REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-18

Subject: Financing of Long-Term Services and Supports

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Referred to: Reference Committee G
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This report, initiated by the Council, addresses the growing need for long-term care services and supports (LTSS) in the US. The report provides an overview of LTSS; details the cost and need for LTSS; discusses the lack of public education on LTSS; provides a summary of the current financing structure for LTSS; outlines possible LTSS financing mechanisms; summarizes relevant policy; and presents policy recommendations to modify the current financing structure of LTSS with options that weave together financing reforms through publicly funded programs and private insurance.

BACKGROUND

Long-term services and supports (LTSS) refers to the range of clinical health and social services that assist individuals in their activities of daily living (ADL) when these individuals are limited or unable to care for themselves.[1] ADLs include eating, bathing, dressing, and instrumental tasks like medication management, house cleaning, and meal preparation. Unlike medical care, LTSS are function-based and holistic in nature.[2] In 2013, national spending for LTSS was $310 billion and by 2015, that figure grew to $331 billion.[3] Medicaid spending accounts for over half of national spending for LTSS and is the primary payer for LTSS across the nation.

NEED FOR REFORM

The need for LTSS is expected to increase sharply in the coming decades; however, a possible funding source, long-term care insurance (LTCI), is too expensive and complex for most consumers, and its traditional policy design has not been sustainable. With few affordable options in the private insurance market and limited coverage under Medicare, individuals with insufficient resources rely on Medicaid to fund their LTSS needs, which puts a strain on Medicaid financing that will worsen as baby boomers age. More effective methods of financing LTSS and expanding the availability and affordability of LTCI through a mix of public and private reforms would help not only alleviate the financial strain on public payers but also avert the need for individuals to deplete their retirement funds and savings to pay for LTSS or to be eligible for Medicaid.

COST AND NEED FOR LTSS

The number of Americans needing LTSS in 2010 was 12 million, and it is expected that by 2050, 27 million Americans will need LTSS.[4] This increased demand for LTSS is driven by a life expectancy that remains relatively high, the aging of the large baby boomer generation, and advances in technology that allow people with chronic illness and disabling conditions to live longer.

The number of elderly people is expected to more than double in the next 40 years. Baby boomers began turning 65 in 2011, and, within the next 20 years, the 65+ population will double and the 80+ population will more than double. Additionally, it is estimated that at least 70 percent of baby boomers will need some form of LTSS at some point in their lives, and 40 percent are expected to require nursing home care.[5]

Not only is the size of the baby boomer generation a strain on the LTSS system, but baby boomers are also more likely than previous generations to be divorced, have fewer children, and have more children in the workforce, making informal family caregiving less likely. Further, many baby boomers have not saved enough for retirement and appear to be unprepared for unplanned expenses such as LTSS. The average retirement savings for baby boomers is about $75,000 while the cost of providing LTSS is significant.[6] For example, in 2017 the average annual cost for a community-based adult day-care center was $16,900; a home health aide was approximately $49,000; and the average annual cost to live in a nursing facility was $97,455. The need for LTSS is one of the primary risks to retirement security, and some aging individuals will have to deplete their retirement savings and overwhelm funding sources such as Medicaid to meet their LTSS needs.

There is great variation in LTSS spending among individuals. Although some individuals will not have any LTSS needs, others will have significantly high spending. About 27 percent of individuals turning 65 will have LTSS costs of at least $100,000 over their lifetimes, and 15 percent will have costs that exceed $250,000.[7]

PAYING FOR LTSS

The responsibility of paying for LTSS is shared among the elderly, people with disabilities, family, friends, volunteer caregivers, communities, states, and the federal government. However, this shared-responsibility system is severely stressed and increasingly will become unable to withstand the swelling demand for LTSS.[8]

LTSS are expensive, with institutional care costs far exceeding costs for home and community-based services (HCBS). Aside from unpaid care provided by friends or relatives, LTSS costs often exceed what individuals and families can afford out-of-pocket. Therefore, many with LTSS needs rely on publicly funded programs to help pay for or supplement the cost of their care needs.

Many people expect Medicare to be their primary source of health coverage in retirement, but long-term care (LTC) is only covered in limited circumstances and for a short period of time.[9] Medicare only pays for LTC for individuals requiring skilled services or rehabilitation care, generally following a hospitalization. Importantly, there is an expectation that the beneficiary will recover from the condition. In a nursing home, Medicare pays for a maximum of 100 days; however, the average covered stay is about 22 days. If a beneficiary is receiving skilled home health or other skilled in-home services, commonly these are provided only for a short period of time. Notably, Medicare does not pay for non-skilled ADL, which make up the majority of needed LTC services.

