Social Insurance: A Critical Base for Financing Long-Term Services and Supports

By Lee Goldberg and G. Lawrence Atkins

This series summarizes current issues in financing long-term care and outlines policy options for increasing affordable access to services.

The Current System

America is graying – fast. Although much attention has been paid to baby boomers who are qualifying for Medicare at the rate of 10,000 a day, the most rapidly growing segment of the population is individuals over the age of 85, who have significantly higher rates of disability. As the median age of the population increases over the next two decades, the demand for long-term services and supports (LTSS) is expected to increase sharply.[1] The issue, however, is not limited to older adults – about 40 percent of individuals who need LTSS are under the age of 65. The nation is ill-prepared to meet this complex demographic challenge. Only a small percentage of the population that will need nursing or home care has coverage ahead of time through either a private plan or a public program.[2] The vast majority of people have no protection against future LTSS liabilities.

Today, there are few options for financing one's LTSS needs in advance. Individuals can increase their level of savings, but few people can accumulate sufficient assets, even over a lifetime to cover the cost of extended institutional care.[3] Home and community-based services (HCBS) may not be as expensive on a per unit basis, but over time the cost of such care can exhaust the resources of even affluent households.[4] Private long-term care insurance is an option – benefits typically cover a significant portion of the care needed by the average policyholder[5] – but the cost of the premiums are prohibitive for most of the population[6] and underwriting requirements eliminate many interested buyers.[7] Individuals may spend down their assets to receive LTSS through Medicaid, but the strict financial eligibility requirements and the prescribed set of benefits available in most states make Medicaid an unattractive outcome.[8] The challenge is to address the needs of the large group in the middle of the income distribution that faces a significant gap between the resources required to maintain their quality of life and what they can actually afford at the time they need care.

The issue with LTSS is not whether there should be government funding. In 2010, the federal government and the states spent more than $200 billion on LTSS, primarily through Medicaid.[9] The state and federal partnership is a critical lifeline for millions of low-income people who cannot afford the LTSS they need, but it is only available after an individual becomes impoverished. Absent is a universally available insurance-based approach that would spread the financial risk of developing and living with a chronic illness or disability.

Reform of our LTSS system may be on the horizon simply because the status quo will be increasingly difficult for governments to manage, especially state governments.[10] Since

1970, state Medicaid spending as a share of Gross Domestic Product has tripled and is projected to double again by 2040.[11] Although the federal government will absorb almost all of the growth in Medicaid spending under the Affordable Care Act (ACA), there is no additional federal funding for projected LTSS expenditures. Federal matching payments for Medicaid LTSS remain unchanged, so the financial burden of an aging population will fall heavily on the states. Reducing the current reliance on Medicaid as the primary funder of LTSS is a political and a policy imperative.

The Case for Social Insurance

Aging is a certainty, but there are large variations in LTSS expenditures among individuals.[12] While most people have reasonably modest LTSS needs, a relatively small percentage of the population will have LTSS costs over $250,000. A sensible way to prepare for such an unpredictable and financially difficult event is through the pooling of risk.[13] Spreading the financial risk of disability across a large population reduces the amount any one person must set aside to try to cover his or her expenses. Spreading the financial risk also increases resources in the aggregate since individuals tend to underestimate their future need.[14]

Insuring an individual against the risk of needing LTSS continues to be a challenge for the private sector. The dimensions of LTSS risk (the probability and the cost of a claim) and the voluntary nature of private coverage require private insurers to either limit their exposure (by limiting services or excluding the highest risk individuals through medical underwriting) or to pass potential losses on to the consumer in the form of higher premiums. In fact, cost is most often cited as the primary reason for foregoing LTSS insurance, although medical underwriting also eliminates a significant share of the market.[15]

In principle, social insurance is universal, contributory, and offers a benefit based on some triggering event. Universality may be achieved through a mandate or by creating compelling economic incentives to enroll that eliminate or at least reduce concerns about adverse selection.[16] The farther one gets from universal participation, however, the greater the need for underwriting or other strategies to manage risk. The trigger for eligibility can be a functional need for assistance (sickness, loss of income or the need for services and supports for individuals with disabilities) or a life event (turning a particular age).

The vast majority of people have no protection against future LTSS liabilities.

Although the most common social insurance programs are designed to address the loss of income when one leaves the labor market (either voluntarily due to retirement or involuntarily due to injury), most also serve broader societal goals that cannot be achieved by individuals contracting with private insurance.[17,18] This is certainly the case with LTSS financing where the failure or inability to plan has an impact beyond the individual who develops functional impairments. Employers who experience an increase in absenteeism and the departure of valuable employees from the workforce are impacted, as are taxpayers who must pay for additional Medicaid services. Financing our LTSS needs is a public problem that requires more than an individual response.

Social and private insurance mechanisms are not mutually exclusive options for managing risk. In fact, the former has often provided a base of support around which the latter has flourished. Building a universal floor for retirement, Social Security laid the foundation for a financial services industry that has prospered as people sought complementary ways to meet their financial needs over the course of a lifetime. Likewise, by offering universal health insurance for older adults, Medicare has facilitated the

development of supplemental plans in the private sector. The heterogeneous nature of the population in terms of income, work history and service needs means that any solution for LTSS financing is likely to require a mix of benefit designs and funding mechanisms.

In principle, social insurance is universal, contributory, and offers a benefit based on some triggering event.

Despite the relative efficiency of Medicare and Social Security, concerns over the solvency of existing programs going forward may make the creation of additional social insurance programs difficult. Though both programs face demographic challenges, it is important not to confuse this particular demographic moment with the overall model, which can be constructed to ensure adequate financing under a variety of demographic scenarios. Given the current political and economic environment, any new program for financing LTSS – whether it is social insurance or subsidies for private insurance – should be able to pay for itself through premiums, taxes, or other revenue streams. An effective approach to LTSS financing will not only reduce the growth in Medicaid expenditures, but also alleviate some of the current pressure on Medicare, particularly for those with chronic health conditions and functional limitations that result in high Medicare spending.[19]

Applying the Social Insurance Construct to LTSS Policy Solutions

Having discussed the applicability of social insurance to the financing of LTSS, it is important to consider how Social Security or Medicare – the nation's two major social insurance programs – can provide a platform to help individuals finance their LTSS needs.

