THE KAISER COMMISSION ON
Medicaid and the Uninsured

FILLING IN THE LONG-TERM CARE GAPS

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Special Committee on Aging
Hearing on
"Role of Private Insurance in Long-Term Care"
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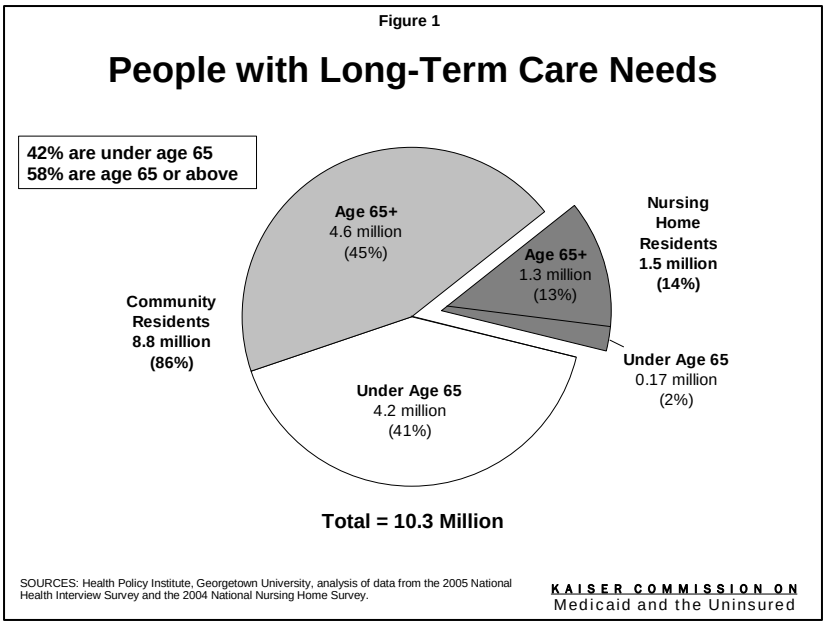
Mr. Chairman and members of the Committee on Aging, thank you for the opportunity to participate in this hearing on long-term care. I am Diane Rowland, Executive Vice President of the Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured. I am also an Adjunct Professor of Health Policy and Management in the Bloomberg School of Public Health at The Johns Hopkins University. My testimony today will focus on how our nation's long-term care system is financed and the key challenges to providing a larger role for private long-term care insurance in financing long-term care for the elderly and people with disabilities.

Who Needs Long-Term Care?

Over 10 million Americans, or almost 5 percent of the total adult population, need long-term services and supports to assist them in life's daily activities (Figure 1). Although the majority of individuals who receive long-term care services are age 65 and above, 42 percent are people with disabilities and chronic illness under age 65. The majority of those with long-term care needs live in the community. Today's nursing home population consists of 1.5 million individuals, most are over age 85, female and widowed. Disease prevalence is higher, and multiple conditions are more common, among nursing home residents today, indicating an increasingly sicker population.

Long-term care includes a range of services and supports that assist individuals with performing activities of daily living (ADLs) and instrumental activities of daily living (IADLS). These range from providing assistance with eating, dressing, and toileting, to assisting with managing a home, preparing food, and medication management. The need for long-term care arises from various causes, including disease, disabling chronic conditions, injury, developmental disabilities, and severe mental illness.

Figure 1



People with long-term care needs span all ages and have diverse needs for services. Some people require care over a lifetime while others may need relatively brief periods, weeks or months, of assistance. Long-term services and supports are especially vital for individuals with disabilities under the age of 65. These include children with intellectual disabilities such as mental retardation and developmental disabilities such as autism, young adults with spinal cord and traumatic brain injuries and those with serious mental illness. Older people with Alzheimer's disease often need some long-term services due to decreasing mobility and cognitive functioning that comes with aging, and those with severely disabling chronic diseases such as diabetes and pulmonary disease need more extensive acute and long-term services as they age.

