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A Federal Catastrophic Long-Term Care Insurance Program

Christine E. Bishop
*Heller School for Social Policy and Management
Brandeis University
Waltham, Massachusetts*

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Health Policy Institute
Georgetown University
3300 Whitehaven Street, Suite 5000
Washington, DC 20057
(202) 687-0880
hpi.georgetown.edu

Preface

At the same time we invest over \$200 billion in public and private resources in long-term care, dissatisfaction with our current public-private financing partnership is widespread. To promote a better partnership for the future, the Georgetown University Long-Term Care Financing Project examined options to move us from a partnership that consists primarily of out-of-pocket financing and last-resort public financing toward a partnership that spreads risk, supports access to quality care, and shares financial responsibility fairly among taxpayers and affected individuals and families.

To identify options, we invited experts to develop their own proposals for new ways to finance long-term care. We sought innovative ideas that varied in the nature of the partnership between the public and private sectors. This working paper is one of a set of eight proposals written for the project. These eight, plus an additional four proposals from other sources, are summarized and assessed in an overview paper, *Long-Term Care Financing: Options for the Future*, written by Judith Feder, Harriet L. Komisar, and Robert B. Friedland. The working papers and the overview can be found at: ltc.georgetown.edu. The Georgetown University Long-Term Care Financing Project is funded by a grant from the Robert Wood Johnson Foundation.

Judith Feder and Sheila Burke

Project Directors

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Christine E. Bishop

Introduction

This brief first presents a rationale for government involvement in funding long-term care (LTC) services, and specifies aspects of LTC that are not appropriate for public funding; in addition, the current situation of Medicaid and the trend of private payers to purchase care in higher-amenity settings are noted. The next section lays out a proposal for a Federal catastrophic long-term care insurance program. The final section comments on simulating the impact of this and other LTC financing policy options, first outlining the dimensions that should be assessed in comparing policy options, and then arguing that the “base case” against which a new policy should be compared should not be what we see today but should encompass the trends we expect to observe over the time frame of any simulated plan. The final section briefly outlines some guesses about the impact of the proposed policy option.

Rationale for Government Involvement

Ideally, life-time consumption planning should involve smoothing of living expenses to balance spending during working years with three interlocking goals for post-work years: 1) spending for desired day-to-day living in retirement; 2) protection for the excess health expense risks of older ages that can deplete living expenses; and 3) protection for the risk of disability in old age, which one may plan to meet through a combination of social support and spending from assets and current income. In the United States, two social

Christine E. Bishop, Ph.D., is a professor at the Schneider Institute for Health Policy at the Heller School for Social Policy and Management at Brandeis University in Waltham, Massachusetts. This paper was written in 2003 and revised in 2006.

insurance programs, Social Security and Medicare, form a foundation for two out of three of these goals. But it is very difficult to prepare for possible future long-term care needs in a way that meets living situation preferences and risks of loss of social support without diverting excess amounts from the income of working years.

The long-term care financing plan presented here springs from the fundamental nature of long-term care services as, first, individually consumed services that support daily functioning for persons with disability;¹ and second, as daily-life services that are consumed where persons with disability live. Even though services are individually consumed, there is an argument for social insurance of long-term care services as a merit good, in that society has an interest in assuring that persons with disability are able to carry out the functions of each life stage even when they are unable purchase support services themselves.² In addition, social insurance for long-term care can spread risks that are very expensive at an individual level; total costs may be lower when risks are shared. However, there is no merit good argument to support more than basic room and board to accompany services, nor to provide services to persons who could pay on their own; and individuals in the U.S. are generally expected to insure themselves for individual risks of losses that cut into assets.

Because of these features of LTC, as an individually-consumed service bound up with residential environment and individual asset risk, it is difficult

¹ Long-term care services are defined as services that support daily function of people with functional limitations. LTC is designed to compensate for chronic functional disability. Functional limitations often result from insults to health, i.e., acute illnesses or injury, but in its strictest definition, LTC does not deal with the illness that may have caused these problems. Instead, it compensates for the disability that the illnesses or injuries have caused.