Like most health insurance plans, Medicare is built around an indemnity/care model that reimburses providers who offer a defined set of services. This model is suitable for services that require significant clinical knowledge and the use of advanced technology. It also works well when the needs of the eligible population are fairly homogeneous and individuals themselves do not possess the knowledge to piece together a package of services.

The indemnity/care model is familiar to most Americans and gives policymakers mechanisms for monitoring utilization, assessing outcomes and controlling costs. But this model has its drawbacks. Claims procedures are complex and require constant scrutiny and a process for resolving disputes; the model also requires tracking of utilization to monitor benefit limits and maximums. Perhaps most importantly in the case of LTSS, the package of benefits can become outdated as modes of service delivery change.

Social Security, in contrast, follows a disability model that provides a monetary benefit. Other examples of programs with monetary benefits include the U.S. Department of Veterans Affairs' Housebound and Aid and Attendance Allowance Program created in 1951, and the Medicaid program known as Cash and Counseling, which started as a demonstration program in four states in the late 1990's.[20] Rather than provide a particular set of services, the disability model is designed to supplement a person's income and improve his or her economic well-being. The disability model has advantages: it can cover a heterogeneous population and offers consumers the flexibility to select the combination of goods and services that they deem necessary; cash models are often associated with greater consumer satisfaction.[21]

There are disadvantages to a monetary benefit. It is almost certainly more expensive since all eligible individuals who make a claim will use 100 percent of the available benefit. The cost differential can be addressed by discounting the cash benefit, as is done in Germany, where the monetary benefit is approximately

half the value of the in-kind option. The other major disadvantage of a monetary benefit may be the difficulty of monitoring how funds are spent – for example, ensuring the quality of care provided and guarding against situations where the monetary payment is spent inappropriately by someone other than the beneficiary. A monetary payment also requires an administrative structure that includes uniform and fairly strict eligibility determinations, counseling, periodic reassessments and other forms of oversight to address concerns of fraud and abuse.

Expanding Medicare to Include LTSS

Medicare has long been seen as a natural platform for creation of an LTSS benefit.[22] Certainly, expanding Medicare makes demographic and administrative sense. The 15 percent of Medicare beneficiaries with chronic conditions and functional limitations account for one-third of Medicare spending.[23] Medicare's near universal reach addresses concerns about adverse selection while also eliminating the incentive to transfer assets that may be created by a means-tested program like Medicaid.[24] Expanding Medicare would also take advantage of current efforts under the ACA to increase the coordination and integration of acute care and LTSS across a range of providers.

Such an approach would require a reworking of Medicare's eligibility rules. Individuals are eligible for Medicare based either on a combination of work history and age, or on a determination of disability. Medicare relies on the definition of disability used by the Social Security Disability Insurance (SSDI) program: the inability to perform one's current work due to a medical condition that is expected to last at least one year or result in death. This is an appropriate disability standard for the provision of health insurance in a system where most people purchase coverage through their employer. It may not be appropriate, however, for a program designed to assist individuals no longer in the workforce who may need help with activities of daily living (ADLs).[25] Including an LTSS benefit in Medicare may instead require borrowing from the eligibility standards used by state Medicaid programs. It may also require for the first time that Medicare have a tiered package of benefits in which not all beneficiaries would be eligible to receive all benefits. For example, individuals might become eligible for acute care coverage when they turn 65 or meet the current SSDI standard for disability but might not be eligible for LTSS benefits until they are considered disabled according to state Medicaid standards.

> *Social and private insurance mechanisms are not mutually exclusive options for managing risk. In fact, the former has often provided a base of support around which the latter has flourished.*

The options outlined below are an attempt to identify the mechanisms within the Medicare program that could be utilized to improve access to LTSS through social insurance. These options are not mutually exclusive; several could be combined to ensure an appropriate mix of public and private insurance mechanisms. This is apparent from the Appendix, which sketches out the basic features of each option and its likely impact.

1. An Incremental Benefit. Ending the "home bound"[26] requirement for Medicare home health services and the three-day hospitalization requirement for Medicare coverage of skilled nursing care would inch Medicare closer to providing an LTSS benefit without changing the basic elements of the program. Such incremental changes would build on the recent legal settlement clarifying access to home health care when a beneficiary's health is not expected to improve.[27] These two incremental steps would also address growing concerns about hospitals keeping beneficiaries for observation without admitting them – a practice that can leave beneficiaries with large out-

of-pocket costs if and when they are moved to a skilled nursing facility.[28] Although an incremental benefit would help individuals in need of post-acute care and would expand the kind of skilled care available to beneficiaries outside a hospital setting, it would do little to improve access to custodial care for individuals who are unable to perform ADLs but want to remain in the community. Nor is it clear that this incremental expansion of benefits would be the least costly option, since it would increase access to a set of high-cost services delivered by agencies and institutions.

2. Limited First-Dollar Coverage. Another option is expanding Medicare Part A to include first-dollar coverage of custodial nursing home care as well as HCBS aimed at diverting people from nursing homes, preventing unnecessary hospitalization and reducing readmissions. Though services would only be available to a beneficiary on a short-term basis, the expanded coverage would help many eligible individuals avoid or postpone institutionalization; it would also enable eligible individuals to avoid or postpone the impoverishment that comes with Medicaid eligibility.[29] Access to the benefit would be based on functional impairment (for example whether an individual needs assistance with two or three ADLs or has a severe cognitive impairment that requires regular supervision). The benefit could include consumer-directed as well as agency-provided HCBS.