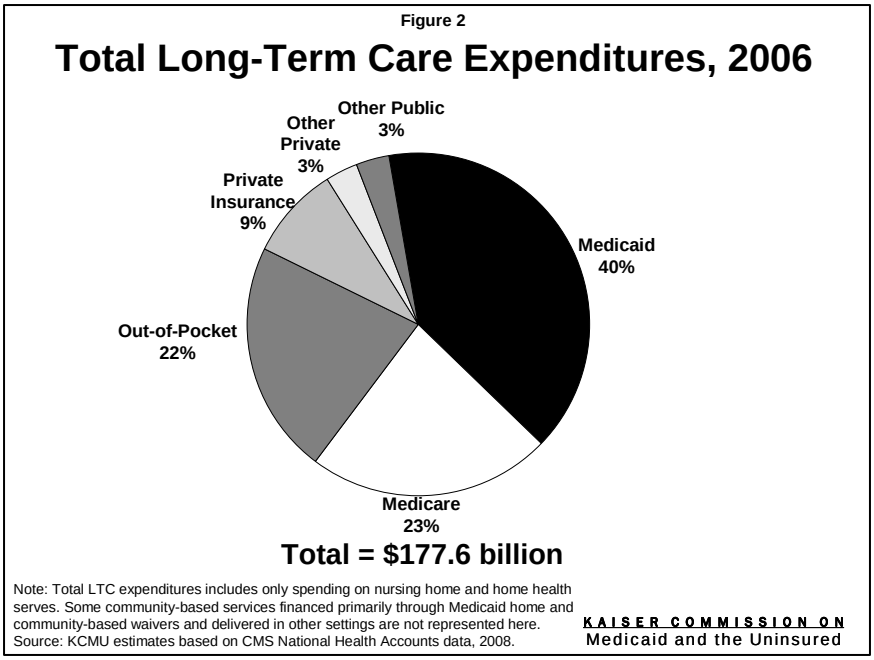
Individuals receive long-term services in a variety of settings including their own homes, adult day centers, assisted living facilities, and nursing homes. The majority (86 percent) of people with long-term services needs live in the community and about 14 percent live in nursing facilities. Most people rely on unpaid help to meet their long-term services needs. Nearly 80 percent of all people with long-term care needs who live in the community have care that is provided by their friends and family. Only a small fraction (8 percent) relies exclusively on paid assistance.

How is Long-Term Care Financed?

Many people who need long-term care rely primarily on unpaid help from family and friends. Paying for long-term services is expensive and can quickly exhaust lifetime savings. Nursing home care averages $70,000 per year, assisted living facilities average $36,000 per year, and home health services average $29 per hour. The cost of these services often exceeds individuals' ability to pay for their care. Most long-term services and supports (including extended stays in nursing homes) are not covered by Medicare, and few people have private long-term care insurance to help pay for nursing home stays.

In 2006, nearly $178 billion was spent on long-term services (Figure 2). Medicaid accounts for 40 percent of total long-term care spending. Medicare accounts for slightly less than one-quarter of spending, direct out-of-pocket care spending by individuals and families accounts for 22 percent, and private insurance accounts for about 9 percent of spending.

Figure 2



Medicare primarily covers physician and hospital-based acute care services and does not play a large role in financing long-term services. However, because it is difficult to draw a bright line between acute care and long-term care services, Medicare does cover some services that could be considered long-term care. For example, Medicare covers up to 100 days of nursing home care for patients needing skilled nursing or rehabilitation services following a hospital stay.

Medicare also covers home health services, without limit, but only while patients require skilled nursing care. These services are primarily intended as short-term transitional care as part of rehabilitation from an acute care episode and do not meet the needs of those with chronic illness or ongoing need for assistance.

Medicare was enacted because the private health insurance market did not work for the elderly. Medicaid was designed as a companion program that provided wrap around services, including nursing home care that Medicare did not provide. Over time, Medicaid has evolved to become the primary payer for long-term services and supports to low-income individuals and a safety net for those who become impoverished as a result of long-term care needs.[1] Because Medicaid is often the only source of coverage for these services, it plays a unique role in our health care system, helping to fill in the gaps in private coverage and Medicare. Medicaid is intended to assist low-income individuals and is not available to everyone who needs long-term services. To qualify for Medicaid individuals must meet stringent income and asset criteria and apply most of their monthly income, including social security payments, toward the cost of care.

