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Forum Brief

EXPANDED DISCUSSION

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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
Healthier Kansans through informed decisions

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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

POLICY IMPLICATIONS

The public policy importance of long-term care financing (LTC) 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[1] 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. In 1998, two-thirds of nursing home residents relied on Medicaid to pay for their care.[2]

• *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.[3] Recent information indicates that about 60 percent of people over age 75 will need LTC services,[4] and two out of five will need nursing facility (NF) care.[5] Even as the number of NF residents decreases, costs continue to rise.

Introduction

People of all ages with disabilities use a variety of long-term care (LTC) services.[6] The elderly, who are the subject of this Brief, make up the largest group of users, but the majority of current public expenditures are for younger persons with disabilities. Individuals finance much of their own LTC services, but public sources fill in the gaps for low-income seniors or those who exhaust their resources. Questions about the ability of the current system of care to meet the needs of current and future elderly Kansans have arisen, particularly in light of the aging of the baby boomers and the concurrent decrease in working age population to support them. Current budget constraints have served to increase policymakers' concerns about the public system's sustainability due to the large proportion of LTC services financed by public programs.

Suggestions for financing services and controlling costs have come from a variety of public and private sources. Financing options are numerous and range from national social insurance to private insurance solutions. No clear answer has yet emerged from the many discussions and analyses devoted to this issue. The solution may reside in a collection of smaller reforms that address pieces of the puzzle as opposed to one sweeping reform. A lesson learned from the already fragmented system however, it is clear that the interrelationships between the pieces must be kept in mind as solutions are developed. This Forum Brief will discuss the current system of financing, the challenges ahead and some of the options and innovations, both public and private, being implemented or discussed around the country.

Private Financing of Long-Term Care

Private sources pay for approximately 40 percent of long-term care expenses. Individuals pay 25 percent of costs out-of-pocket, and private insurance pays another 10 percent. Families and friends provide significant informal caregiver services. In fact, an estimated 60 percent of the elderly needing assistance living in the community rely solely on these unpaid caregivers for their care.[7] One report estimated that if these unpaid caregivers were replaced by paid home care providers it would cost approximately $196 billion nationally.[8]

Baby boomers, who will significantly increase the number of elderly in coming decades, are often described as more informed, better educated, more financially secure and willing to demand more services than the current elderly population. However, a recent draft report predicts that many people born between 1936 and 1964 will not have enough income to pay for the costs of living, much less extensive long-term care services, raising the potential need for publicly funded services.[9] A report from AARP indicates that personal debt burdens among people aged 50 to 64 increased during the 1990s while personal savings decreased dramatically.[10] Additionally, the current recession has significantly decreased many people's retirement savings.

Increased public knowledge about long-term care costs, financing and options may be critical to the success of a number of state reform initiatives, especially those that require action by individuals. A survey by AARP found that a vast majority of adults age 45 and over does not know the cost of long-term care services, including nursing homes, assisted living and in-home visits.[11] A second survey (results shown in box on this page) illustrates both a lack of knowledge of how long-term care services are financed and a lack of preparation. In light of this information, policymakers may want to consider initiatives that help to inform younger people about the realities of long-term care. 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. Several organizations, including AARP, are working with employers and their own members to increase the information available so that people can make better informed decisions about their future and plan accordingly. The Kansas Department on Aging and the Kansas Insurance Department have a variety of information available to help inform the public about LTC services and financing options.

What Baby Boomers Know about Long-Term Care[12]

A survey of baby boomers discovered:

- Four out of five do not know how long-term care is financed.
- Only 15 percent identified Medicaid, not Medicare, as a principle source of nursing home financing.
- Two thirds are unwilling to be forced into poverty to get government assistance, even though Medicaid currently requires this.
- Sixty-eight percent say they are not financially prepared for long-term care and half have not given any thought to how they will pay for it.
- Twenty-seven percent, probably mistakenly, think they are covered by long-term care insurance.

Sources of private financing include:

• *Out-of-Pocket* — Individuals and families pay LTC service providers directly from personal resources. Less obvious costs taken on by unpaid caregivers, including lost wages for time taken off to provide care, transportation and meals are often not taken into consideration when calculating total out-of-pocket expenditures. Many Kansans can afford to pay for all of their services and eventually exhaust their resources, becoming Medicaid eligible. A recent report suggests that the retirement income of many aging baby-boomers will not be adequate to fund even basic expenses, raising questions about the role that public entities will play in bridging the gap.[13]

• *LTC Insurance* — Private long-term care insurance policies pay for long-term care services much like health insurance policies pay for general health care expenses. LTC insurance rates are set on the assumption that claims will be made in the future and are designed to ensure that a pot of money from premiums will have accumulated in time to pay for future long-term care costs, almost like an annuity plan. Like life insurance, the cost of a long-term care policy is much less for younger beneficiaries as there is expected to be more time for premiums to accumulate before expenses are incurred. Currently only a small proportion, less than 10 percent, of elderly persons are covered by long-term care insurance and even fewer near-elderly (age 55-64) have policies. However, the number of people covered has risen significantly from 1.7 million in 1992 to 4.1 million in 1998.[14]

Methods of Encouraging the Purchase of Long-Term Care Insurance

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

One way to reduce the cost burden of LTC services late in life for individuals and to potentially limit Medicaid expenditures is to increase the ability of individuals to purchase LTC insurance long before it is needed. Current purchasing of LTC insurance is limited by several factors. Many people either do not understand their potential responsibilities or refuse to acknowledge their potential need for long-term care services, reducing the likelihood of purchasing long-term care insurance. The cost of premiums, particularly for people who purchase LTC insurance later in life, may prohibit the purchase of coverage. Earlier in life when policies are more affordable, LTC insurance premiums must compete with other household needs and expenses. Finally, uncertainty about the benefits offered and a lack of standardization among policies may also make people wary of buying.