The benefit would provide some measure of assistance for all people with ADL limitations. A two-year benefit would assist 42 percent of people who qualify for the duration of their disability; a one-year benefit would assist 25 percent of people for the duration of their disability.[30] The financial burden created by the waiting period would depend on the services needed by the individual. Three months of skilled home health care cost an average of $10,000; three months of care in a nursing home (with a semi-private room) cost an average of $18,450.[31]

Such limited coverage has clear design flaws. Younger people with disabilities may outlive the benefit, remaining financially vulnerable. Some services, such as care coordination, may require continued updating, while others, such as transitional care, may be necessary after each episode of illness. This design, however, is intended to avoid the potentially open-ended liability of other options. The benefit would also slow the growth of state Medicaid expenditures since fewer people would spend down to become dually eligible.[32]

Such an expansion of traditional Medicare would, however, require greater coordination between the federal government and the states, which would retain responsibility for certifying providers and ensuring a set of labor and quality standards in a particular state. The federal government could even contract with individual state Medicaid agencies to deliver benefits to eligible individuals living in their jurisdiction.

Critics note that a limited first-dollar benefit targets resources poorly since middle-income individuals with relatively light LTSS needs would be able to get assistance with services that they could purchase on their own in the absence of a benefit. Such an argument misrepresents the nature of social insurance, which seeks to provide a broad pooling of risk and a universal floor of support so that everyone participates and everyone may potentially benefit. In this case, targeting

is achieved through a narrower definition of services, not eligibility.

3. Catastrophic Coverage. This option would create a Medicare Part A benefit that covers out-of-pocket expenses after a lengthy waiting period defined either in time (beneficiary has paid for three years of home care services) or expenditures (beneficiary has paid for $50,000 in home care services).[33] Expressing the waiting period in service hours would create an incentive for individuals to manage their needs in the most economic manner possible. State Medicaid programs would see savings since they would transfer to Medicare expenses above threshold. Providers would also benefit since private insurance and Medicare reimburses at a higher level than Medicaid, as do uninsured private pay consumers.[34]

This option would offer risk-averse individuals some certainty about the upper limit of their LTSS costs; it would create an insurable zone – a front-end space – that could be filled by personal savings or private insurance. Having the federal government provide reinsurance would reduce plan liabilities significantly and lower LTSS insurance premiums. For individuals with chronic functional impairment, a benefit that covers their catastrophic care may enable them to avoid impoverishment if they can afford insurance or can pay for the initial services.

The benefit, however, would be available to anyone with sufficient functional impairment, regardless of whether they could actually pay the out-of-pocket cost of care during the waiting period or had to rely on Medicaid. Most people with chronic functional impairment who rely on Medicaid would continue to rely on Medicaid for services below the threshold.[35] If the waiting period is very long – such as three years – then catastrophic coverage may not assist individuals with average out-of-pocket costs that are unlikely to exceed the threshold.

4. Expanding Medicare Managed Care. Incorporating LTSS coverage into Medicare Advantage (MA) plans would highlight new methods of organizing care and emphasize the potential benefits of care integration. Plans could include case management, personal care services, transportation, daycare, prepared meals, respite care and social services. This approach would build on the lessons learned from the development of Social Health Maintenance Organizations (S/HMOs), the Program of All-inclusive Care for the Elderly (PACE) and the current dual eligible integration projects that offer eligible beneficiaries access to LTSS through capitated financing arrangements.

If traditional Medicare were expanded to include LTSS coverage, the expanded benefit would naturally become the basis for the MA benefit. In this case, federal payments to managed care plans would be increased to reflect the additional costs of providing LTSS in fee-for-service Medicare.

Even without an expansion of traditional Medicare, MA plans could still be allowed to offer LTSS as an optional supplemental benefit for which plans could charge an additional premium. Benefits and premiums would vary among plans but would presumably be limited to minimize plans' financial exposure and control premiums. The optional supplemental package might be expensive, given the potential for adverse selection, which could be exacerbated by variations in benefits and pricing among plans.

Alternatively, MA plans could be required to include LTSS as part of the basic benefit set by the federal government, with capitation amounts adjusted accordingly. Requiring all MA plans to include some minimum LTSS would reduce the potential for adverse selection among plans. Without LTSS as a component of traditional Medicare, however, it is not clear if federal payments could be risk-adjusted adequately to compensate plans for both the cost of LTSS and the more significant health risk of beneficiaries that would be attracted to MA plans. This option also raises a number of questions about the phase-in needed for plans to develop the capacity to provide and manage such benefits.

5. Comprehensive Public Insurance. Expanding Medicare to cover LTSS more fully can be accomplished in number of ways. One option is to create a new voluntary part of Medicare (such as a Medicare Part E) with benefits comparable to private insurance.[36] As with Parts B and D, this new benefit would be voluntary and financed through a combination of beneficiary premiums and general revenues, with the latter used to reduce premiums, attract enrollment and increase the size of the risk pool. With voluntary enrollment, the enrollment period would need to be limited and it might be necessary to impose cost-sharing on current Medicare benefits that resemble LTSS in order to avoid gaming the system.

Eligibility would be based on the inability to perform either two or three ADLs and benefits would be available after an initial waiting period of 90-days. The benefit would last longer than the temporary first-dollar coverage described above (private long-term care contracts currently offer services from anywhere between two and 10 years, with five years as a common upper limit). Individuals who are functionally eligible but cannot afford services or arrange for informal care during the waiting period would receive LTSS through Medicaid.[37] The new LTSS benefit would be a blend of the indemnity and disability models since it could provide reimbursement for care up to a certain dollar amount per day.

The new LTSS benefit would replace private insurance in its current form, since premiums for private coverage would exceed the subsidized premiums for the new Medicare benefit. The replacement would carry a substantial cost since societal subsidies for the new Medicare Part E would replace a portion of the beneficiary dollars that now go into private insurance.

