for their care.[1]

• *The cost of providing LTC services is growing at a dramatic rate due to the combined effects of increasing demand and higher prices*. Kansans aged 85 and older, who are most likely to need services, are expected to grow at a steady pace until 2031, when the baby boomers will increase this population dramatically. Recent information indicates that about 60 percent of people over age 75 will need LTC services,[3] and two out of five will need nursing facility (NF) care.[4] Even as the number of NF residents decreases, costs continue to rise.

Private Financing of Long-Term Care

As a way to increase the ability of people to finance their own LTC costs, states can work to increase public knowledge about LTC services and financing. Recent information indicates that four out of five baby-boomers do not know how LTC is financed, and 68 percent say they are not prepared to finance their LTC needs.[5] People who are unaware of potential risks and expenses are less likely to plan appropriately to pay for their own care, potentially requiring public financing. The Kansas Insurance Department and the Kansas Department on Aging currently provide a variety of information on their Web sites and through Area Agencies on Aging about long-term care options and insurance.[6]

One way to reduce the cost burden of LTC services late in life and to potentially limit Medicaid expenditures is for individuals or their employers to purchase LTC insurance well before it is needed. Purchasing of long-term care insurance is limited by factors such as a lack of understanding of risks; denial of the potential need for services; cost of premiums (particularly for those purchasing insurance later in life); and confusion about non-standardized benefits.

Skepticism exists among policy analysts about the ability of private insurance to play a substantial role in financing LTC. Some argue that it will not significantly reduce public expenditures. Most of the shift will come from out-of-pocket expenditures, they claim, because the people who are most likely to afford LTC insurance are now paying for care themselves, and Medicare-covered services are excluded from insurance coverage. Others argue that LTC insurance will never be affordable for a large percentage of the population.

Nevertheless, some states and the federal government have taken steps to encourage the purchase of private long-term care insurance. Among the strategies they have employed are:

• *Offer tax incentives in the form of deductions or credits*. Some states allow the deduction of long-term care insurance premium costs from taxable income, while others offer credits against a person's state tax liability if they have purchased insurance.[7] Federal law allows employer contributions to qualified, private long-term care insurance to be treated as a deductible business expense in the same manner as regular health insurance. By targeting the tax incentive to employers, federal lawmakers attempted to encourage the purchasing of benefits at a younger age.

Methods of Encouraging the Purchase of Long-Term Care Insurance

- Implement individual or employer tax incentives
- Lead by example
- Initiate public/private partnerships

• *Offer LTC coverage to state and federal employees*. At least 19 states, including Kansas, and the federal government have begun offering group long-term care insurance coverage benefits for their own employees, retirees, and spouses to serve as an example to private employers.

• *Develop public/private partnerships that allow citizens who purchase state-approved LTC insurance policies to become eligible for Medicaid after their insurance benefits are exhausted*. This approach would not require that persons first spend down their assets to become eligible for Medicaid. Goals for implementing partnerships include: increasing the number of middle income people who are protected from impoverishment; encouraging personal responsibility; containing the growth of public long-term care expenditures; and improving the quality and availability of private insurance policies (since only approved policies can be used to gain protection).[8]

Public Financing of Long-Term Care

Because of the limited role played by Medicare, this discussion of the role of public health insurance in financing LTC services for the elderly will focus on Medicaid. In Kansas, the Department on Aging (KDOA) administers LTC Medicaid benefits for the elderly.

In the not too distant past, LTC services were synonymous with nursing facility (NF) care, but the nature of publicly funded services in Kansas has changed over the last decade. The most notable change has been the shift from institutional to community-based services. This transition had the dual goals of providing elders with a broader range of care choices and of helping to save public expenditures, or at least contain cost increases.[9]

Some policymakers question whether community services save money or whether the availability of publicly funded community services supplants informal services elders might receive from other sources such as personal savings, family, friends or community volunteers (referred to as the "woodwork effect," or induced demand).[10] While some additional demand for community-based services may be induced, there can be little doubt that their availability reduces demand for nursing facility use.

Methods of Reducing Public Financing of Long-Term Care

- Substitute community-based services for NF care
- Increase housing options
- Support informal caregivers
- Expand case management and managed care

At a time when the number of elderly clients being served in Kansas increased, the number of Medicaid-financed NF residents actually decreased. The number of nursing facility beneficiaries fell two to four percent per year between FY 1998 and FY 2001, but costs per beneficiary increased approximately nine percent per year. The number of Medicaid home and community-based services beneficiaries increased between seven and 29 percent per year during the same period, while monthly costs increased between six and eight percent per beneficiary.[11]

The substitution of community-based care for institutional care is not a one-to-one exchange: community-based services cost the Medicaid program approximately one-third the amount of nursing facility care. KDOA estimates that state Medicaid savings (cost-avoidance) of having an equal number of people in community-based service options for LTC services were approximately $104 million from FY 1998 to FY 2001.[12]

Demand and price increases will continue to push up the cost of providing both community-based and nursing facility services through Medicaid. The clear challenge for policymakers will be to improve the efficiency of the system and to assure the quality of services delivered. Some options suggested to date include:

• *Increase the availability of housing options*. Increasing the number of housing options with a range of supportive services allows people who may otherwise have been admitted to a nursing facility to remain in the community. In Kansas, KDOA has implemented the Partnership Loan Program (PLP). Loan proceeds may be used for the conversion of all or part of facilities to alternative housing options; modification of space in rural hospitals to provide a long-term care unit; adult care home quality improvement; construction of congregate housing in small towns; and funding for contractual services for physicians, physician assistants, or professional nurses by rural hospitals.