Already, about 40 percent of state Medicaid budgets go toward LTSS.[10] Medicaid pays for most of LTSS while Medicare post-acute care pays for 23 percent of LTSS. The remaining sources of funding include out-of-pocket spending, LTCI, other private sources, and other public sources.[11]

Because many middle-class people fail to anticipate and plan for their LTC needs, Medicaid has effectively become the default payer instead of a safety net for the poorest individuals. This creates an enormous strain in funding and threatens services for the poorest and most vulnerable.

Individuals are only eligible for public LTC coverage through Medicaid after they spend down most, if not all, of their personal liquid financial resources.[12] In order to qualify for Medicaid services, one's income must be below a certain level and must meet minimum state eligibility requirements based on the amount of assistance needed with ADL. Generally, in order to qualify for Medicaid, one cannot have assets exceeding $2,000, which excludes a car or home if the applicant intends to move back into the home or a spouse or dependent lives in the home.[13] Medicaid is the default payer for about 65 percent of nursing home residents.[14]

Individuals and families must pay for LTSS that are not covered or partially covered by a public or private insurance program. Individuals pay for about 53 percent of their total LTSS expenditures out-of-pocket, typically through savings, retirement funds, or borrowed funds such as a reverse mortgage. For those who lack sufficient personal resources to pay for LTSS out-of-pocket, Medicaid is the primary payer. As baby boomers begin to need these services and supports, states will face a great challenge balancing their budgets with an increasing amount used in financing LTSS under Medicaid.

LACK OF PUBLIC EDUCATION

Exacerbating the lack of funding for LTSS is the public's misunderstanding of how much such care costs and how it is currently financed. Many Americans mistakenly believe that Medicare will pay for their LTSS needs. A recent survey conducted by the SCAN Foundation found that 57 percent of respondents said that they expect to rely on Medicare for LTSS. Only 25 percent of respondents think that they will get help from Medicaid, and many respondents are counting on Social Security to finance LTSS needs, even though average Social Security benefits would pay for less than 15 percent of the cost of a typical nursing home and perhaps one-third of the cost of assisted living.[15]

Some others know parents or friends who have received LTSS through Medicaid and fail to understand the limits of Medicaid coverage and strict eligibility criteria. In order to qualify for Medicaid, individuals have to have spent practically all of their assets or have appropriately given away or transferred them at least five years before the date that they are applying for Medicaid benefits. Some generally have a belief that the government will ultimately pay for any future LTSS needs, further encouraging them to avoid the expense and discomfort of purchasing LTCI.

HURDLES TO LONG-TERM CARE INSURANCE ENROLLMENT

LTCI provides an opportunity to shift some of the cost of providing LTSS from Medicaid but has remained a relatively niche product. Not only is LTCI often cost-prohibitive, but also, often potential purchasers do not believe that they will need the benefit later in life, are in denial about the probability of future care needs, or erroneously believe that Medicare will pay for their LTSS needs. Less than 10 percent of individuals in their early 60s have LTCI, which puts pressure on the Medicaid program to bear most of this burden.[16]

Because of the declining LTCI market, many insurance carriers are reluctant to offer LTCI due to the difficulty of predicting costs far in the future and the risk that many beneficiaries will live for a long time. This reluctance to participate in the LTCI market and inability to predict future costs drives up premiums, especially for those in their 60s when they are likely to have preexisting conditions that may disqualify them from coverage and fewer working years to pay premiums that usually increase with age.[17,18]

In addition, LTCI marketing materials are often confusing, and, at this stage in life, consumers are also balancing other competing financial demands such as saving for their own retirement and paying for children's college tuition.

PUBLIC CATASTROPHIC INSURANCE

Seventy percent of older Americans will need LTSS at some point in their lives.[19] Fifteen percent of the population will have significant LTSS expenses representing lifetime costs of over $250,000. For this high-cost population in particular, personal assets and informal family caregiving will not meet their care needs. The vast majority of those facing catastrophic costs must deplete their personal savings and sell assets to qualify for Medicaid.

In 2015, Milliman, Inc. and the Urban Institute conducted a microsimulation analysis of financing options for LTSS.[20] The analysis found that a universal approach would not only be less expensive for individuals than a voluntary approach but also save the Medicaid program and states significant funds and avert out-of-pocket spending. For example, they projected that a mandatory public catastrophic insurance plan would reduce Medicaid LTSS spending by 35 percent in 2070, while a voluntary subsidized public catastrophic plan would reduce Medicaid LTSS by 7 percent.