Alternatively, the comprehensive LTSS package could be incorporated as a component of Medicare Part A. By building it into Part A, the benefit would be mandatory and financed by current workers through an increase in the payroll tax rather than financed by current consumers and taxpayers through a combination of premiums and general revenue. This benefit design would also eliminate the market for private LTSS insurance or at least limit it to providing supplemental coverage for the highest-cost cases.

With all of these options, the financial impact on states would depend on whether the federal government created a "claw back" provision to recoup dollars for services that are currently provided under Medicaid.

Of course, it is not necessary to organize or administer an LTSS benefit through Medicare. An LTSS benefit could be established as a stand-alone federal program with its own dedicated funding. This scenario would require additional efforts to ensure that the new benefit would be integrated with the

existing Medicare program to provide seamless access to the continuum of LTSS and acute care medical services and was structured to be financially solvent.

An effective approach to LTSS financing will not only reduce the growth in Medicaid expenditures, but also alleviate some of the current pressure on Medicare, particularly for those with chronic health conditions and functional limitations that result in high Medicare spending.

An LTSS Benefit Based on Social Security

Medicare was created to help people access complex services provided by highly skilled medical professionals. LTSS is fundamentally different. While some LTSS is provided by skilled and licensed staff, often the care people want most – personal care services, respite care, home modification services and transportation services – is provided by unlicensed workers and guided by the personal preferences of consumers. Consumer-directed care has become popular because LTSS is much more personalized than acute care.

Arguably an LTSS benefit is as much about income replacement as it is about providing access to a standardized set of skilled services. Social Security, designed as a cash benefit to boost the income of older adults, may be a good model for an LTSS benefit, especially if the onset of a disability leaves an individual with a modest gap in financial resources.[38] A benefit of $70 a day, for example, may fund enough home care each week to meet the needs of the average older adult with disabilities; such a benefit could also complement the incremental expansion of Medicare described above. By itself, however, a monetary benefit is likely to fall short for people with serious medical needs that require around-the-clock home health care or seek institutional care.

A monetary benefit would complement the efforts of states and the federal government to improve models of capitated, risk-based managed care for the dually eligible with LTSS needs. At least 25 states are actively working with the federal government to integrate Medicaid and Medicare services.[39] The next few years may be a time to focus on a monetary benefit that increases the resources of individuals with disabilities – complementing rather than competing with or complicating changes currently ongoing in the health care delivery system.

The duration of the benefit is a key design issue. A lifetime benefit is an attractive feature of existing social insurance programs like Medicare and Social Security, but it would in the case of LTSS drive up program costs significantly. A benefit of limited duration would offer some assistance to all who are functionally eligible; that would in many cases be sufficient to meet the needs of a beneficiary.[40] Of course, the shorter the duration of the benefit, the greater the opportunity for private plans to offer a wrap-around benefit.

One could also cap coverage by limiting the benefit to the cost of a specific basket of services. For example, one proposal developed by stakeholders in Washington State would offer a monetary benefit pegged to the annual cost of the nursing care provided in a skilled nursing facility.[41] This was done not simply for budgetary reasons but to make the assistance site neutral.

A monetary benefit allows policymakers to project costs with relative confidence and to avoid reliance on reimbursement methodologies that inevitably become vulnerable to political manipulation and redefinition in a way that distorts markets. For people who acquired a disability early in life or developed a serious medical illness lasting many years, this kind of temporary monetary benefit will need to be combined with other LTSS benefits.

Financing Mechanisms for these New Options

America's social insurance programs were originally financed through a payroll tax on current workers that funded benefits for current retirees. Surplus revenues were invested in government-backed securities to help future retirees. Social Security and Medicare are intergenerational transfers that build on the promise that future workers will finance the future retirement benefits of today's workers. Medicare also relies (in Part B and Part D) on premiums paid by current beneficiaries combined with subsidies from general tax revenues. Participation in the tax-financed programs is mandatory, whereas participation in premium-financed programs is voluntary (with an opt-out in Part B and an opt-in in Part D). General revenue subsidies in Parts B and D substantially reduce the premium cost to beneficiaries, providing an incentive to enroll and ensuring adequate take-up rates. Such social insurance programs are paid for by current enrollees and taxpayers – many of whom have a personal or family stake in the provision of services.

The choice of an appropriate financing mechanism for a social insurance LTSS program is contingent upon decisions about the mandatory or voluntary nature of the program, the suitability of intergenerational transfer versus beneficiary financing, and the degree of progressivity needed to make the program equitable and workable.

The proportionality of payroll taxes make them moderately regressive, particularly when taxable wages are capped, wage earners no longer receive the gains from productivity, and rapidly growing non-wage compensation is excluded from the tax. While the progressivity in Social Security's benefit formula can offset some of the regressivity in the tax, benefits in the Medicare program are generally unrelated to income. While an LTSS benefit could have higher cost-sharing for high-income beneficiaries, it will not be able to offset a regressive financing mechanism with a progressive set of benefits.

A more progressive way to structure the tax financing of an LTSS program would be to add an income surcharge on all tax brackets. An across-the-board income surcharge of one percentage point applied to all federal tax brackets would raise substantial revenue – estimated to be $55 billion annually, with a relatively small burden on households with income in the bottom 40th percentile.[42] An important consideration in any tax approach is the extent to which the revenues are tied to growth in the economy. Taxing any commodity or economic activity that is declining would be counterproductive, particularly since any legislative adjustment would be challenging in the current political environment.