Most individuals self-finance their long-term care needs because, unlike insurance for health care services, relatively few people have private insurance for long-term care. Individuals often express reluctance to purchase private long-term care coverage because it is expensive and they are uncertain about their risk of disability and service needs 20 or 30 years in the future. People with chronic conditions and disabilities are excluded from coverage by pre-existing conditions, regardless of its affordability. Also, private long-term care insurance is primarily offered through the individual market which has limitations – even for health insurance, only 6 percent of individuals obtain coverage through the individual market where potential immediacy of needing coverage is more apparent. Private long-term care insurance has rarely been offered as part of employer sponsored insurance and when it has been offered, take-up rate has been low.

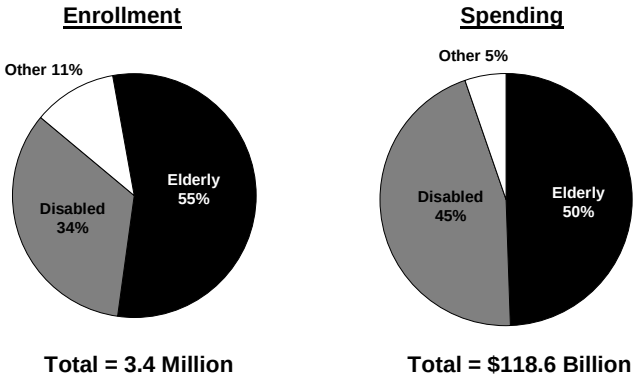
Public Funding of Long-Term Care through Medicaid

Medicaid plays a critical role for low-income people of all ages with long-term care needs. Persons 65 and older constitute over half (55%) of those who use Medicaid long-term care services, but roughly one-third (34%) are individuals under age 65 with a disability (Figure 3).

Another 11 percent are adults and children who rely on Medicaid's long-term services and supports, but became eligible for Medicaid through pathways other than disability.

Figure 3

Medicaid Enrollees Who Use Long-Term Care Services



Total = 3.4 Million **Total = $118.6 Billion**

Note: Other includes individuals who use long-term care services but qualify on the basis of income or eligibility categories other than "disabled."

Source: KCMU and Urban Institute estimates based on MSIS 2002 data; Sommers, Cohen, and O'Malley 2006.

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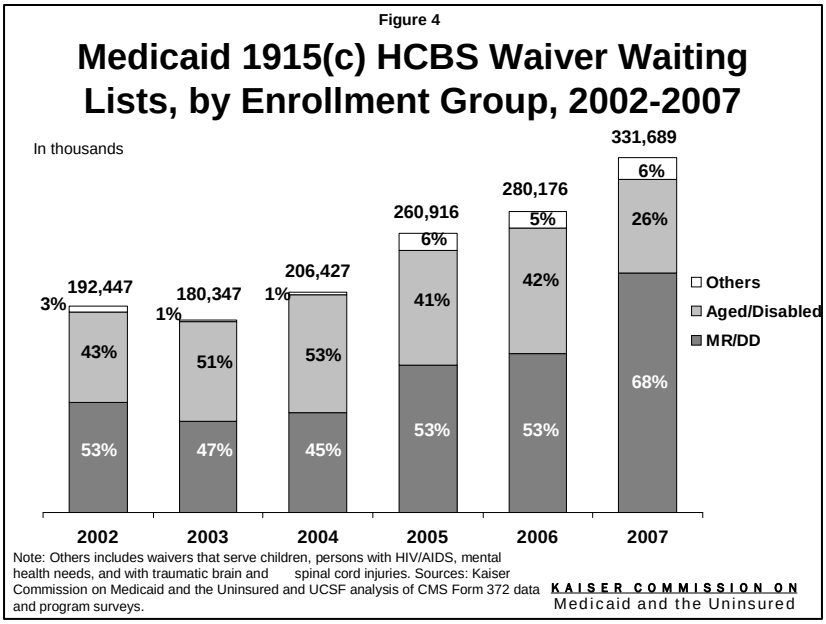
Medicaid's strict eligibility rules require people who need long-term care to spend-down all of their assets and contribute nearly all of their income to the cost of care. Many elderly people in the community have already spent their retirement savings supporting themselves in retirement and paying for care in the community – and thus qualify for Medicaid at admission to the nursing home. They must, however, contribute their entire income, including pension and social security payments (except for a small personal needs allowance) to the cost of care. Others with modest savings above Medicaid's resource thresholds must spend down their available assets before they can qualify for assistance.