² A merit good is a good or service where consumption by one individual is highly valued by others, regardless of the value placed upon it by the individual who consumes the good. This may lead to a situation where the community will pay an individual to consume a good (like a vaccination) or will

to argue for a universal social insurance plan for all LTC, even with income-related premiums and deductibles that would more equitably share the universal risk of LTC need. Such a plan is especially implausible in a nation that does not yet have universal coverage for health care. In addition, age-specific mortality is generally inversely correlated with income, so that on average fewer individuals with limited life chances survive old age, with disabilities or not. It is important to be mindful of the distributional effects of any plan that would tax workers to provide residence expenses as well as services to elders, in effect reducing daily basic consumption of working-aged persons who may have lower chances of ever using the service, while enhancing daily consumption of the few who have survived to enter care.

So it seems that government should not be redistributing income to support long-term care for elders who are not poor, and certainly not for the room and board/housing component of long-term care.

Problems with Medicaid

Medicaid has evolved into a highly imperfect answer to the LTC conundrum. Persons with disability need not go without long-term care services if they are eligible for Medicaid. Medicaid eligibility criteria may be met through low incomes and assets or, in most states, through spending virtually all income and assets on care. But publicly-funded services are still mainly provided in institutional settings, so that recipients must move into a nursing home rather than staying at home. The care supported by Medicaid has substantial quality problems: a recent report to Congress on staffing in the nation's nursing homes found that nine out of ten were understaffed in relation to the needs of their resident mix.³ Apparently, quality of care has not been a

subsidize consumption (like housing) when an individual's consumer choices given income would mean consumption below what society considers an acceptable standard.

³ (Centers for Medicare and Medicaid Services 2002)

uniform part of the merit good approach – intensity of care (nursing hours per unit of resident need) varies widely across states, suggesting that the implicit minimum standard for care differs across Medicaid programs.⁴

In attempting a solution to the problem of inadequate resources of persons with LTC needs, Medicaid has developed more problems of its own. Medicaid was conceived as a means-tested program to provide health services to poor people, and does so in every other aspect of its services. But in the LTC case, it has not been possible to limit Medicaid eligibility to people who are poor in some lifetime income sense, both because of the vagaries of retirement income, but more importantly because nursing home bills can exhaust income and assets of even middle-income elders. This is especially the case when they have made little preparation for LTC risk during working years, which would require setting aside “extra” retirement savings that exceed expected living expenses. Rather than limiting Medicaid nursing home eligibility, states have controlled access to nursing homes in total, by limiting supply both directly and through low Medicaid payment rates that constrain returns to nursing home investment. Despite these limitations, and even though recipients contribute most of their own income to the purchase of services, nursing home care takes up more than 20% of state Medicaid budgets, and on average absorbs 5% of state general revenues, for a recipient group that makes up about 5% of total Medicaid beneficiaries.

Medicaid and Nonpoor Elders

Despite these difficulties, Medicaid programs are meeting the goal of serving elders in nursing homes who are too poor to pay the bills. In failing to plan for an uncertain individual future, many middle and even upper-income people will end up using Medicaid as a way of funding LTC, whether they intend

⁴ (Bishop and Visconti 2001)

to or not. Implicitly and understandably, they prefer to spend on other consumer goods and services rather than saving for uncertain future LTC needs, because Medicaid will cover their care in a nursing home should they need it – they will not go without any care.⁵

However, the quality of care they would receive as Medicaid beneficiaries makes a difference. Early in the evolution of private LTC insurance, it appeared that people were more likely to buy private LTC insurance in states where Medicaid nursing home care was a less attractive alternative.⁶ As budget pressures grow on states, Medicaid is likely to lose its role as a stop-loss insurer for middle and upper-income people, because the care provided under Medicaid will decrease in quality and amenity level. We are already seeing more elders paying for services in higher amenity settings, at home or in assisted living. They are using private assets and income, and some private LTC insurance, to fund this care. Conceivably, one way to “solve” the LTC financing problem would be to allow Medicaid-funded care to become virtually unacceptable, so that over time families would strive to fund care out of private resources, just as more families further down the income distribution strive and sacrifice to pay for private schools in areas where public schools have deteriorated.⁷