The reliance on tax-financing can be reduced by developing a premium that would shift some portion of the costs from wage earners to current beneficiaries and taxpayers more broadly. Premiums reinforce the notion that the program is a form of insurance and they allow individuals to make a straightforward cost-benefit calculation. A recent survey of Hawaii residents found that a clear majority (57 percent) would be willing to pay an amount less than $40 a month for an LTSS program with a monetary benefit.[43] While a uniform premium is the most regressive form of financing, it can be moderated by subsidies for low-income beneficiaries (as with Medicare Part D) or means-tested for higher-income beneficiaries (as with Medicare Part B).

It is time to change the paradigm for LTSS financing, moving away from a welfare program in which assistance is provided on a means-tested basis and toward an insurance-based model that allows people to spread risk and plan ahead for their LTSS needs.

Conclusion

The current system of LTSS financing is problematic at best. The lack of coverage leads to significant unmet need, while governmental payers strain under the cost of providing LTSS through vital programs such as Medicaid. Since middle-income Americans have few financially viable options to plan ahead for their potential LTSS needs, one's income security often depends on medical luck. Medicare covers surgery for congestive heart failure, but it often does not cover the daily care needs of someone with symptoms of late-stage Alzheimer's disease. Someone who needs the latter care is on his or her own. As a country, we have a program to help with LTSS when someone becomes impoverished, but nothing to prevent it.

It is time to change the paradigm for LTSS financing, moving away from a welfare program in which assistance is provided on a means-tested basis and toward an insurance-based model that allows people to spread risk and plan ahead for their LTSS needs. While a means-tested program like Medicaid has a critical role in ensuring millions of low-income individuals and individuals overwhelmed by the cost of care have access to LTSS, social insurance is the most efficient and affordable way to address the risks of disability and aging in advance. A universal compulsory program that spreads risk broadly could improve access to affordable services, relieve the burden on state Medicaid programs, and provide a vehicle for Americans to take greater personal responsibility for their LTSS needs.

Addressing LTSS is not an all-or-nothing proposition. It is not necessary to address every kind of risk that a person faces to improve the current situation. Social insurance programs typically allow private market mechanisms to provide supplemental coverage. More importantly, there may be a political as well as a practical wisdom in focusing on LTSS changes that start to shift us away from the current system while we explore the complementary roles of government and the private sector in meeting our LTSS needs. Only once that has been accomplished can policymakers focus on critical decisions around benefit design and financing options that hold real promise of improving the quality of life for the large number of Americans in need of LTSS today and tomorrow.

Appendix

A Summary of Medicare Options

Type of Benefit	Description	Comment
Incremental Benefit	Modify Part A by eliminating the "home bound" requirement for home health benefit and the three-day hospital rule for SNF coverage.	Helps with post-acute care, increases access to skilled care. Does not help with people seeking access to HCBS or custodial care.
Temporary, First-Dollar Coverage	Expand Part A to provide time-limited access to custodial nursing care, HCBS, transitional care services. May include consumer-directed, agency-provided HCBS.	Assists all ADL-eligible individuals with LTSS needs; allows some individuals to avoid or postpone institutionalization. Reduces Medicaid expenditures. Allows for respite care. Younger people with disabilities likely to outlast the benefit. Avoids federal open-ended liabilities.
Catastrophic Coverage	Expand Part A to include a lifetime benefit covering most out-of-pocket costs after significant waiting period. (2-3 years or $50,000 in services).	Helps small number of people with high-cost needs. Reduces state Medicaid expenditures by transferring custodial care in nursing homes and other high cost cases to Medicare. Most people who become Medicaid eligible will continue to rely on Medicaid for services below the threshold. Increases reimbursement for providers. Creates insurable zone, but increase in private insurance coverage likely to be small.
Managed LTSS	(1) MA plans permitted to add LTSS as optional supplemental benefit and charge enrollees an additional premium. Benefits, premiums would vary among plans. (2) Mandatory expansion of current MA program to cover specified benefits; plans would have flexibility to offer additional benefits.	Provides LTSS as part of a package of integrated care. Concern whether MA plans will have experience integrating acute care and LTSS but current demonstration should provide CMS with expertise and may bring Medicaid managed care plans into Medicare.
Comprehensive Public Insurance	(1) Create a Medicare Part E with similar benefits as above. Voluntary enrollment during limited window of time. Subsidies, added cost-sharing on existing Medicare benefits that overlap with LTSS to control for adverse selection. (2) Expand Part A to cover LTSS services similar to what is currently offered by private plans. Mandatory enrollment; no medical underwriting, no subsidies.	Designed to cover needs of the average older adult. Waiting period unlikely to impose major financial burden. Expansion of Part A to become the basis for expanded MA coverage. Private LTSS insurance would be eliminated in option (1) and (2).

Authors

Lee Goldberg, J.D., M.A., is Vice President for Health Policy at the National Academy of Social Insurance (NASI).

G. Lawrence Atkins, Ph.D., is President of the National Academy of Social Insurance (NASI).

Acknowledgements

The authors are grateful for the assistance of Sabiha Zainulbhai, NASI Health Policy Associate.

References and Endnotes

1. LTSS includes services or devices provided over an extended period of time and designed to meet the medical, personal and social needs of a person in a variety of settings that enable him or her to live as independently as possible. See Family Caregiver Alliance. Selected Long-Term Care Statistics; http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=440. Accessed February 4, 2013. LTSS is often defined in terms of helping individuals who have difficulty performing activities of daily living (ADLs) such as eating, bathing, dressing, toileting and transferring or instrumental activities of daily living or IADLs (light housework, managing medications, managing money, preparing meals and using the telephone). See Reinard S, Kassner E, Houser A. How the Affordable Care Act Can Help Move States Toward A High-Performing System of Long-Term Services and Supports. *Health Affairs*. 2011; 30(3): 447-453.

2. Family and friends provide the bulk of care needed informally, but the increase in the demand for care is expected to outstrip the supply of family caregivers. This paper focuses on the financing of paid services.