Medicaid partnership programs were designed to help bridge the gap between private long-term care insurance and Medicaid. Currently at least 30 states have partnership programs in place. Partnership programs are insurance policies in which Medicaid disregards an amount of assets or resources when determining eligibility for Medicaid equal to the insurance benefit payable under the insurance policy. This disregard allows policyholders to retain a certain portion of their assets and qualify for Medicaid coverage.

There is considerable diversity in the services used and the settings where these services are provided among those who rely on Medicaid to meet long-term care needs. Nursing home

services are used predominantly by older people, while home and community-based services serve a broad age spectrum but are especially important for younger disabled people. Medicaid covers services needed by people to live independently in the community such as home health care and personal care, as well as services provided in institutions such as nursing homes. While many people prefer to remain in their homes, some individuals with extensive needs require nursing home care. States are required by the federal government to pay for institutional care because it is a mandatory benefit, but long-term care services in the community, such as personal care and waiver services, are provided at state option. Over the last two decades, states have been shifting more of their resources towards home and community-based services and away from institutional settings, as a result of the Olmstead decision and consumer preferences. Demand for services in the community is growing and currently 2.8 million individuals are being served through Medicaid home and community-based services. The number of individuals who can participate in these programs is limited; however, as evidenced by the 331,000 individuals on waiting lists for services in 2007 (Figure 4).[2]

Figure 4



Private Funding of Long-Term Care

American families today are struggling to pay for long-term care, particularly in the current environment. Individuals and families are caught in the crosshairs of an economic meltdown dramatically reducing the personal resources that have fueled over 25 percent of the nation's

long-term care spending until now. These sources of out-of-pocket financing, which include home equity, personal savings, and income from adult children, have provided critical private funding for a long-term care system in which insurance has played a very small role, covering only about 10 percent of all seniors.

The decline in personal financial resources comes at a time when states are facing negative growth in revenue collections and unprecedented budgetary shortfalls, pressuring them to find ways to trim their budgets for state programs such as Medicaid, the nation's long-term care safety net and major financing source for long-term care. Medicaid pays for approximately 70 percent of nursing home patients, 12 percent of assisted living residents, and nearly all people with developmental disabilities. Reductions to Medicaid combined with a diminishing pool of private resources could worsen the long-standing funding gap between long-term care need and available financing.

Private insurance for long-term care is still a limited option for financing care. Insurance carriers have sold about 10 million long-term care insurance policies since 1987. Of the 6 to 7 million of these that remain current, the industry sold about 4 million through individual agents and slightly more than 2 million through employers or groups. These policies specifically cover the costs of long-term care services that can include nursing home care (average cost of $70,000 per year), assisted living facilities ($35,000 per year), and home healthcare ($35 per hour for a certified aide). In 2007, long-term care insurance policies paid $4 billion in claims on behalf of disabled policyholders, a small fraction of the over $200 billion in national long-term care spending.

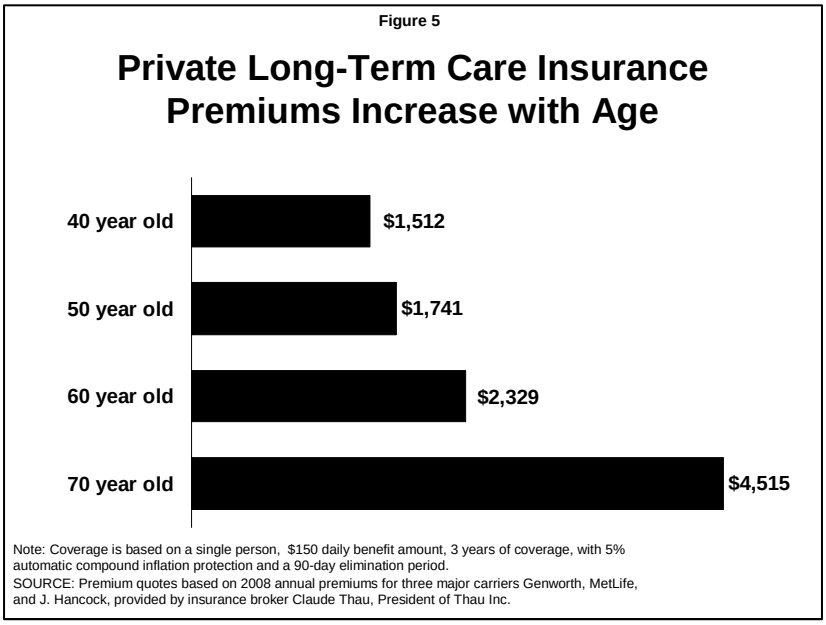
Addressing the Long-Term Care Funding Gap

