Financing Long-Term Services and Supports: What Should States Do?

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Problems of Long-Term Care Financing

- Services are expensive
- Medicare does not cover and few people have private insurance coverage
- Routine catastrophic costs that impoverish people who have been independent all their lives
- Primary source of financing is Medicaid, a means-tested welfare program
- Bias towards nursing homes, rather than home care
- With aging population, public and private spending sure to grow
## Financing for Long-Term Care: 1988 and 2011, ($ billions)

<table>
<thead>
<tr>
<th>Financing Source</th>
<th>1988</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>24.4</td>
<td>136.2</td>
</tr>
<tr>
<td>Medicare</td>
<td>2.9</td>
<td>62.5</td>
</tr>
<tr>
<td>Other payers</td>
<td>5.0</td>
<td>9.7</td>
</tr>
<tr>
<td>Out-of-pocket</td>
<td>15.7</td>
<td>45.5</td>
</tr>
<tr>
<td>Private insurance and other private</td>
<td>4.0</td>
<td>24.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>52.0</strong></td>
<td><strong>278.3</strong></td>
</tr>
</tbody>
</table>

Source: Truven Health Analytics, various years; Centers for Medicare & Medicaid Services, various years; National Health Policy Forum.
Projected Public Long-Term Care Expenditures (All Ages) in Selected Countries, as a Percentage of GDP, 2005 and 2050

Source: OECD, 2006.
Population Age 85 and Older and Number of Nursing Home Residents, 1990, 2000, and 2010

Source: U.S. Census Bureau, National Center for Health Statistics, and American Health Care Association
## Medicare Post-Acute Care Expenditures (in $ billions)

<table>
<thead>
<tr>
<th>Service</th>
<th>1988</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facilities</td>
<td>1.0</td>
<td>30.3</td>
</tr>
<tr>
<td>Home Health</td>
<td>1.9</td>
<td>18.5</td>
</tr>
<tr>
<td>Hospice</td>
<td>0.0</td>
<td>13.7</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>2.9</strong></td>
<td><strong>62.5</strong></td>
</tr>
</tbody>
</table>

Source: Centers for Medicare & Medicaid Services, 2012
# Medicaid Expenditures for LTC, 1988 and 2011 (in $ billions)

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>1988</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-institutional LTC Services</td>
<td>2.4</td>
<td>64.3</td>
</tr>
<tr>
<td>Nursing home</td>
<td>14.6</td>
<td>52.4</td>
</tr>
<tr>
<td>ICF-IID</td>
<td>5.9</td>
<td>13.3</td>
</tr>
<tr>
<td>Mental health facilities and mental health DSH</td>
<td>1.5</td>
<td>6.2</td>
</tr>
<tr>
<td>Total LTC</td>
<td>24.4</td>
<td>136.2</td>
</tr>
<tr>
<td>Total Medicaid</td>
<td>58.6</td>
<td>410.9</td>
</tr>
</tbody>
</table>

Source: Truven Health Analytics, various years
Percentage of Medicaid LTSS for HCBS, for Aged and Disabled, 1995–2008

Source: Thomson Reuters, various years.
## Medicaid Transitions by Age and Transition Status

<table>
<thead>
<tr>
<th>Medicaid Transition Measure</th>
<th>&lt;65 in 1996 (%)</th>
<th>65+ in 1996 (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Medicaid at Baseline</td>
<td>6.9</td>
<td>12.9</td>
<td>9.6</td>
</tr>
<tr>
<td>Medicaid at Some Time During Study Period</td>
<td>68.0</td>
<td>61.9</td>
<td>64.2</td>
</tr>
<tr>
<td>Total Population at Baseline</td>
<td>6.6</td>
<td>11.8</td>
<td>9.0</td>
</tr>
</tbody>
</table>

Source: RTI International analysis of Health and Retirement Study merged with Medicare data.
## Medicaid Transitions by Use of LTSS

<table>
<thead>
<tr>
<th>Spend Down Measure</th>
<th>No LTSS Use (%)</th>
<th>Only Personal Care (%)</th>
<th>Only Nursing Home Care (%)</th>
<th>Nursing Home &amp; Personal Care (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Medicaid at Baseline</td>
<td>46.1</td>
<td>7.1</td>
<td>33.1</td>
<td>13.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Medicaid During Study Period</td>
<td>48.0</td>
<td>7.0</td>
<td>31.1</td>
<td>13.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Total Population</td>
<td>45.4</td>
<td>7.3</td>
<td>33.3</td>
<td>14.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: RTI analysis of Health and Retirement Study merged with Medicare data.
## Financial Status of Long-Term Care Medicaid Transition Population at Baseline, by Quartiles, 1996

<table>
<thead>
<tr>
<th>Income Quartiles</th>
<th>Total Assets Less IRAs (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0–38,899</td>
</tr>
<tr>
<td>$0–15,939</td>
<td>39.0</td>
</tr>
<tr>
<td>$15,940–31,908</td>
<td>9.8</td>
</tr>
<tr>
<td>$31,909–60,999</td>
<td>2.5</td>
</tr>
<tr>
<td>$61,000+</td>
<td>0.4</td>
</tr>
<tr>
<td>Total</td>
<td>51.7</td>
</tr>
</tbody>
</table>

Source: RTI International analysis of Health and Retirement Study merged with Medicare data.