• *Support the network of informal caregivers*. Some experts estimate that approximately 60 percent of the disabled elderly living in communities rely solely on families and other unpaid caregivers. Congress passed the National Family Caregiver Support Program in 2000. Grants given to states can be used to provide respite care, counseling, information and training for caregivers.[1] There are no income or resource limitations for obtaining services. Kansas received $1.1 million in federal fiscal year 2002 and has applied for an additional pilot grant to expand respite programs through the Red Cross.

• *Expand case management and managed care programs*. A chief goal of the LTC system is to provide appropriate services to elders at the right time. The system, however, can be a confusing amalgam of services and providers, which seniors and their informal supporters have difficulty navigating. Provision of effective case management services is one way to assist the client and potentially to reduce unnecessary expenditures. Case mangers can help coordinate the care of seniors across a range of services. A more

aggressive attempt to control the provision of LTC services is to treat the continuum of services provided to the elderly as parts of a prepaid managed care system. Many analysts believe that integrating and managing hospital, nursing home, and community-based services for the elderly will yield benefits in reduced cost and higher quality of life. Both of these options have been employed in Kansas: Targeted Case Management is provided through the Senior Care Act and HCBS programs, and a small Program of All-Inclusive Services for the Elderly (PACE) — an integrated managed care program funded by both Medicare and Medicaid — in Fall 2002.

Methods of Controlling Public Long-Term Care Costs

- Reduce supply of providers and services
- Limit demand for services
- Regulate prices and reimbursement
- Improve NF efficiency
- Promote healthy lifestyles

Controlling Public Long-Term Care Costs

Through the 1970s and 1980s, policymakers attempted to control health care costs through a variety of methods. All of them worked to one degree of success or another, but none were implemented without controversy and some amount of pain.

The methods shared some characteristics. They either attempted to reduce the supply of health services, control the demand for their use, or regulate the price of services. The two primary methods for reducing the supply of long-term care services were limiting the number of providers through a certificate-of-need program or nursing facility bed moratorium and restricting covered Medicaid benefits. Demand for long-term care services has been reduced by making it more difficult for people to qualify for services (for example, by raising the level-of-care score) and implementing waiting lists, particularly for Medicaid waiver services. Two examples of ways to reduce the price of long-term care services are prospective payment systems and reductions or freezes in reimbursement rates to providers.

Two other methods of controlling LTC costs are:

• *Improve NF efficiency*. Improvements in NF efficiency will allow the Medicaid program to moderate payment rates without harming the financial health of facilities. Conscientious providers are interested in improving efficiency to lower prices to patients and to improve profitability. Because they are able to retain amounts above the fixed reimbursement rate, prospective payment systems encourage providers to improve efficiency. Some providers, though, may lack the skill to improve efficiency and may be aided by state-supported advice, training or technical assistance.

• *Promote healthy lifestyles*. Another way of reducing demand for LTC services is by reducing the rate of disability in the elderly population through the promotion of healthy lifestyles and disease prevention. State programs, such as Massachusetts' "Keep Moving" and Delaware's "Millennium March to Wellness," focus on increasing physical activity through walking and providing nutrition education. Broad-based health promotion may have a positive effect on future health care expenditures of the state.

An Immodest Proposal

Some policy analysts have suggested the need for a national social insurance program, to which everyone would contribute and be guaranteed long-term care services. The most common suggestion is to expand Medicare (Part D) to include long-term care coverage. Despite the current economic downturn and the movement to include a prescription drug benefit for the elderly in Medicare, the idea of a LTC expansion to Medicare is not wildly idealistic: the federal government, through Medicare and the federal portion of Medicaid, already finances

approximately 40 percent of national LTC expenditures.

Social insurance programs are also being explored on a state basis. In 2002, Hawaii enacted legislation that established a new long-term care financing program and a state fund to cover the costs of LTC services for the elderly. The legislation uses mandatory payroll premium assessments to create the Hawaii Long-Term Care Benefits Fund.

Arguments for and against social insurance for LTC abound. Arguments for the implementation of such a program include: universal participation and financing distributes the burden and increases fairness of obtaining services; uniformity of benefits; uniformity of quality standards; improved coordination of services; and overcoming the failure of the private market to produce a fair price for coverage. Arguments against social insurance include: high cost; induced demand, which would increase total costs; reluctance to provide benefits to the wealthy; and the superior efficiency of the private sector.[13]

The challenge for policymakers is to seek out cost-saving opportunities that make the LTC system better, rather than selecting cost-cutting measures that merely reduce public spending."