At the same time, federal policymakers are grappling with a contentious policy environment that could diminish their ability to use publicly funded solutions to the growing financing gap for long-term care. Priorities include addressing the federal deficit and the concern over the impact of rising health costs on entitlement programs like Medicare and Medicaid. Some policymakers may consider these policy goals to conflict with adding federal funds to the long-term care system through new programs or other public solutions. Facing multiple priorities and scarce public dollars, policymakers may be interested in exploring whether private long-term care insurance could play a larger role in financing America's long-term care needs.

In assessing the potential for broader application of long-term care insurance in the financing mix for long-term care, it is important to highlight questions such as: how adequate is the coverage from these policies, how well does the market work, what protections are in place for consumers, and what transparency is offered? We have reviewed many of these questions and challenges around coverage and financing of long-term care in a report by the Kaiser Commission on Medicaid and the Uninsured entitled, "Closing the Long-Term Care Funding Gap: The Challenge of Private Long-Term Care Insurance," which we have submitted for the record.[3] Key findings from the report include:

Cost is a key barrier to expanding the role of private insurance. People who shop for, but do not buy, long-term care insurance cite cost as the most important reason for their decision. Premium amounts vary by age at purchase. For individuals age 60 with no partner, the annual premiums for a typical policy averaged $2,329 across three products offered by three major carriers (Figure 5). For a couple the same age, premiums for the same policy design averaged $3,096 combined for the two people. If purchased at age 70, premiums would cost, on average across these products, $4,515 per year for an individual and $6,010 for a married couple. Policymakers seeking to increase the purchase of long-term care insurance will have to address its cost and the ability of consumers to pay premiums.

Figure 5



In general, the majority of long-term care insurance purchasers buy their policies directly through individual insurance sales agents. These purchasers are usually married, in their late

50s, and more financially secure than the overall population. About 50 percent of people buying long-term care insurance earn above $75,000 annually compared to 31 percent of the general population age 50 and older. Three-quarters of purchasers have liquid assets (i.e., assets not including the home) over $100,000 compared to 30 percent of the general population. About 16 percent of long-term care insurance buyers earn less than $35,000 annually.

Health risk can deny consumers coverage. Before purchasing insurance, many consumers must undergo a detailed health screening and evaluation to determine their insurability and risk rating. Underwriting techniques assess the applicant's likelihood of developing a cognitive impairment or chronic degenerative condition that carries a high risk of needing long-term care. Industry experts estimate that 15 to 20 percent of those who apply do not get coverage. Once an insurer accepts an applicant, the insurer will place him or her into one of three health risk categories: preferred, standard, or substandard. A substandard rating would result in the highest premium, all other things being equal. Policymakers interested in promoting the role of private long-term care insurance will need to seek ways to reduce coverage denial rates or provide private financing alternatives for individuals denied coverage.

Buyers face complex product design issues. The complexity of today's long-term care insurance products reflects a market in which consumers traditionally have worked with individual agents to tailor products along multiple dimensions such as how much they will receive in daily benefits, how long the coverage will last, and how their benefits will be protected from inflation. Even policies with the same design elements can differ from one insurance carrier to another in even more subtle ways such as the definition of certain services. Any policy effort to expand the marketing and appeal of long-term care insurance to a broader group will require product simplification and consumer education.

Time lag between purchase and use of benefits creates problems in service use. One of the major challenges of long-term care insurance is the time lag element, since it can be 20 to 30 years before the purchased insurance is used. Before paying benefits under a long-term care insurance policy, an insurer must determine that the policyholder has a significant disability that necessitates long-term care. When Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996, it specified how disabled an insured person must be and how to measure that disability in order for the policyholder to receive benefits under a tax-favored long-term care insurance policy. Nearly all policies sold today define and measure need

for long-term care according to HIPAA. These disability requirements, which are worse than health insurance, are referred to as “benefit triggers” and they can either be physical or cognitive.