Help from another person to carry out activities of daily living can be provided in a variety of settings. Acquiring housing and food is traditionally

⁵ Individuals need not make explicit use of “Medicaid estate planning” or divest assets prior to nursing home entry for this to hold – it is an issue of lifetime consumption planning. Families with sufficient resources to plan for future long-term care needs have instead understandably chosen higher expenditures at an earlier stage in life rather than saving, and reach old age with low assets that make them eligible for Medicaid after some LTC use. A recent estimate finds that Medicaid is covering very few individuals who have divested financial assets at or close to the time of needing LTC (O'Brien 2005), but this is trivial next to the pattern of allocation of resources to current consumption and saving for LTC over a lifetime. Could more working aged families “afford” to save for LTC? Many are not even saving for retirement. The problem, of course, is that a universal LTC program would force transfers from taxpayers, many working aged families, to elders in need of LTC. On use of asset protection strategies at the time of service need, see also: (Burwell, Adams et al. 1990; Adams, Meiners et al. 1993; Ohio Department of Human Services 1999; and Stum 2001).

⁶ (Kumar, Cohen et al. 1995)

considered to be the responsibility of individuals. Expenditures on housing and food typically rise with household income. We would expect persons with higher income and assets to be willing to pay for higher-cost room and board in settings providing LTC services - including their own homes. Recent trends appear to show the location of LTC services responding to these market forces, as elders with assets seek out private home care and assisted living services.⁸ The room and board of the LTC setting are not logically part of the “merit good” justification for public spending, except in the minimal sense of a social commitment to keep people from hunger and homelessness. When they need services, people express strong preferences for care at home or in a home-like setting, and market supply appears to be responding to the wishes of the elders with higher assets and income who can buy what they prefer.

Because LTC services are so bound up with personal living arrangements and preferences and have few community spillover effects, it is logical to allow and encourage individuals to prepare for the risks of LTC need on an individual basis, just as they prepare for retirement, and to make personal decisions about these arrangements if and when LTC is needed. The market economy and public policy determine how productive resources are used, and for whose benefit. Traditionally, most long-term care has been acquired by individuals using individual resources - which in this case includes family resources, including family time. A relatively small portion of total long-term care has been purchased by governments on behalf of individuals - for example, support in the county poor farm, Medicaid nursing home care, state-subsidized services for the aged. It is unlikely that a public program could be as successful in meeting consumers’ needs and preferences concerning living arrangements and

⁷ In this case, families also move to school districts with better schools, so the analogy is far from perfect.
⁸(Hawes, Rose et al. 1999; Cohen and Miller 2000) (Bishop 1999). This may hasten their Medicaid eligibility, because eligibility is based not on lifetime resources but on current income and assets (Moore 1999).

amenities as private market approaches. At the same time, if Medicaid ceases to be the catastrophic insurance program for the nonpoor, policy makers must attend more closely to the options and quality of care available to elders dependent on Medicaid, because middle-income families will hold lower stakes in Medicaid nursing home debates.

This plan addresses the merit good aspect of LTC by expanding and standardizing Medicaid to assure that poor elders and individuals who become poor in old age due to long-term care expenses have access to needed care in basic living accommodations, and works to reduce the private risk that non-poor individuals must bear by providing this same basic level of service for all persons who have experienced a three-year period of long-term care need. It represents an attempt to channel forces that are inherent in the current LTC situation. By standardizing Medicaid LTC in a manner that assures good care in modest settings, it attempts to return Medicaid back to basics as a program for poor elders, less attractive to middle income families, while attempting to keep it from the fate of other “poor only” programs. This would encourage middle- and upper-income families to do more to prepare for future LTC needs, so that they can avoid low-amenity Medicaid care. By providing universal public catastrophic coverage for those with long-duration LTC needs, it assists with that planning by increasing the feasibility and attractiveness of private insurance, which would only need to cover care during the three-year elimination period.