3. The average private pay cost of a nursing home stay is $88,000 a year and in ten states exceeds $100,000 a year. The base rate for assisted living facilities averages $41,000 a year, while adult day services average $66 per day. See Ujvari K, Long-Term Care Insurance: 2012 Update; http://www.aarp.org/health/medicare-insurance/info-06-2012/long-term-care-insurance-2012-update.html. Accessed February 4, 2013.

4. Agency-provided home care services costs an average of $20 per hour or an average of $40,000 per year. See Genworth Financial. Genworth 2012 Cost of Care Survey: Home Care Providers, Adult Day Health Care Facilities, Assisted Living Facilities and Nursing Homes. 2012; https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/coc_12.pdf. Accessed on February 4, 2013. The cost of care from an unlicensed home care worker averages approximately $550 per month, or $6,600 per year. See Kaye HS, Harrington C, LaPlante MP. Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much? *Health Affairs*. 2010; 29(1): 11-21.

5. The average policy offers five years worth of coverage paying for care in all settings at $153 per day. The amount of the benefit typically increases using either simple inflation adjustments or compound inflation adjustments. See Stone J. Long-Term Care: Financing Overview and Issues for Congress. 2010; http://aging.senate.gov/crs/aging27.pdf. Accessed on February 4, 2013.

6. Using criteria from the National Association of Insurance Commissioners (NAIC), only 21 percent of individuals age 60 and above can afford mid-range coverage. NAIC suggests buyers should spend no more than seven percent of their gross income on premiums and have at least $35,000 in financial assets. Three-quarters of people between the ages of 35 and 59 meet those criteria, but that figure goes down to 33 percent when eliminating individuals without adequate retirement savings, life insurance or health insurance; that figure goes down to 20 percent excluding individuals who are the principle wage earner and do not have adequate disability insurance. See Feder J, Komisar HL, Friedland R. Long-Term Care Financing: Policy Options for the Future. 2007; http://ltc.georgetown.edu/forum/ltcfinalpaper061107.pdf. Accessed February 6, 2013.

7. According to the latest data, the percentage of applicants precluded from coverage due to underwriting is approximately 19 percent, although the figure varies by age of the applicant and excludes non-applicants who know they will be denied coverage. See Frank R, Cohen M, Mahoney N. Making Progress: Expanding Risk Protection for Long-Term Services and Supports through Private Long-Term Care Insurance. 2013. See also Tumlinson A, Aguiar C, Watts M. Closing the Long-Term Care Funding Gap: The Challenge of Private Long Term Care Insurance. 2009; http://www.kff.org/insurance/upload/Closing-the-Long-Term-Care-Funding-Gap-The-Challenge-of-Private-Long-Term-Care-Insurance-Report.pdf. Accessed on February 4, 2013.

8. In many states, monthly income for an individual may not exceed $2,094; asset limits range from $1,000 to $15,000, but most commonly do not exceed $2,000. Individuals may also qualify in many states if the cost of care exceeds their income.

9. O'Shaughnessy CV. The Basics: National Spending for Long-Term Services and Supports. 2012; http://www.nhpf.org/library/the-basics/Basics_LongTermServicesSupports_02-23-12.pdf. Accessed February 4, 2013.

10. The impact of Medicaid on state budgets varies considerably, from 8 percent in Hawaii to over 60 percent in North Dakota, often having to do with the availability of HCBS. AARP Public Policy Institute. Across the States: Profiles of Long-Term Services and Supports. 2012; http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf. Accessed February 4, 2013.

11. Burman LE. The Perverse Public and Private Finances of Long-Term Care. In: Folbre N and Wolf DA eds. *Universal Coverage of Long-Term Care In the United States: Can We Get There From Here?* Russell Sage; 2012. See also Keckley P. Medicaid Long-term Care: The ticking time bomb. Deloitte, LLP. 2010; http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_2010LTCinMedicaid_062110.pdf. Accessed February 5, 2013.

12. The average older adult will need three years of LTSS, but there is significant variation: one-third of seniors won't need any LTSS, while one-fifth will need at least five years. The variation in costs is even greater given the use of informal care by most people. The average older adult needs to set aside $47,000 to meet his or her LTSS needs, but 42 percent – almost half of older adults – won't have any LTSS costs while 16 percent will have expenditures of at least $100,000. See Kemper P, Komisar HL, Alecxih L. Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect? *Inquiry.* 2005; 42(4): 335-350.

13. Burke SP, Feder J, Van de Water PN eds. Developing a Better Long-Term Care Policy: A Vision and A Strategy for America's Future, 2005; http://www.nasi.org/research/2005/developing-better-long-term-care-policy-vision-strategy. Accessed February 4, 2013.

14. Folbre N, Wolf DA. Long-Term Care Coverage For All: Getting There From Here. In: Folbre N, Wolf DA eds. *Universal Coverage of Long-Term Care In the United States: Can We Get There From Here?* Russell Sage; 2012.

15. Tumlinson A, Aguiar C, O'Malley Watts M. Closing the Long-Term Care Funding Gap: The Challenge of Private Long-Term Care Insurance, 2009; http://www.kff.org/insurance/upload/Closing-the-Long-Term-Care-Funding-Gap-The-Challenge-of-Private-Long-Term-Care-Insurance-Report.pdf. Accessed February 4, 2013. Other reasons that private long-term care insurance has failed to gain a greater foothold include consumer concerns about rate stability and the willingness of the carrier to stay in the market during the lengthy period that typically elapses between enrollment and first claim. See Gleckman H. What's Killing the Long-Term Care Insurance Industry. Fortune [published online ahead of print August 29, 2012]; http://www.forbes.com/sites/howardgleckman/2012/08/29/whats-killing-the-long-term-care-insurance-industry/. Accessed February 5, 2013.