Skepticism exists about the ability of private insurance to play a substantial role in financing LTC. One argument is that it is simply not affordable for the portion of the population who would be most likely to eventually use public benefits. Some argue that it will not significantly reduce public, Medicaid and Medicare expenditures. Most of the shift will come from out-of-pocket expenditures, they claim, because people who are most likely to afford LTC insurance are paying for care themselves, and expenses covered by Medicare are excluded by LTC insurance policies.[15] Others argue it may exacerbate a dual level of care to the detriment of the quality of Medicaid-funded services. Finally, even if long-term care insurance can affect public expenditures, the effect will likely not be seen for decades when today's working age individuals, who may be most likely to afford it, reach ages where they might use the benefits.[16]

Despite uncertainty about the potential value of LTC insurance, states and the federal government have used tax incentives and public/private partnerships to encourage its purchase.[17] A report from the Kansas Insurance Department looking at the feasibility of alliances between states and the private market listed some potential options for Kansas to increase the purchase of LTC insurance. Options include state income tax incentives; educational efforts focused on employers, educational efforts focused on state employees, mandates for standardization of policies, pre-payment options and policy benefit guarantees. The analysis concluded that while most of these options have potential there are also risks and limitations associated with them.[18]

• *Offer tax incentives*. Tax incentives for individuals can come 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. The federal government also implemented a program in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that allows for limited tax incentives for qualified premiums under limited conditions. States and the federal government also have

sought to target efforts at younger purchasers by using tax incentives to encourage employer-based policies. Some states (e.g., Maine, Oregon and Maryland) provide tax credits to companies that contribute toward the cost of long-term care insurance for their employees. Federally, HIPAA specifies that employer contributions to qualified private long-term care insurance costs are tax deductible as a business expense, much the same as health insurance.

• *Offer LTC coverage to public employees*. At least 19 states, including Kansas, and the federal government have begun offering group long-term care insurance coverage for their own employees, retirees and spouses to serve as an example to private employers. Contribution toward the cost of policies is generally not provided but states attempt to use group bargaining power to obtain more favorable premium rates. Thus far, response to these programs has been very limited.[19]

• *Develop public/private partnerships that allow citizens who purchase state-approved policies to become eligible for Medicaid after their insurance benefits are exhausted without first spending down their assets as is usually required*.[20] Such partnerships are currently underway in Connecticut, Indiana, California and New York. Although other states have expressed interest in beginning a partnership program, federal estate recovery law limits further expansion at this time.[21] So, while states can implement programs that do not require a spend-down of assets during the beneficiary's lifetime in order to qualify for Medicaid, states would be required to recover the assets from the estate after the person's death. Legislation is currently under consideration in Congress to expand the number of states that may participate.[22]

Partnership programs operate under two different models: dollar-for-dollar (used by California and Connecticut) and total assets (New York). Indiana uses a hybrid model. The dollar-for-dollar model allows people to purchase insurance benefits equal to the amount of assets they want to protect. The total assets approach provides unlimited protection of assets for people who purchase a state-approved policy. In Indiana, people who purchase policies with a set dollar amount of coverage receive total asset protection, while those who purchase a lower-level policy receive dollar-for-dollar protection.

Goals for states wanting to implement these types of programs are varied but include: increasing the number of middle-income people who are protected from impoverishment through purchasing insurance; encouraging people to purchase policies to support personal responsibility; containing the growth of public long-term care expenditures; improving the quality and availability of private insurance policies (since only approved policies can be used to gain protection); and enhancing public information about the costs and options for long-term care.[23]

The ability of these partnerships to make a significant impact on the number of people purchasing insurance is unclear. Potential limitations include: the upfront cost of the policies; the lack of knowledge that Medicaid requires the spend-down of assets, thus asset protection is not a major motivator for purchasing coverage; a lack of interest in having easier access to public programs; and the non-transferability of asset protection benefits from state to state.[24] Long-term care insurers may be hesitant to join partnerships because easier access to public benefits runs counter to their marketing strategy of avoiding the need for public programs. Additionally, some people may not be able to obtain coverage because they are considered unacceptable risks.

A key consideration for state officials is whether increasing the purchase of LTC insurance will help to contain public expenditures. The two main sources of savings to Medicaid are the number of people who would have been eligible after spending down assets but whose need for Medicaid services has been delayed by having access to private coverage and the number of people who would not have spent down their assets to become eligible but eventually use Medicaid because they exhaust their resources anyway. Savings to the Medicaid program are dependent on the amount of benefits people will

use; whether policies remain in force long enough to defray public expenditures and whether enough people can be encouraged to purchase policies to actually reduce Medicaid spending.

Public Financing of Long-Term Care

Public sources financed over sixty percent of national community-based and nursing facility services in 1999, with Medicaid paying over forty percent, Medicare paying fourteen percent and other programs filling in the remainder.[25] Traditionally, these financing sources have paid for institutional care, but the nature of publicly funded services in Kansas has shifted over the last decade to emphasize community-based services. This transition had the dual goals of offering care choices and controlling public expenditures. Changing attitudes toward community-based services were reinforced by the 1999 U.S. Supreme Court *Olmstead*[26] decision, which found that unnecessarily institutionalizing disabled individuals is a form of discrimination under the Americans with Disabilities Act of 1990. This trend can also be seen in the proportion of Medicaid funding spent on institutional versus community-based services. Kansas spends approximately 52.5 percent of its Medicaid long-term care dollars on institutional care for all persons with disabilities, compared to 71 percent nationally. In 1990, more than 90 percent of national Medicaid funding went to institutional services.[27]

The following is a description of the major sources of public funding for long-term care services:

• *Medicare* — Medicare, a federally funded and administered health care program for the elderly, is not a major component of long-term care services. Medicare covers acute care services and short-term health care needs primarily in the form of limited stays in skilled nursing facilities following hospitalization and home health services.