Limitations of Public Policy

Regardless of the public LTC financing policies that are enacted, the number of people needing services will continue to grow, and the unit costs of providing services will continue to increase. At best, public policies will have a marginal impact on the rate of growth of public spending. Because of the magnitude of the issue, however, a marginal impact still amounts to millions of dollars of savings.

LTC delivery systems are in a state of flux. There is wide consensus that the system, as it exists today, will have to change to meet the needs of current and future elderly citizens. In some cases, public financing will lead the change. In other cases, public financing will need to react to LTC delivery system changes so that financing systems do not impede needed progress. Without doubt, public LTC financing and private delivery systems must develop jointly to provide high quality, economically efficient services to elderly Kansans. The challenge for policymakers is to seek out cost-saving opportunities that make the LTC system better, rather than selecting cost-cutting measures that merely reduce public spending.

Additional Online Resources

AARP Public Policy Institute
www.aarp.org/ppi

Kansas Department on Aging
www.agingkansas.org/kdoa/index.htm

Kansas Insurance Department
www.ksinsurance.org

National Conference of State Legislatures
www.ncsl.org/programs/health/longcare.htm

National Governors Association
www.nga.org/center/topics/1,1188,D_611,00.html

The Urban Institute
www.urban.org/content/PolicyCenters/HealthPolicy/Overview.htm

University of Kansas Medical Center, Center on Aging
www2.kumc.edu/coa

Other KHI Information on Long-Term Care

- This Forum Brief summarizes a more comprehensive paper on the subject of long-term care financing.
- For a general description of the long-term care system please see the Forum Brief prepared for the August 2001 Kansas Health Policy Forum, *The Aging of Kansas: Implications for the Future of Long-Term Care*.

These two documents can be found at www.khi.org or by calling 785-233-5443.

Endnotes

[1] United States General Accounting Office. (2001). *Long-Term Care: Baby Boom Generation Increases Challenge of Financing Needed Services* (GAO Publication No. GAO-01-563T). Washington, DC: U.S. General Accounting Office.

[2] American Council of Life Insurers. (2002). *Long-Term Care Insurance*. Retrieved August 12, 2002 from www.acli.org/ACLIDocuments/public/subframe_cons.htm

[3] United States Senate Special Committee on Aging. (2002, June). *Aging Committee: Hearing Finding Summary*. Washington, DC: U.S. Government Printing Office.

[4] American Health Care Association. (2002). *Top 15 Q & A About Long-Term Care*. Retrieved July 17, 2002 from http://www.ahca.org/secure/top15.htm.

[5] American Health Care Association. (1999, April 7). *Survey Finds Boomers Headed for Financial Disaster in Golden Years*. Retrieved July 17, 2002 from http://www.ahca.org/brief/arch-ived_releases/nr990407.pdf

[6] The 2002 Kansas Legislature directed that KDOA begin a campaign to educate and make Kansans aware of the cost of long-term care, and to encourage them to consider the purchase of long-term care insurance at an age when it is affordable.

[7] Deductions are taken when calculating taxable income, while credits are deducted from tax liability. Many predict that the effect of these incentives will be marginal because they do not address the upfront costs of insurance and state tax rates are relatively low.

[8] Further expansion of partnerships at this time is limited by federal estate recovery requirements. Congress is currently considering a bill expanding the number of states that may participate. Wiener, J., Tilly, J., & Goldenson, S. (2000). *Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance*. The Elder Law Journal, 8(1), 57-99; National Academy of Elder Law Attorneys Long-Term Care Task Force. (2000). *White paper on Reforming the Delivery, Accessibility and Financing of Long-Term Care in the United States*. Tucson, AZ: National Academy of Elder Law Attorneys.

[9] A further discussion of the movement towards community-based services can be found in an August 2001 KHI Forum Brief entitled The Aging of Kansas: Implications for the Future of Long-Term Care. The potential impact of the U.S. Supreme Court's decision in Olmstead v. L.C. can be found in an soon to be released KHI Issue Brief.

[10] People must be determined financially and functionally eligible for NF services before receiving Medicaid home and community-based (HCBS) services. Once they are determined eligible, elders may choose NF or HCBS placement. The 'woodwork effect' hinges on the belief that people are more interested in Medicaid services if they can receive them in the community and would not apply for Medicaid NF services alone.

[11] Kansas Department on Aging, personal communication, June 18, 2002.

[12] This estimate only reflects the difference in cost between nursing facility services and HCBS services for a constant number of people and does not reflect costs for increasing numbers of beneficiaries. This amount is the State General Fund portion of Medicaid which is approximately 40 percent of the total amount.

[13] Merlis, M. (1999, September). *Financing Long-Term Care in the Twenty-First Century: The Public and Private Roles* (Publication No. 343). Washington, DC: Georgetown University Institute for Health Care Policy and Research.