A Federal Catastrophic LTC Coverage

A Federal universal catastrophic LTC plan with a three-year elimination period would address some of these problems. A deductible denoted in time rather than funds (an elimination period) would encourage people to manage their long-term care needs economically. The plan covers direct LTC services only, i.e., the benefit, which is denoted in priced hours, does not explicitly cover living expenses (room and board). At the same time, the plan calls for

standardization of a Medicaid LTC program that restricts eligibility to poor elders.

The goals of this LTC public insurance intervention are:

- To increase equity of public provision of care in relation to lifetime resources by requiring all but initially eligible elderly to cover three years of LTC services out of private resources
- To increase the ability of nonpoor persons to insure for risk of LTC needs by covering services beyond three years as a social insurance program; this would foster the development of insurance plans that cover a maximum of three years of care, so risk would be better defined for insurers and plans would be more uniform and marketable.
- To set up explicit separation between charges for LTC services and room and board charges.
- To assure that nursing home care across the nation meets minimum case-mix adjusted staffing standards, because access goals cannot be met by poor care.

Benefit Trigger

Need for personal assistance in two ADLs or due to a certain level of cognitive impairment would trigger the beginning of the elimination period. Assessment would be conducted by independent local organizations. Being assessed as eligible for benefits would trigger appropriate service provision for Medicaid eligibles and payment of benefits according to insurance contracts for persons holding private LTC insurance policies. All elders with the minimum level of assessed disability would begin the elimination period. Periodic assessments to verify continuation of this level of disability would be used to determine Medicaid benefits for Medicaid eligibles, and could be used by private insurance companies to determine private benefits.

The per diem amount paid for services by the Federal program after the three-year elimination period would be denoted in hours of direct care needed plus a supplement for 24-hour supervision. The amount available to pay for services (nursing home, assisted living facility, home care agency, or independent provider) is the number of hours of assessed need multiplied by a standard labor cost, for example \$30 an hour, adjusted for inflation and area wage differences. The recipient could use the assessed amount to purchase services at home, in adult day care, in assisted living, or in a nursing home. Elders choosing or needing residential settings for care would pay out-of-pocket for the difference between their disability service payment and total cost (including room and board); Medicaid would continue to pay the difference for Medicaid eligibles. The assessed services amount can be “cashed out,” perhaps at a discount, for use by the individual, to support relatives or other informal providers or to use in other ways.⁹

Services for Poor Elders

After an assessment showing a qualifying level of disability, elders eligible for Medicaid by virtue of income and assets are able to receive appropriate services at home or in a nursing home, depending on the service mix supported in their state.

Standardization of Medicaid

The option standardizes eligibility for Medicaid across states at the most generous current level.

The option standardizes the services portion of Medicaid payment rates across states, by adding to a state-determined base the direct care portion of

⁹ For example, an elder with assessed need of two hours per day might purchase 10 hours of service each week and put the remainder of his fund toward the congregate housing setting he shares with his wife, who provides additional informal care.

the Medicare per diem prospective payment system (PPS) for residents by type as assessed by the Minimum Data Set (MDS). The Resource Utilization Groups (RUGs) assessment method encompasses residents with needs in over 40 categories, including but not limited to the Medicare skilled nursing facility (SNF) patients it is now used for. The payment for direct care will be fixed, and states will not receive Federal matching funds for payments above these standard rates.¹⁰ The remainder of the PPS-type payment, in recognition of room and board costs, would be capped at a modest level for purposes of the Federal match. Assisted living would be covered to the extent it was available based on these modest room and board payment levels and was able to meet recipients' assessed needs.

Federal standards would require that nursing homes supply the average daily staff hours assessed for their residents. Federal funding would support better monitoring and enforcement. These provisions would add to public expense of the option, but it is not reasonable to preserve Medicaid without improving and standardizing what Medicaid actually provides for nursing-home-resident Medicaid beneficiaries.

Access of Medicaid eligibles to home care and adult day health hours would be standardized across states so that Medicaid would look more like private insurance in its coverage of both community-based and institutional services. Payment to community-care providers would be based on assessed hours needed and provided, plus an allowance for transportation.