• *Medicaid* — Medicaid is a joint federal and state program that provides health care services for low-income individuals. The largest numbers of people participating in the program are pregnant women and children, but the largest expenditures are for people with disabilities, including the elderly. Medicaid covers a variety of long-term care services both in institutions and in the community. Community services can be funded through standard Medicaid services or through Home and Community-Based Services (HCBS) waivers. Kansas Medicaid expenditures for nursing facility, targeted case management and HCBS services for the elderly for fiscal year (FY) 2002 are expected to be about $360.1 million.[28]

• *State-Only Funds* — States operate a variety of programs that seek to allow people to stay in their homes and emphasize prevention and early intervention services. Using only state funds allows more flexibility than federal matching programs, like Medicaid, but increases the share of program costs that states must provide. Under these programs, states can design their own eligibility criteria allowing them to serve people who would otherwise not qualify for income-based programs. Additionally, cost sharing mechanisms, such as co-pays or sliding scale fees, can be used to offset costs or promote personal responsibility. Expenditures of approximately $9.5 million were approved for state-funded services for the elderly for FY 2002.

The 2001 Kansas Legislature directed the Kansas Department on Aging (KDOA) to combine a number of state funded programs into the Senior Care Act program to reduce confusion among consumers and streamline administrative processes. Programs combined by the bill include the Senior Care Act, Case Management, Environmental Modification, Custom Care and the Income Eligible programs. Services provided in this combined program include adult day care, attendant care, chore and homemaker services, personal emergency response, respite care, transportation, case management and environmental modifications. In-home nutrition programs also

are funded by the state but were not combined under the Senior Care Act.

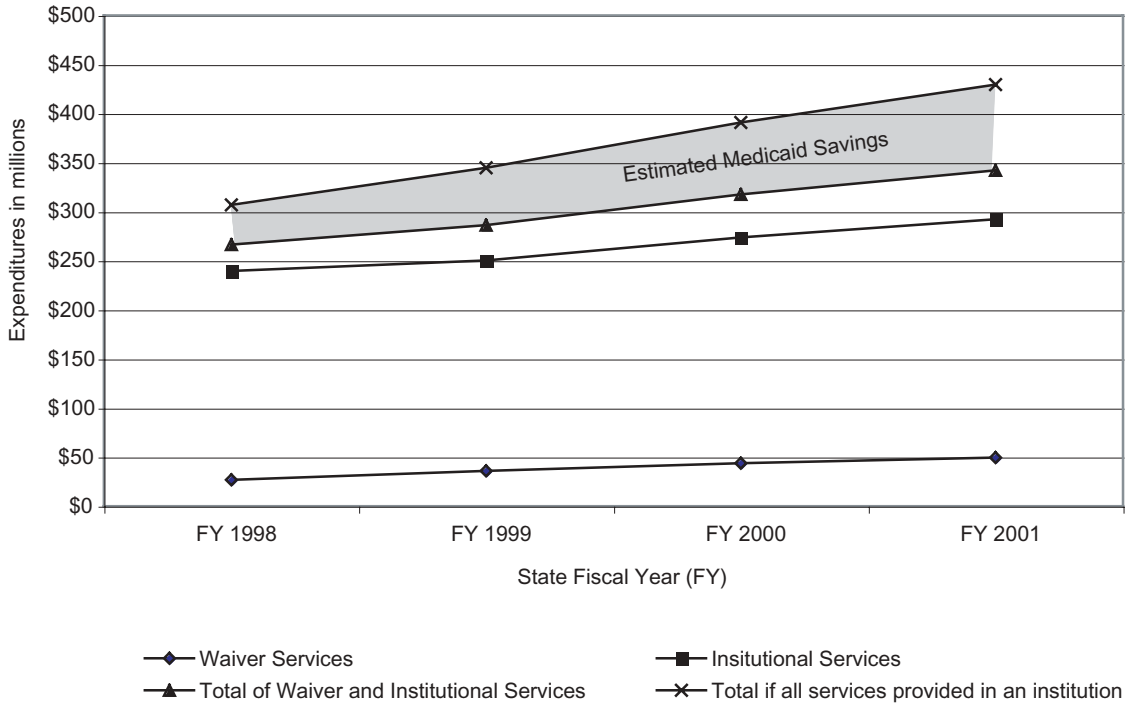
• *Older Americans Act* — The Older Americans Act is a federally funded program for people aged 60 years and older that is administered by the state. Supportive services in four areas are provided: 1) access services including case management and transportation; 2) in-home services including chore, homemaker, personal care and meals; 3) community services including senior centers, congregate meals, and adult day care; 4) caregiver services including respite care, counseling and education. Approved expenditures in Kansas for fiscal year 2002 are approximately $9.9 million. 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 or implemented to date include:

Methods of Reducing State Financing of Long-Term Care

- Enhancing community-based services
- Implementing managed care and case management
- Increasing housing options
- Supporting informal caregivers
- Consolidating programs
- Developing local funding
- Reducing artificial impoverishment

• *Enhancing Home and Community-Based Services* — In an effort to contain rising institutional nursing facility costs and serve clients in the community, states have implemented Medicaid HCBS waivers. Under federal Medicaid waiver rules, aggregate costs for beneficiaries on HCBS programs cannot exceed the costs of serving the population in nursing facilities. People who

Figure 1
Estimated Medicaid Cost Avoidance of Community-Based Services
FY 1998-FY 2001



meet financial and functional qualifications for nursing facilities can choose to receive services in the community or in a nursing facility. Waivers are used to provide services not normally covered by Medicaid, such as attendant and respite care, to help keep people living in the community longer and diverting them from more expensive nursing facility services. Services available under the HCBS waiver for the Frail Elderly (HCBS-FE) are adult day care, sleep cycle support, installation and rental of personal emergency response equipment, wellness monitoring, respite care, attendant care services, assistive technology and nursing evaluation visits.