16. Adverse selection occurs when insurance coverage attracts more individuals with higher-than-average costs and fewer individuals with lower-than-average costs. If premiums are set to cover expected payouts, then the latter group will opt-out of coverage. That, in turn, requires raising the premium to cover the higher than average losses among those who remain in the insurance pool. As premiums are continually increased, more and more people will opt-out, leading to a "death spiral" of ever-increasing premiums to cover losses within an ever-decreasing pool of higher risk individuals. See Folbre N, Wolf DA. Long-Term Care Coverage For All: Getting There From Here. In: Folbre N, Wolf DA eds. *Universal Coverage of Long-Term Care In the United States: Can We Get There From Here?* Russell Sage; 2012.

17. Graetz MJ, Mashaw JL. *True Security: Rethinking American Social Insurance.* Yale University; 1999.

18. Ball RM, Bethell TN. *Because We're All In This Together: The Case For A National Long Term Care Insurance Policy*. Washington, DC: Families USA Foundation; 1989.

19. Feder J, Komisar HL. The Importance of Federal Financing to the Nation's Long-Term Care Safety Net. 2012; http://www.thescanfoundation.org/sites/thescanfoundation.org/files/Georgetown_Importance_Federal_Financing_LTC_2.pdf. Accessed February 6, 2013.

20. Stone RI. Providing Long-Term Care Benefits In Cash: Moving To A Disability Model. *Health Affairs*. 2001; 20(6): 96-108. See also Spillman BC, Black KJ, Ormond BA. Beyond Cash and Counseling: An Inventory of Individual Budget-based Community Long Term Care Programs for the Elderly. 2006; http://www.kff.org/medicaid/upload/7485.pdf. Accessed February 4, 2013.

21. A survey of private plans showed 95 percent satisfaction with the cash option compared to 60 percent satisfaction among policyholders whose plan only allowed a service benefit. See Merlis M. Long-Term Care Financing: Models and Issues. 2004; http://www.nasi.org/sites/default/files/research/Merlis_LongTerm_Care_Financing.pdf. Accessed February 4, 2013.

22. For a comprehensive overview of legislative proposals prior to Clinton Administration, see Wiener J, Estes C, Goldenson S, Goldberg S. What Happened to Long-Term Care in the Health Reform Debate of 1993-1994? Lessons for the Future. Milbank Q. 2001; 79(2): 207-52, IV. For a review of subsequent proposals see Feder J, Komisar HL, Friedland R. Long-Term Care Financing: Policy Options for the Future. 2007; http://ltc.georgetown.edu/forum/ltcfinalpaper061107.pdf. Accessed February 6, 2013.

23. Individuals are considered to have functional limitations and therefore need LTSS when they receive hands-on or standby assistance from another person with at least one in five ADLs or at least three of five IADLs. See Feder J, Komisar H. The Importance of Federal Financing to the Nation's Long-Term Care Safety Net, 2012; http://www.thescanfoundation.org/sites/thescanfoundation.org/files/Georgetown_Importance_Federal_Financing_LTC_2.pdf. Accessed February 4, 2013.

24. Medicaid covers necessary LTSS only after private insurance has paid. In theory, this creates a disincentive to purchase private insurance since plans typically pay for services that would be covered under Medicaid. See Burman LE. The Perverse Public and Private Finances of Long-Term Care. In: Folbre N and Wolf D eds. *Universal Coverage of Long-Term Care In the United States: Can We Get There From Here?* Russell Sage; 2012. A universal public program that covers LTSS would eliminate any disincentive for supplemental private coverage.

25. Mashaw JL, Reno VP eds. *Balancing Security and Opportunity: The Challenge of Disability Income Policy*. National Academy of Social Insurance; 1996.

26. Home health services are covered under Medicare if, among other things, an individual cannot leave home or doing so requires a considerable and taxing effort. Attendance at an adult day care center or religious services is not an automatic bar to meeting the homebound requirement. See *Medicare and Home Health Care*. Baltimore, MD: Centers for Medicare & Medicaid Services (CMS); 2012. http://www.medicare.gov/Pubs/pdf/10969.pdf. Accessed February 4, 2013.

27. *Jimmo v. Sebelius*, No. 11-cv-17 (D.Vt.). 2011; http://www.medicareadvocacy.org/2012/11/01/jimmo-v-sebelius/. Accessed February 4, 2013.

28. Hospitals are increasingly holding beneficiaries for observation and evaluation, rather than admitting them. This is done to avoid any subsequent penalties for readmission. However, the period of time that person is held for observation and evaluation does not count toward the three-day hospitalization requirement needed to trigger skilled nursing facility coverage under Medicare. This leaves a beneficiary with significant out-of-pocket costs for rehabilitation services. Gengler A. The Painful New Trend in Medicare, CNN-Money. August 7, 2012; http://money.cnn.com/2012/08/07/pf/medicare-rehab-costs.moneymag/index.htm. Accessed February 6, 2013. See also Gleckman H. What the Ongoing Battle over Medicare's Observation Stays Means for Seniors. Fortune [published online ahead of print September 5, 2012]. Available online at http://www.forbes.com/sites/howardgleckman/2012/09/05/what-the-ongoing-battle-over-medicares-observation-stays-means-for-seniors/. Accessed February 6, 2013.

29. Robert Ball, the former Commissioner of the Social Security Administration and founder of NASI introduced the idea of first-dollar coverage by suggesting Medicare be expanded to cover the first six months of nursing home stays for all Medicare beneficiaries. See Liu K, Perozek M. Effects of Multiple Admissions on Nursing Home Use: Implications for "Front-End" Policies. 1990; http://aspe.hhs.gov/daltcp/reports/muladmes.pdf. Accessed February 4, 2013. More recently, the 1990 Pepper Commission recommended coverage for the first three months of a nursing home stay. See U.S. Bipartisan Commission on Comprehensive Health Care. A Call For Action. 1990; http://www.allhealth.org/publications/Uninsured/Pepper_Commission_Final_Report_Executive_Summary_72.pdf. Accessed February 4, 2013. Similar coverage was also proposed in legislation sponsored by Sen. Edward Kennedy (D-MA) included reimbursement of home care and up to six-months of skilled nursing care for each episode of illness. See also *Life Care, Long-Term Care Protection Act*, S. 2163, 101 Cong. 2nd sess. (1990).