Services for Non poor Elders

After an assessment showing qualifying disability, elders who are not eligible for Medicaid would be “on their own” to provide their own care during

¹⁰ These rates will generally be higher than what is now paid, so this is a moot point.

the elimination period. They would support this care through private resources, including family caring, personal income and wealth, and private long-term care insurance. If they spent down, they would go onto Medicaid.

Private LTC Insurance

Private LTC insurance contracts would continue to be written with a variety of benefits, for example per diem cash benefits based on assessed need, deductibles, and per diem expenditure limits. Policies might be written with coverage extending beyond the elimination time period, but this portion of coverage would be supplemental to the national catastrophic plan. Private LTC insurance is not currently insuring the “tail” of the distribution of expenditure. Companies writing individual insurance take on substantial risk if they contract to provide coverage for the very small number of people who have very long stays and huge service expenditures, so many policies limit the total time covered, rather than insuring for the real risk of long duration and high expense. This is arguably an appropriate function of a public reinsurance – e.g. the catastrophic insurance envisioned here.

The option could be developed to further encourage the purchase of private LTC insurance, but findings with respect to acute care coverage, and from the current public-private partnership model, do not hold much promise that subsidies or tax breaks will do much to increase purchase.¹¹ The basic level of Medicaid service coverage and the defined period of needed coverage (three year elimination period) are expected to make private purchase of LTC insurance more feasible and attractive as asset protection and choice enhancement.

¹¹ (Chernew, Frick et al. 1997; Gruber and Levitt 2000; Swartz and Garnick 2000; Meiners 2001; Swartz 2001)

Catastrophic Coverage

After the elimination period, a Federal program would cover all elders. The per diem amount of coverage would be determined based on assessed functional status and cognitive functioning. Elders for whom a nursing home level of care is appropriate would have that the direct service portion of care paid for at standard per diem PPS rates. Individuals would remain responsible for the room and board component of nursing home charges, which they would cover with private funds or private insurance. Medicaid or Supplemental Security Income (SSI) would cover the room and board amount for Medicaid recipients. Care in the community would be supported on the same basis, with variable amounts of benefit based on assessed need. Elders would be able to supplement this per diem coverage for needed direct care with their own resources, allowing them to use the Federal program to remain in assisted living, in high-amenity nursing homes, or at home at levels of need not generally supported.¹²

¹² The hours of direct care need would have an added supplement for elders in need of supervision time, but it is not envisioned that full-time care directly equivalent to nursing home round-the-clock supervision would be supported in the community.

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Georgetown University Long-Term Care Financing Project
Working Papers

- No. 1 **Medi-LTC: A New Medicare Long-Term Care Proposal**
John Cutler, Lisa M. Shulman, and Mark Litow
- No. 2 **The Life Care Annuity: A Proposal for an Insurance Product Innovation to Simultaneously Improve Financing and Benefit Provision for Long-Term Care and to Insure the Risk of Outliving Assets in Retirement**
Mark J. Warshawsky
- No. 3 **Forced Savings as an Option to Improve Financing of Long-Term Care**
James Knickman
- No. 4 **Long-Term Care Policy Option Proposal: Consumer Controlled Chronic, Home, and Community Care for the Elderly and Disabled**
Marty Lynch, Carroll Estes, and Mauro Hernandez
- No. 5 **A Federal Catastrophic Long-Term Care Insurance Program**
Christine E. Bishop
- No. 6 **Linking Medicare and Private Health Insurance for Long-Term Care**
Anne Tumlinson and Jeanne Lambrew
- No. 7 **A Trade-Off Proposal for Funding Long-Term Care**
Yung-Ping Chen
- No. 8 **A Proposal to Finance Long-Term Care Services Through Medicare With an Income Tax Surcharge**
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About the Project

The *Georgetown University Long-Term Care Financing Project* pursues analysis designed to stimulate public policy discussion about current long-term care financing and ways to improve it. The project is funded by a grant from The Robert Wood Johnson Foundation. More information about the project and other publications can be found at <http://ltc.georgetown.edu>.