Goals of Managed Long-Term Care[31]

- Better quality care due to integration of services
- Lower costs
- Reduce the number of providers dealt with to focus on setting contract standards and monitoring performance (MA, MN, WI)
- Shift financial risk from government to providers to make state spending more predictable.

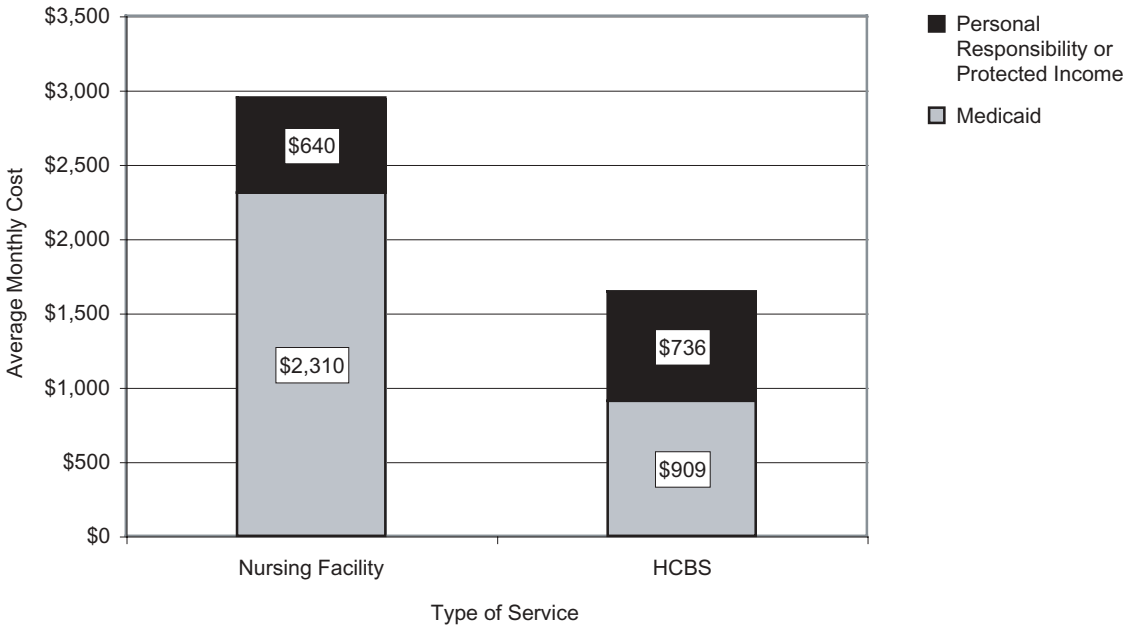
In an effort to improve the predictability of costs and shift some risk to providers, states are also experimenting with making monthly capitated payments under their HCBS waivers. These systems work much like capitated managed care in health insurance. Essentially, the states make one monthly payment to a coordinating organization or person that is intended to cover both administrative costs and services. The coordinator is then responsible for paying for and coordinating all needed services for their clients. These "capitated waivers" are currently underway in a number of states including Michigan and Wisconsin.[29]

Many policymakers question whether community services save them money or whether the availability of publicly funded community services supplants informal services elders might receive from other sources such as personal savings/resources, family, friends or community volunteers. Determining whether this is true is difficult because of the number of factors that could influence people's use or non-use of public services. KDOA suggests that, based on a constant population, there have been state savings or avoided costs by providing services in the community. Figure 1 shows the estimated cost avoidance of serving equal numbers of people in the Medicaid HCBS-FE waiver program as opposed to nursing facility services. The savings are illustrated by the difference between total NF and HCBS-FE expenditures and total expenditures if the whole group was served in a nursing facility. This chart does not account for additional people who might choose to apply for Medicaid services to receive community-based services but not nursing facility placement, the crux of many policymakers' concerns. The savings from state and federal funds were estimated at $87.5 million in FY 2001 and totaled $260 million from FY 1998 through FY 2001.[30]

On a per user basis, HCBS services cost less on average than NF services. Figure 2 compares the FY 2002 average monthly expenditure for nursing facility patients versus clients receiving HCBS-FE and targeted case management services in the community. "Personal responsibility" is the portion of nursing facility costs the individual is responsible for paying out of personal resources. "Protected income" in community-based services is the amount of income a person receiving services is allowed to receive and still qualify. These funds are used to pay for items such as housing, transportation, and food. Adjustments to these levels may affect people's ability to pay for housing and remain in the community. The total cost of community-based services if all public and private contributions are accounted for, including family caregiver out-of-pocket costs and lost wages, is somewhat higher that this chart reflects, but these amounts are difficult to quantify.

Figure 2

Monthly Nursing Facility vs. Waiver Service Costs



Movement toward community-based services can be seen by comparing the number of clients served in nursing facilities and the HCBS-FE waiver. Even as the total number of Medicaid-funded elderly clients increased, the number of nursing facility clients fell 2 percent to 4 percent per year between FY 1998 and FY 2001. At the same time, HCBS-FE beneficiaries increased between 7 percent and 29 percent per year.