Quartile classes are determined by the income and assets of the total population at baseline.
Transfer of Assets a Small Problem

- Claim by some that large number of people transfer assets to appear artificially poor to qualify for Medicaid
- Transfer of assets is relatively infrequent and usually involves quite small amounts of funds (Bassett, 2004; Lee, Kim and Tannenbaum, 2006; O’Brien, 2005; Norton, 1995; Sloan and Shayne, 1993, Waidmann and Liu, 2006)
- Wiener et al. (2013) found that transfer of assets rate for people who spend down was half the rate of people who do not spend down
- Maximum estimate of asset transfer is about 1 percent of Medicaid nursing home expenditures (Bassett, 2004; Waidmann and Liu, 2006)
Number of People with Private Long-Term Care Insurance, 1992-2010

Source: National Association of Insurance Commissioners, 2011
Private Long-Term Care Insurance

- Dream not matched by reality: 12% of 65 and older; 5% of 45 and older

- Market collapse, especially since recession:
  - Most insurers exit market
  - Most insurers have substantially raised premiums (100% not unusual)
  - Tighten underwriting and reduce benefits

- What’s going on? Accurately pricing premiums is impossible
  - Low to negative rate of return on reserves
  - Lower lapse rate than assumed
Options to Promote Private Long-Term Care Insurance: Tax Incentives

- Goal of tax incentives for private long-term care insurance is to make product more affordable
- Tax incentives ineffective in substantially increasing number of people with policies
  - Wiener, Illston and Hanley (1994) found that a 20% nonrefundable tax credit increases the number of people with insurance by a third
  - Nixon (2006) found that offering a state tax incentive did not increase market penetration
  - Kim (2008) found the price elasticity of private long-term care insurance to be -0.08
 Tax Incentives for Private Long-Term Care Insurance

- Goda (2010) found that average tax subsidy increased private long-term care insurance coverage rates by only 2.7 percentage points

- Tax loss would not be offset by Medicaid savings
  - Wiener, Illston, and Hanley (1994) found that Medicaid savings would not offset the lost revenue
  - Goda (2010) found that a dollar of state tax expenditure produces approximately $0.84 in Medicaid savings, half of which would result in savings to federal government. State tax incentive would be 100% state funded
  - Wiener, Illston, and Hanley (1994) found that tax incentives are likely to be regressive, flowing mostly to well-to-do and upper middle income people
Partnership for Long-Term Care

- Allows people who purchase state-approved private long-term care insurance to become Medicaid eligible, while keeping more of their assets than usually allowed.
- Life-time asset protection without buying a lifetime policy, which no longer exist.
- Not succeed in increasing long-term care insurance penetration—about 3.2 percent of 65+ in 4 states with longest experience (California Partnership for LTC, 2010; Guttchen, 2011; Indiana Long-Term Care Insurance Program, 2010; New York Partnership for Long-Term Care, 2010, U.S. Census Bureau, 2011).
Partnership for LTC (cont.)

- Shorter periods of coverage still expensive; 2 year coverage at age 60 with compound inflation was $2,400 in 2010 (Federal Long-Term Care Insurance Program)
- Partnership purchasers have higher income and higher assets (General Accountability Office, 2005)
- Partnerships likely to increase Medicaid expenditures (Sun and Webb, 2013)
Public Long-Term Care Insurance

- Societal responsibility
- Failure of private sector and means-tested programs to solve problems
- Long-term services and supports should be treated same as medical care
- Mandatory public long-term care insurance, financed by combination of taxes and premiums
  - Netherlands, Germany, and Japan; starting in Taiwan and Korea, even movement in England
  - Non-means tested programs in Scandinavia
  - Hawaii Long-Term Care Commission propose bare bones program, which state is investigating
Which Way for Long-Term Services and Supports Financing?

- Increasing number of older people means higher spending, but it is a manageable problem
- Medicaid
  - Liberalize financial eligibility criteria
  - Raise personal needs allowance in nursing homes
  - Expand home and community-based services
- Private Long-Term Care Insurance
  - Current model is not viable for more than small percentage of population
  - Model based on predicting the future 30 years from now is doomed
Which Way for Long-Term Services and Supports Financing?

- Strengthen regulation, especially inflation protection
- Tax incentives and Partnership for LTC not work
- Perhaps try to integrate into acute care insurance
- Front-end private insurance coverage not workable without very substantial subsidies

Public Insurance
- Failure of private insurance and limits of Medicaid leads to public insurance
- Join Hawaii in considering mandatory public insurance program for the state
- State examples may be necessary for national action, like state experiments in health insurance
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