Changing service definitions and the evolution of new forms of residential care as well as the advent of assistive technologies test the flexibility of long-term care insurance products. Unlike well-understood and defined services such as nursing home and home care, assisted living and other forms of residential care do not always meet the service definitions contained in long-term care insurance policies. Future users of long-term care may receive assistance at home from a range of technologies that include motion sensors and other remote monitoring devices. While the alternate plan of care feature may provide some coverage of assistive technology, today’s contracts do not explicitly cover technology nor are they designed for the type of large one-time purchases that home technology installations may require. Policymakers must consider how to ensure the product flexibility that will provide today’s purchaser with tomorrow’s services and technology.

Employer-based market offers promise but adequacy of coverage is a concern. At the same time that private long-term care insurance policies sold individually by agents have been declining, insurers have been selling a growing number of long-term care insurance policies through employers or other groups. Product options sold in this manner are often simpler than the individual market and underwriting is more limited. However, buyers in the group market tend to earn less than buyers in the individual market and therefore opt for less expensive policies in which benefits do not automatically grow with inflation. Policymakers interested in boosting the employer-based market must carefully consider how to balance growth among younger consumers with the need to ensure that inflation does not erode their coverage over time. At the same time, employer-based health coverage is being scaled back and retiree health coverage is eroding making this market’s viability uncertain.

Medicaid Partnership Program will shape products and the market. At least 30 states have approved state plan amendments to participate in a long-term care insurance partnership program with Medicaid that allows long-term care insurance policyholders to qualify for a Medicaid asset disregard. This disregard allows policyholders to retain a certain portion of their assets and quality for Medicaid coverage. A policyholder who receives $150,000 in benefits from his or her long-term care insurance policy, for example, and meets all other program

requirements can qualify for Medicaid using an asset test that is $150,000 higher than the ordinary Medicaid asset test (which is typically $2,000). One potential outcome of this program is that, going forward, nearly every policy sold in the 30 or more partnership states will likely qualify for the program and therefore include a Medicaid asset disregard. This makes Medicaid an integral component of many private long-term care insurance policies. Any policy effort to expand the role of private insurance should consider explicitly how the Medicaid partnership program can complement and work in tandem with other efforts to attract long-term care insurance purchasers.

Conclusion

As the nation faces a growing elderly population and the potential for a substantial increase of people in need of assistance with long-term care, it is important that we move now to address how to structure and pay for the long-term care services that will be required. Broadening the ability of individuals and families to pay for care when needed through their own resources should be a central component of any approach. Extending the reach of private long-term care insurance can help support the care for more families than are helped today by the limited reach of private coverage.

However, if long-term care insurance is to become more available and utilized, the limitations of the current private long-term care insurance market should be examined and addressed as part of creating a broader market. Many of the concerns that have led to the current health reform efforts focusing on regulation and changes in the individual health insurance market apply equally to the current long-term care market. Most notably, high administrative costs, unaffordable premiums, exclusion based on health status, and complexity and lack of comparability across plans would all have to be addressed as part of reforming and extending the private long-term care insurance market.

With such revisions, private long-term care insurance could play a broader role in the long-term care financing mix. However, given the substantial role already played by public coverage through Medicaid and the limited applicability of long-term care insurance for the non-elderly disability population, the potential for private long-term care insurance to finance our future long-term care needs should not be overstated.

Thank you for the opportunity to discuss these critical issues with the Committee today. We look forward to working with the Committee to identify ways to broaden and improve the availability and affordability of long-term care services for the many Americans with chronic illness and disabilities as the nation faces the challenge of an aging population.

ENDNOTES

[1] Judith Kasper, Barbara Lyons and Molly O'Malley, "Long-Term Services and Supports: The Future Role and Challenges for Medicaid," The Kaiser Commission on Medicaid and the Uninsured, September 2007, http://www.kff.org/medicaid/7671.cfm.

[2] Terence Ng, Charlene Harrington and Molly O'Malley, Medicaid Home and Community-based Service Programs: Data Update, Kaiser Commission on Medicaid and the Uninsured, December 2008. http://www.kff.org/medicaid/7720.cfm

[3] Anne Tumlinson, Christine Aguiar, and Molly O'Malley Watts, "Closing the Long-Term Funding Gap: The Challenge of Private Long-Term Care Insurance," The Kaiser Commission on Medicaid and the Uninsured, June 2009.