Additionally, the analysis found that public catastrophic plans that cover LTSS later by providing back-end benefits would offset more Medicaid spending than alternatives that cover only front-end costs.[21] Without the ability to accurately predict future costs, many insurers have instituted significant rate increases further driving potential buyers out of the private insurance market. However, a public catastrophic insurance option could ease the reluctance of insurance carriers to offer LTCI and the reluctance of consumers to purchase LTCI thereby reducing the cost of private LTCI. Importantly, a back-end catastrophic program would have the effect of stabilizing the private insurance market. For example, a back-end catastrophic program with a five year waiting period and a $100 per day lifetime benefit would cost a median-income worker about $300 per year.[22]

Insurers will only participate in the private market on any meaningful scale if they have enough information to accurately price their products, and a public back-end catastrophic program allows for accurate prediction. The path to affordable private LTCI depends on a competitive and growing private insurance market, which relies on predictability.[23] Offering public back-end insurance could encourage new private insurers to enter the market in the context of well-defined public and private responsibilities.[24]

LTCI BENEFIT UNDER MEDIGAP AND MEDICARE ADVANTAGE

Most seniors are enrolled in either Medicare with a supplemental insurance policy (Medigap) or a Medicare Advantage (MA) plan, but they do not have LTCI.[25] Medigap insurance is offered on a guaranteed basis without medical underwriting at the time a beneficiary enrolls in Medicare. Many MA plans also provide supplemental benefits for services that are not covered under Medicare Part A or Part B. MA plans can provide either mandatory supplemental benefits that generally must be provided to all beneficiaries or optional supplemental benefits in which the MA plan provides the beneficiary with the option of enrolling in coverage of additional services not covered by Medicare in exchange for additional premiums that are paid by the beneficiary.[26]

In February 2018, Congress passed the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care (CHRONIC) Act that will, for the first time, allow MA plans to pay for some LTSS.[27] While the law does not change the rules for traditional FFS Medicare, it allows MA

plans to include in their benefit packages nonmedical services such as home-delivered meals or transportation to and from medical appointments.

Milliman, Inc. and the Bipartisan Policy Center analyzed a potential limited LTSS benefit for Medigap and MA plans wherein the Centers for Medicare & Medicaid Services (CMS) would amend Medigap and MA requirements to permit plans to offer existing benefits as well as a new limited and voluntary LTSS benefit.[28] In the model analysis, beneficiaries could choose to enroll in and pay corresponding premiums to cover the cost of the new benefit. When estimating the added cost of the benefit to Medigap or MA premiums, one analysis assumed a $75 daily benefit with a 180-day elimination period that would need to be satisfied prior to commencement of the benefit.[29] Consistent with existing Medigap policies, beneficiaries would have a one-time option to purchase this coverage when enrolling in Medicare. The analysis suggests that this policy could result in premiums of $35-$40 per member per month.[30]

RESPITE CARE

A significant amount of LTSS is provided by unpaid caregivers who are typically family members or friends. Though potentially rewarding, caregiving can be strenuous physically, mentally, and financially. Many caregivers often miss work time or leave the labor market altogether thereby eroding their ability to accumulate resources for retirement and their own LTC needs. Though valuing unpaid care is difficult, it is estimated that, in 2013, 40 million family caregivers in the US provided 37 billion hours of care to adults with ADL limitations representing a total economic value of unpaid caregiving of $470 billion.[31]

Family caregivers on average spend 13 days per month on tasks such as shopping and housekeeping and six days per month on personal tasks such as feeding, dressing, and grooming. Taken together, the average individual with LTSS needs who relies exclusively on family for help receives about 173 hours of care over the course of a month, which is equivalent to a full-time job.[32] Without this family-provided support, the economic cost of providing LTSS would rise sharply and worsen the current financing crisis.

Respite care helps individuals needing assistance to stay in their homes while giving their caregivers a reprieve from caregiving, which can prevent the caregiver from declining physically or emotionally.[33] Currently, respite care benefits are only available for Medicare beneficiaries who are enrolled in Medicare's hospice benefit, a benefit that is only available for beneficiaries expected to die within six months.[34]

The Urban Institute and the Bipartisan Policy Center analyzed the cost of a potential respite care benefit in Medicare and MA that would be triggered when certain Medicare providers determined that respite care was needed. Among several analyses, one found that the 10-year federal budgetary cost of a 96-hour respite benefit would cost $29 billion if beneficiaries with spousal caregivers were eligible for the benefit.[35]