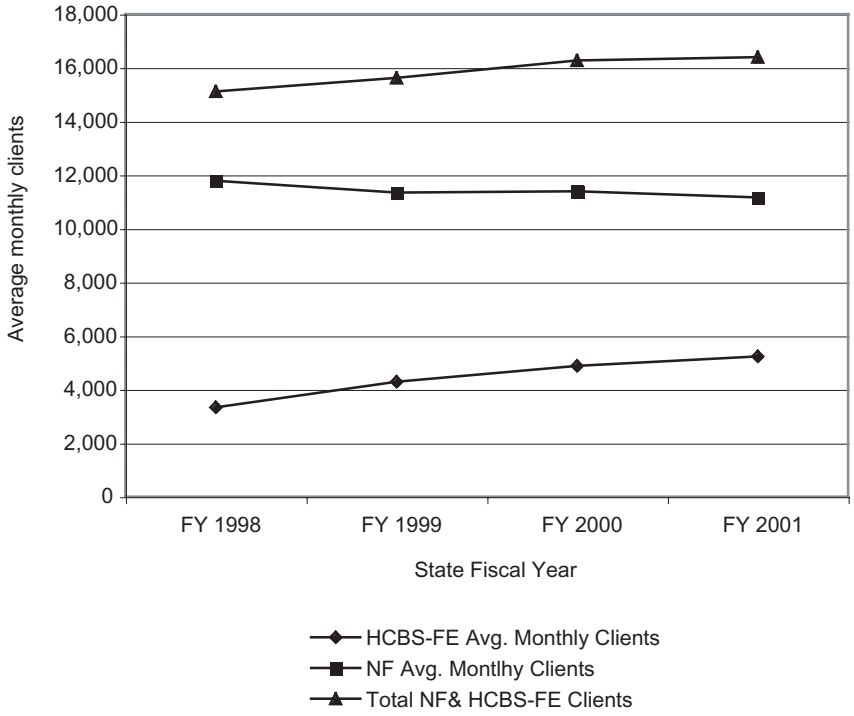
• *Implementing Managed Care and Case Management* — To address issues of a fragmented delivery and financing system, some states have designed managed care programs to integrate acute and long-term care or incorporated case management services into Medicaid and state-funded programs.

States can implement managed care programs such as Programs of All-inclusive Care for the Elderly (PACE) and Social Health Maintenance Organizations (Social HMO) using Medicaid waivers. Both programs focus on people who are dually eligible for both Medicare and Medicaid in order to receive funding from both sources. PACE programs offer services at specific sites providing all acute and long-term care services to individuals who are eligible for nursing facility placement. Monthly payments are made to providers who are then responsible for providing all necessary services to enrolled clients. Kansas will open a PACE site with the Via Christi Regional Medical Center in Wichita during the second half of 2002 to a small number of participants. Social HMOs operate as traditional HMOs but offer a limited number of long-term care benefits and enroll elderly persons across a range of disability levels. Enrollment in both of these types of programs is very limited at this time.

Other variations of managed care programs are operating or being planned in a number of states, including Minnesota, Colorado, Florida, Texas and Massachusetts. These programs borrow concepts from PACE and Social HMOs but focus on slightly different populations or services. Some states (New York, Michigan and

Figure 3

Medicaid Clients for Institutional (NF) and Community-Based (HCBS-FE) Services FY 1998 - FY 2001



Wisconsin) have begun integrating their long-term care services without adding in acute care services.[32]

Almost all of these managed care initiatives are slow to get started for several reasons including the need to obtain waiver authority from the federal government; criticism from advocates who are concerned that acute care services will take precedence and that managed care organizations are not experienced in providing long-term care; and recent turmoil in the Medicaid and Medicare managed care programs.[33] The ability of any of these programs to enroll significant numbers of people is uncertain at this time.

Kansas has incorporated targeted case management services into both the HCBS-FE waiver and Senior Care Act programs to ensure that elders receive the right services at the right time and in the right amounts. By reducing the provision of duplicate, inappropriate or unnecessary services, public programs can operate more efficiently and use resources more judiciously.

• *Increasing the Availability of Housing Options* — The availability of affordable housing is critical to state efforts to allow seniors to remain in the community and out of expensive nursing facilities. Consequently, a number of states have begun loan programs to help increase the availability of housing options. KDOA has implemented the Partnership Loan Program (PLP) to encourage adult day care facilities, boarding care homes, home plus, residential health care, assisted living, and nursing facilities as well as some hospital, private residences and senior housing projects to develop housing choices for elderly citizens in Kansas. The PLP may be especially helpful in less-populated areas of

Kansas where 37 counties do not have a licensed assisted living or residential health care option available. Approximately $9 million was available to fund the program in FY 2002 from the Inter-Governmental Transfer (IGT) program. Repaid principle from the loans is returned to the fund. Interest from the fund may be used to make grants for case management quality improvements, adult care home improvements or financial assurance grants for community service providers.

Loan proceeds may be used for a variety of purposes including the conversion of all or part of adult care homes, such as nursing facilities, to alternative housing options; conversion of private homes to home plus facilities, provided the owners intend to continue to reside in the home; modification of space in rural hospitals to provide a long-term care unit; adult care home quality improvement; construction of congregate housing for seniors in cities with populations of 2,500 people or fewer; and funding for contractual services for physicians, physician assistants, or professional nurses by rural hospitals.

• *Supporting Caregivers* —States and private organizations have created programs that support the network of informal/unpaid caregivers, acknowledging the cost savings they provide. Services such as respite care, including adult day care and attendant care, have been made a part of state-funded programs and Medicaid HCBS waivers. States, including Kansas, have also begun to emphasize and encourage the use of adult day care benefits as part of plans of care to provide support to caregivers increasing the potential that elders will be able to stay in the community for longer periods of time. Several states, including Oklahoma, Oregon, Nebraska and Wisconsin, have implemented respite programs that expand the supply of respite care providers and increase integration of services by giving authority to one agency to integrate available funds.[34] Congress passed the National Family Caregiver Support Program in 2000 as a part of the renewal of the Older Americans Act. Grants given to states can be used to provide respite care, counseling, information and training for caregivers with no income or resource limitations. 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.