30. These estimates are based on the incidence of LTSS. See Kemper P, Komisar HL, Alecxih L. Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect? *Inquiry*. 2005; 42(4): 335-350.

31. See MetLife Mature Market Institute. Market Survey of Long-Term Care Costs: The 2011 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs. 2011; https://www.metlife.com/assets/cao/mmi/publications/studies/2011/mmi-market-survey-nursing-home-assisted-living-adult-day-services-costs.pdf. Accessed February 4, 2013.

32. Although it is unclear the impact this particular benefit would have on the availability of informal services, there is evidence that the presence of paid care generally does not significantly reduce the informal care provided by most caregivers. Cohen MA, Miller J, Murphy E, Weinrobe M. A Descriptive Analysis of Patterns of Informal and Formal Caregiving among Privately Insured and Non-Privately Insured Disabled Elders Living in the Community. Final report to the Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy (April 1999); http://aspe.hhs.gov/daltcp/reports/ifpattrn.pdf. The substitution effect may be selective. Paid services financed by insurance companies may substitute for informal care by adult children but not informal care provided by a spouse. However, the presence of paid care may adversely impact the provision of informal care in other cultures. Kim H and Lim W. Formal Long-Term Care Subsidies, Informal Care, and Medical Expenditures. Department of Economics, Columbia University. July 2012; http://www.columbia.edu/~hk2405/ltc_for_publication_v04.pdf. Accessed February 13, 2013.

33. Bishop CE. A Federal Catastrophic Long-Term Insurance Program. 2007; http://ltc.georgetown.edu/forum/5bishop061107.pdf. Accessed February 4, 2013.

34. A variation would be to link the creation of limited set of LTSS benefits under Medicare to the voluntary purchase of private long-term care insurance that would act as a first-payer. See Tumlinson A, Lambrew J. Linking Medicare and Private Health Insurance for Long-Term Care. 2007; http://ltc.georgetown.edu/forum/6tumlinsonlambrew061107.pdf. Accessed February 4, 2013. Under this proposal, LTSS needs such as home health covered by private insurance instead of Medicare Part B, at least until the private coverage is exhausted. At that point, a Medicare LTSS benefit would be triggered, so there would be a seamless transition between private coverage and a new Medicare benefit. The assumption is that the initial savings from reduced Medicare Part B expenditures on home health would pay for the subsequent benefit. The minimum value of the plan that beneficiaries' would have to purchase to qualify for a Medicare LTSS benefit could vary based on the beneficiaries income, although low-income beneficiaries would have to purchase some level of private coverage to receive the Medicare LTSS benefit down the road. This option may result in a small improvement over the status quo in terms of coverage and an even smaller improvement in the economic security of people needing LTSS. While this plan may make private insurance more affordable, it may only raise the share of older adults with private LTSS insurance from 10 percent to perhaps 20 percent of the overall market. See Feder J, Komisar HL. The Importance of Federal Financing to the Nation's Long-Term Care Safety Net. 2012; http://www.thescanfoundation.org/sites/thescanfoundation.org/files/Georgetown_Importance_Federal_Financing_LTC_2.pdf. Accessed February 6, 2013. The vast majority of people may still find private insurance unaffordable.

35. Feder J, Komisar HL, Friedland R. Long-Term Care Financing: Policy Options for the Future. 2007; http://ltc.georgetown.edu/forum/ltcfinalpaper061107.pdf. Accessed February 6, 2013.

36. New types of benefits with distinct financing are often added to Medicare as a separate "part." Medicare Part C was added to the original Parts A and B in 1997 to allow enrollees to receive benefits through a private plan; Part D was created in 2003 to add a prescription drug benefit. A LTSS benefit would logically be labeled Medicare Part E.

37. Policymakers would need to decide if the elimination period would run during the use of other Medicare-covered services. For example, stays in a skilled nursing home – conceivably the most expensive care an individual would need during the elimination – could be covered by Medicare if it was preceded by a three-day hospital stay.

38. Such a program would likely not be an expansion of Social Security itself, since that would require a major reworking of the benefit formula, but a parallel program with an in-kind benefit and first-dollar coverage.

39. Houser A, Ujvari K, Fox-Gage W. In Brief: Across the States 2012: Profiles of Long-Term Services and Supports. 2012; http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-in-brief-AARP-ppi-ltc.pdf. Accessed February 4, 2013.

40. These estimates are based on the incidence of LTSS. See Kemper P, Komisar HL, Alecxih L. Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect? *Inquiry*. 2005; 42(4): 335-350.

41. Friedland R. Washington State Long-Term Care Authority: A Proposal For Helping Washingtonian Families Confront Long-Term Care. AARP Washington and the Service Employees International Union 775. April 2007; http://infoassist.panpha.org/docushare/dsweb/Get/Document-20257/2007%20Washington%20State%20Long-Term%20Car.pdf. Accessed on February 21, 2013.

42. Johnson RW, Burman LE. A Proposal to Finance LTC Services Through Medicare. 2007;http://ltc.georgetown.edu/forum/8burmanjohnson061107.pdf. Accessed February 4, 2013.

43. Wiener J. Preliminary Hawaii Long-Term Care Survey Results. Presented to Hawaii Long-Term Care Commission, October 2010. Available online at http://www.publicpolicycenter.hawaii.edu/documents/RTI-Survey_Results_Report-FINAL.pdf. Accessed February 6, 2013.

For more information contact:
The SCAN Foundation
3800 Kilroy Airport Way, Suite 400, Long Beach, CA 90806
www.TheSCANFoundation.org
(888) 569-7226 | info@TheSCANFoundation.org