HOME AND COMMUNITY-BASED SETTINGS (HCBS)

Historically, states and the federal government have limited the use of Medicaid-funded LTSS by restricting eligibility for services and providing care primarily in institutional settings such as nursing homes and residential facilities. However, there has been significant agreement that the current bias toward LTSS being delivered in an institution should be eliminated.[36] Not only are HCBS significantly cheaper than institutional care, but also, there has been a growth in beneficiary and societal preferences for them.[37] Over the years, states have used waivers and state plan options

to enable Medicaid-funded LTSS to be delivered in other less expensive settings. Progress has been made at the community level in finding ways to keep seniors and people with disabilities out of institutions and in the community. HCBS keep people happier, less isolated, and can be provided more effectively and cheaper than nursing home facilities. Expanding HCBS could provide individuals with more flexibility in how they receive LTSS and a higher quality of life.

There has also been a call to better integrate medical care and social care, predominantly for the dually eligible population. The Program of All-Inclusive Care for the Elderly (PACE) both supports HCBS and improves the delivery of LTSS through better care integration for this particular population. PACE is a program under Medicare wherein states can elect to provide services to Medicaid beneficiaries as an optional Medicaid benefit.[38] The PACE program becomes the sole source of Medicaid and Medicare benefits for participants. It provides comprehensive medical and social services to certain frail, elderly individuals enabling them to remain in the community rather than receive care in a nursing home. The PACE program is an interdisciplinary team of health professionals providing participants with coordinated care. Notably, financing for the program is bundled, allowing the providers to deliver all services participants need rather than only those reimbursable under Medicare and Medicaid fee-for-service plans.[39]

RELEVANT AMA POLICY

Policy H-280.991 addresses financing of LTC and outlines relevant principles and policy proposals for LTC. It states that programs to finance LTC should cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual and coordinate benefits across different LTC financing programs. Policy H-210.994 echoes providing LTC services in the least restrictive setting by affirming support of home health care as an alternative to nursing home or institutional care. Further, Policy H-280.991 suggests providing coverage for the medical components of LTC through Medicaid for all individuals with income below 100 percent of the poverty level and providing sliding scale subsidies for the purchase of LTCI coverage for individuals with income between 100-200 percent of the poverty level.

Policy H-280.991 also considers tax incentives and employer-based LTC coverage to help fund LTC including creating tax incentives to allow individuals to prospectively finance the cost of LTC coverage and encouraging employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTCI premiums and expenses. Additionally, the policy supports use of a tax deduction or credit to encourage family caregiving.

Furthermore, Policy H-280.991 states that consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional Medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to provide an environment within their states that permits innovative LTC financing and delivery arrangements, and assures that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high quality care. Additionally, consistent with other AMA policy on state-based innovation, Policy H-280.991 supports health system reform legislative initiatives that could increase state flexibility to design and implement long-term care delivery and financing programs.

Policy H-165.852 supports legislation promoting the establishment and use of Health Savings Accounts (HSAs) and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care.

Policy H-290.982 supports allowing states to use LTC eligibility criteria that distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related LTC needs; and supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new LTC infrastructures and to encourage expansion of LTC financing to middle-income families who need assistance.

DISCUSSION

The Council's recommendations are intended to provide feasible steps forward to alleviating the financial strain of providing LTSS on Medicaid and families. The Council's recommendations are not intended to solve the LTSS financing crisis in its entirety. The Council recognizes that a growing consensus has emerged around a set of incremental steps that have the ability to improve the availability and affordability of LTSS. To that end, the Council proposes a multi-pronged approach to alter the financing and viability of LTSS through a mix of public and private reforms. Though the following recommendations are consistent with Policy H-280.991, the Council considers these recommendations to be distinct and with a broader view of LTSS financing.

The Council believes it is important to help consumers prepare thoughtfully for their LTSS needs and to provide individuals with a reasonable assessment of the likelihood of future need. Accordingly, the Council recommends reaffirming Policy H-280.991, which states that consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional Medigap policies.

Regarding private reform, the Council firmly believes in the importance of strengthening and improving the private insurance market. There are a number of steps that may be taken to revitalize the market for private LTCI. First, the Council recommends a policy statement to standardize and simplify private LTCI to achieve increased coverage and improved affordability. Additionally, Policy H-280.991 encourages employers to offer LTCI policies as a part of employee benefit packages, and the Council recommends expanding this principle to support adding LTCI coverage as part of workplace automatic enrollment with an opt-out provision. In this case, enrollment in the LTCI coverage would be paid through annual premiums that are almost half the cost of typical current-market LTCI policies. Additionally, the Council stipulates that these employer-offered plans should be available to both current employees and retirees.