According to a July 2002 *New York Times* article, private employers have also begun to offer caregiver assistance benefits to their employees who provide care for their elderly family members. A number of businesses offer geriatric care managers to advise employees, and some are providing in-home assessments. According to a 1997 survey, companies lose approximately $11 billion per year from lost productivity, absenteeism and turnover among their employees who care for an elderly person. Workers who take care of a relative who lives more than one hour away miss at least one day of work per month. An average of five percent of employees use geriatric care benefits at companies where they are available.[35]

• *Consolidating Programs for the Elderly* — To reduce fragmentation and increase efficiency, some states have consolidated programs for the elderly under one state agency. Kansas consolidated its federal and state-funded programs under KDOA in 1997.

• *Developing Local Funding* — A potential option for states looking at inadequate state resources to fund long-term care services or for localities not satisfied with state and federal funding is the development of local funding. A recent report indicates that local property tax levies may be a viable funding source for long-term care services. The report indicates that local agencies on aging may be well suited to coordinate such levy initiatives. Key components to the success of these initiatives are well-planned, comprehensive campaign strategies to generate voter support and campaigns and pro-

grams that take into account the county culture, history and politics.[36]

• *Reducing Artificial Impoverishment* — States have attempted to contain costs by decreasing the number of people becoming 'artificially' eligible for Medicaid services. The practice of transferring, sheltering or under-reporting assets in order to qualify for Medicaid is often referred to as "Medicaid Estate Planning." People attempt to "hide" their assets so they can receive public services yet retain and pass on their wealth. The 1997 Balanced Budget Act made it illegal for lawyers and financial advisors to counsel elders on transferring assets to qualify for Medicaid nursing facility services. The effectiveness of these types of restrictions is questionable because they are difficult to enforce. States have implemented "look back provisions" which examine potential transfers of assets occurring within a specified period when determining Medicaid eligibility. The amounts of transfers determine how long a person must wait before becoming eligible. In Kansas, the look-back period for general transfers is three years and the period for transfers to trusts is five years. Transfers made within the look-back period incur one month of ineligibility for every $2000 of uncompensated value, and the duration of the penalty is unlimited.[37] Potential savings to the Medicaid program come from the number of people who choose not to divest their assets due to the length of the look-back period and delay their use of Medicaid resources. The amount of activity around transferring assets is unknown, and thus it is difficult to tell whether extending look-back periods, as has been discussed in Kansas and other states, will generate substantial savings.

Federal law requires states to recover assets from the estates of elderly long-term care beneficiaries after their death (and the death of their spouse, if applicable). Estate recovery has dual purposes of trying to recover the costs of Medicaid services provided and discouraging people from transferring assets to become Medicaid eligible. In some ways, estate recovery could be seen as a backup method for catching transfers of assets after death that were missed in the initial eligibility determination process. Kansas has had a legal requirement for estate recovery since 1992, preceding the federal 1993 Omnibus Budget Reconciliation Act. Approximately $20 million has been recovered since the inception of the program in Kansas.[38] Although it is not widely seen as a source of significant public savings, states have begun to pursue recovery more aggressively.

Methods of Controlling LTC Costs

- Reducing the Supply of Services
- Controlling Demand for Services
- Regulating the Price of Services
- Improving the Function of Nursing Facilities
- Encouraging Healthy Aging

Controlling Long-Term Care Costs

Policymakers have used a variety of cost control methods over the years with varying levels of success. Traditional methods attempt to reduce the supply of services, control demand for services, or regulate the price of services. Controlling Medicaid expenditures is limited by the entitlement nature of the program. Services must be provided to all people who are determined to be eligible, although the state does have some control over the types and amounts of services provided. Other suggested methods are less traditional but still have the goals of containing overall costs of LTC. Implementing cost controls does not necessarily result in immediate financial returns to state coffers. Most reforms are designed to be long-term efficiencies that result in cost avoidance. Unfortunately, these effects are often difficult to identify and quantify.

Some analysts predict that baby boomers will have a disproportionate impact of the demand for publicly paid services as they will have fewer informal sources of unpaid support such

as a spouse or adult children. This results from a combination of smaller families, geographic dispersion of families and the rising percentage of two-worker families where women, who have been the traditional unpaid support, are no longer available to provide care.[39]

Reducing the supply of services — The two primary methods for reducing the supply of LTC services are limiting providers and restricting benefits.

• The supply of Medicaid-funded services can be limited through certificate-of-need or moratoria on nursing facility construction. Certificate-of-need programs require nursing facilities to obtain approval from states before constructing new facilities or adding beds to current facilities. Moratoria feature prohibitions on construction of new beds or restrictions on the certification of new beds for Medicaid reimbursement. Kansas had a certificate-of-need program at one time but discontinued it in the late 1980s. From a policy perspective, reducing beds does not diminish the needs for service nor does it address the long-term supply needs of the growing population of disabled elderly.

• States can also restrict program benefits. A state's ability to restrict Medicaid benefits is limited by Federal rules that mandate basic benefit packages for Medicaid beneficiaries based on how they are eligible. States may provide services beyond these mandated services, referred to as optional services. Within these limitations, states can choose either to not cover specific services or restrict the amount of service received. In state-only funded programs, states have complete freedom to design a benefit package. Decisions about services provided should be carefully considered in light of the needs of the clients and the potential for simply shifting costs to other services.

Controlling demand for services — Demand for long-term care services has traditionally been reduced by making it more difficult for people to qualify for publicly paid services and implementing waiting lists for services, particularly in Medicaid HCBS waiver programs.