To further improve the market for private insurance, the Council recommends allowing retirement savings to be used for LTCI premiums. Such a strategy includes supporting penalty-free withdrawals from employer-based retirement savings accounts for purchase of private LTCI. The Council notes that Policy H-280.991 already supports the creation of tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs for payment of LTC insurance premiums and expenses. Similarly, the Council recommends reaffirming Policy H-165.852 promoting the establishment and use of HSAs and allowing the

tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care. The Council is confident that such private reforms would reduce premium costs while reaching segments of the population that are not yet served by private LTCI.

As another step toward developing the private insurance market, the Council recommends exploring innovations in LTCI product design. Such innovations may include LTCI covering home and community-based LTC needs as well as marketing products with health insurance, life insurance, or annuities. Not only is home and community-based care less expensive than traditional facility-based care, but also, most people are able to stay at home and avoid nursing home care altogether.[40]

The Council believes increasing the availability of LTCI is vital to a sustainable financing structure moving forward. As such, the Council recommends supporting the ability of Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit, or as a separate insurance policy, financed through additional premiums paid by the beneficiaries who choose to enroll. Similarly, the Council recommends supporting the implementation of the CHRONIC Act allowing MA plans to offer social supports in benefit packages. Correspondingly, the Council recommends permitting a respite care benefit as part of Medigap and MA policies.

There is widespread agreement among advocacy organizations and think tanks of the need for a public catastrophic program for individuals with extraordinary LTSS costs to protect against poverty and bankruptcy.[41] There is also public support for such a program. A recent survey found that about two-thirds of people favor a public catastrophic insurance program.[42] Many agree that a public catastrophic option should help cover the back-end risk of LTSS costs that discourages private insurers from offering comprehensive protection. Back-end catastrophic coverage could be compared to the concept of reinsurance in that it may protect against premium increases in the private LTCI market by serving as a safety-net to those high-cost individuals who may require LTSS for a long period of time. It would be used in the event of catastrophic LTSS expenses after a period of using private LTCI or self-funding. Therefore, such a program could stabilize the private insurance market and allow insurers to focus on shorter-term, defined, and predictable coverage. The Council believes that a back-end public catastrophic insurance program could help shift away from the current welfare-based model and toward a system of insurance.

Consistent with Policy H-280.991 advocating for states to be permitted to pilot innovative LTSS financing and delivery arrangements, the Council suggests incentivizing states to expand the availability of and access to HCBS. Such services could help individuals remain in home and community settings for a longer period of time and relieve some of the burden of more costly LTSS care such as that provided in nursing homes. Increasing the availability of HCBS not only helps in eliminating the current bias in financing toward more expensive institutional care but also relieves family caregivers and allows them some time off. Furthermore, and consistent with Policy H-280.991 supporting the coverage of services in a coordinated manner in the least restrictive setting, the Council supports better integration of health and social services and supports, including the PACE.

Demand for LTSS will more than double over the next 30 years, and the challenges to affordable and politically viable LTSS financing mechanisms are varied and complex. While it is unlikely that there is one straightforward solution to the growing demand for LTSS, the Council offers these recommendations as a pragmatic step forward to address the needs of an aging population and help shift away from an LTSS system dependent on insolvency and last-resort public financing to a sustainable system of meaningful insurance.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-280.991 supporting consumer education regarding the likelihood of future need for long-term services and supports (LTSS) and the limits of public funding sources and supporting tax-free withdrawals from retirement savings accounts for payment of long-term care insurance (LTCI) premiums and expenses. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-165.852 supporting legislation promoting the establishment and use of Health Savings Accounts and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care. (Reaffirm HOD Policy)

3. That our AMA support policies that standardize and simplify private LTCI to achieve increased coverage and improved affordability. (New HOD Policy)

4. That our AMA support adding LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees. (New HOD Policy)

5. That our AMA support allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI. (New HOD Policy)

6. That our AMA support innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities. (New HOD Policy)

7. That our AMA support permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy. (New HOD Policy)

8. That our AMA support Medicare Advantage plans offering LTSS in their benefit packages. (New HOD Policy)

9. That our AMA support permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit. (New HOD Policy)

10. That our AMA support a back-end public catastrophic long-term care insurance program. (New HOD Policy)

11. That our AMA support incentivizing states to expand the availability of and access to home and community-based services. (New HOD Policy)

12. That our AMA support better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly. (New HOD Policy)

Fiscal Note: Less than $500.

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