• To qualify for Medicaid-funded nursing home placements, individuals must meet both financial and functional eligibility criteria. Functional eligibility is assessed and measured by a level-of-care score (LOC, previously referred to as a PASRR score), which measures a person's ability to safely care for themselves. Individuals applying for a Medicaid HCBS waiver must first be financially and functionally qualified to receive nursing facility placement. States can limit the number of people receiving waiver services by raising the required level-of-care score. Potential effects of raising LOC scores may be increases in the use of other state-funded services or a lack of services causing a worsening of elders' conditions to the point that they eventually qualify with greater care needs.

• To control the number of people receiving HCBS waiver services, states may freeze entry and institute waiting lists for services. People who are found eligible for nursing facility services, but cannot receive HCBS due to a waiting list, may choose to enter a nursing facility or remain in the community and find services under other types of programs or through informal networks. Kansas implemented a waiting list on the HCBS waiver for the Frail Elderly on July 1, 1999 that ended on October 18, 1999. Due to current budget shortfalls, a new waiting list was implemented on April 22, 2002. The full effect of waiting lists is unknown, but recent analysis by KDOA suggests that waiting lists cost Medicaid money. At the time the 1999 waiting list was implemented, previous decreases in nursing facility admissions reversed course and increased but began to decrease again after the waiting list was lifted. KDOA estimated that the net cost to the state was about $3.5 million after accounting for increased nursing facility costs and a savings in the waiv-

er program.[40] The public policy decision to use waiting lists may be affected by the *Olmstead* decision, which prohibits unnecessary institutionalization, including nursing facility placement for the elderly.

Regulating the price of services — Two examples of ways to reduce the price of long-term care services are prospective payment systems and reductions in reimbursements to providers.

• Reducing reimbursement rates, particularly for high cost nursing facilities, has a more predictable and immediate impact than other types of cost control options.[41] States have a large degree of discretion in setting Medicaid rates, including those for nursing facilities. This is especially true after the repeal of the Boren Amendment, which governed the way states set rates from 1980 to 1997. The Boren Amendment required that rates be reasonably equivalent to costs. Two potential implications of reducing reimbursement rates are provider withdrawal from Medicaid and negative affects on the quality of services provided.

• The federal Medicare program implemented prospective payment systems for home care and skilled nursing facilities in the Balanced Budget Act of 1997.[42] Essentially, prospective payment systems switch financing from cost-based reimbursements to fixed payments for defined services. These systems require significant business practice adjustments by providers to create profit opportunities. The ability of providers to make this shift effectively, while still providing sufficient, quality services, is still not clear. Prospective payment systems have been in place for acute care services since 1984.

Improving the Function of Nursing Facilities — Even with continuing efforts to expand community-based services, institutional services will likely maintain a key place in the long-term care continuum. To this end, states can take steps to improve the efficiency and control future costs of NFs. For instance, states may be able to assist providers in adapting to alternate payment mechanisms, such as prospective payment systems, that reward efficiencies. Private initiatives are attempting to change the environment of nursing facilities to focus on the needs of residents. Preliminary analysis suggests that these changed environments may also help to reduce costs and improve quality through improved staff recruitment and retention. Work force issues are extremely important to nursing facilities as they are facing high turnover and a shrinking worker pool. Other potential areas for reform that increase the cost of nursing facility services include rising health care costs and dramatic increases in liability insurance costs.

KDOA has implement the Promoting Excellent Alternatives in Kansas (PEAK) program that recognizes nursing facilities that make changes to create a more home-like environment and improve services.

Encouraging Healthy Aging — Healthy lifestyles and preventive actions can improve health, reduce the impact of disease and delay disabilities, potentially reducing demand for and costs of future services. The Aging States Project, a combined effort between the National Association of State Units on Aging (KDOA in Kansas) and the Association of State and Territorial Chronic Disease Program Directors in collaboration with the federal Centers for Disease Control, is designed to enhance efforts in health promotion/disease prevention for older persons. Activities highlighted by this effort focus on increasing physical activity through walking and nutrition education. Additionally, the federal Administration on Aging has also developed a pilot project called "USA On the Move: Steps to Healthy Aging" that highlights nutrition and physical fitness. Private organizations, like AARP, have implemented a number of programs and informational products that promote healthy aging.

An Immodest Proposal

Arguments have been made that the current system, often viewed as fragmented and inefficient, will be unable to accommodate the need for LTC services in the future. Some form of national social insurance system, much like Medicare,[43] where everyone contributes and then is guaranteed LTC services when needed, has been offered as a possible response to these issues.

Arguments in favor of the implementation of a Medicare-like program to finance LTC services include: universal participation and financing to distribute burden and increase fairness; uniformity of benefits; uniformity of quality standards; and improved coordination of services. Another argument for social insurance might be that the private market is failing and people are unable to purchase insurance coverage on their own because the price is unfair. Arguments against the implementation of social insurance for LTC include: high cost; induced demand or a 'woodwork effect' which would increase total costs because people would use these services instead of informal supports; reluctance to provide benefits to the wealthy; and the superior efficiency of the private sector.[44]

If a federally run national social insurance program covering long-term care services was implemented, it could take a sizeable Medicaid financing burden off of states, but states would likely lose their ability to design programs for their particular situations. Also, it is probably unreasonable to assume that the federal government will take on this additional responsibility without some type of offsetting decrease in other support provided to states (e.g., Medicaid).

Social insurance programs are also being explored on a state basis. In 2002, Hawaii enacted legislation that establishes a new long-term care financing program and a state fund to cover the costs of long-term care services for the elderly. The legislation uses mandatory payroll premium assessments to create the Hawaii Long-Term Care Benefits Fund that then pays out benefits to qualified persons with disabilities.[45]

Conclusion

There is wide consensus that the system, as it exists today, will need to change in order to meet the needs of both current and future elderly citizens needing LTC services. There is disagreement, however, about the extent of the changes and what those changes or improvements should be. It is not even clear whether the best solution will be a series of incremental reforms or a sweeping comprehensive overhaul.

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 are likely to have only marginal impact on the rate of growth of public spending. However, because expenditures are so large, even a marginal impact amounts to millions of dollars of savings. 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.

Other KHI Information on Long-Term Care

- This Forum Brief: Expanded Discussion has been summarized in a four-page Forum Brief of the same title.
- 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.

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

Endnotes

[1] American Council of Life Insurers. (2002). Long-Term Care Insurance. Retrieved August 12, 2002 from www.acli.org.

[2] 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.

[3] Kansas Department on Aging. (2002). Accessed July18, 2002 at www.agingkansas.org.

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

[5] 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.

[6] This Forum Brief will focus on expenditure information related to the elderly although many of the same financing options and cost containment methods are applicable along the continuum.

[7] United States General Accounting Office. (2001).

[8] United States Senate Special Committee on Aging. (2002, June).

[9] VanDerhei, J., Copeland, C. (2002, June 12

[10] AARP. (2001, December). The Costs of Long-Term Care: Public Perceptions Versus Reality. Washington, DC: AARP.

[11] AARP. (2001, December).

[12] American Health Care Association. (1999, April 7). Survey Finds Boomers Headed for Financial Disaster in Golden Years. Retrieved July 17, 2002 from www.ahca.org.

[13] VanDerhei, J., Copeland, C. (2002, June 12).). Kansas Future Retirement Income Assessment Project: Second Draft. Presented at the July 11, 2002 meeting of the Kansas Long-Term Care Services Taskforce, Topeka, KS.

[14] United States General Accounting Office. (2001).

[15] 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.

[16] Merlis, M. (1999, September).

[17] United States Office of Personnel Management. (n.d.). State Long Term Care Tax Incentives. Retrieved July 12, 2002, from www.opm.gov. As of October 2001, 22 states had implemented tax incentives.

[18] Kansas Insurance Department. (2001, August). Report of the Kansas Insurance Department to the Long-Term Care Services Taskforce. Topeka, KS: Kathleen Sebelius.

[19] Wiener, J., Tilly, J., & Goldenson, S. (2000).

[20] 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. The concept of using public/private partnerships to encourage the purchase of long-term care insurance began in the late 1980s through a Robert Wood Johnson Foundation grant.

[21] Federal Medicaid rules require states to recover the cost Medicaid benefits provided, including any assets protected by insurance, from the estates of beneficiaries after their death.

[22] Senator Craig of Idaho introduced S. 2199, the "Long-Term Care Insurance Partnership Program Act of 2002".

[23] National Academy of Elder Law Attorneys Long-Term Care Task Force. (2000). Wiener, J., Tilly, J., & Goldenson, S. (2000).

[24] Wiener, J., Tilly, J., & Goldenson, S. (2000).

[25] United States General Accounting Office. (2001).

[26] Olmstead v. L.C., 527 U.S. 581 (1999).

[27] Coleman, B., Fox-Grage, W., & Folkemer, D. (2002). State Long-Term Care: Recent Developments and Policy Directions. Washington, DC: National Conference of State Legislatures. This analysis compares Medicaid expenditures for nursing facilities and home and community-based services waivers in FY 2002 for all disabled populations.

[28] This does not include cost for younger people with disabilities for whom the majority of total long-term care dollars are currently spent.

[29] Wiener, J., Tilly, J., & Alecxih, L. (2002). Home and Community Based Services in Seven States. Health Care Financing Review, 23(3), 89-114.

[30] Kansas Department on Aging, personal communication, June 18, 2002. Note that this chart may be overstated as people may be served in both programs during a year and some people may not choose to enter a nursing facility even if they are eligible to do so.

[31] Congressional Research Service. (2000, May 8).

[32] Congressional Research Service. (2000, May 8).

[33] Congressional Research Service. (2000, May 8).

[34] Fox-Grage, W., Folkemer, D., Burwell, B., & Horahan, D. (2001). Community-Based Long-Term Care. Washington, DC: National Conference of State Legislatures, Forum for State Health Policy Leadership.

[35] Companies Adding Benefits for Care of the Elderly. (2002, July 7). The New York Times, Late Edition - Final, Sec.3, p. 8.

[36] Logan, R. (2000, November). Creating Local Funding for Long-Term Community-Based Services (Working Paper ISC55-11/00). Lawrenceville, NJ: Center for Health Care Strategies, Inc.

[37] Take, for example, an elderly Medicaid applicant who gave her daughter a gift of $20,000 in 1999. Then, in Jan. 2001, the person required nursing home care. Because three years have not passed since the gift was made there will be a waiting period for Medicaid eligibility (assuming other criteria is met). To determine the length of the waiting period the $20,000 transfer is divided by $2,000, resulting in a waiting period for eligibility of 10 months from the time of the transfer.

[38] Kansas Department of Social and Rehabilitation Services (2001, August). Estate Recovery Fact Sheet. Accessed July 18, 2002 at www.srskansas.org.

[39] United States General Accounting Office. (2001).

[40] Kansas Department on Aging. (2002, February 25). Health Care Services. Testimony presented to the Kansas House Health and Human Services Committee, Topeka, KS.

[41] Congressional Research Service. (2000, May 8).

[42] Prospective payment systems are intended to control costs through decreased utilization in addition to price reductions.

[43] The Medicare system is funded through payroll taxes and general fund revenue and is administered by the federal government and is available to elderly persons regardless of income or assets.

[44] Merlis, M. (1999, September).

[45] House Bill 2638, Hawaii House of Representatives (2002) (Enacted). Accessed on July 20, 2002 at www.capitol.hawaii.gov.