Overview

- How do we pay for long-term services and supports (LTSS)?
  - Mainly: out-of-pocket and Medicaid

- Closer looker at:
  - Medicare (doesn’t cover LTSS)
  - Private long-term care insurance (small role)
  - Medicaid (role as safety net, “nursing home bias,” wide variation among states)
SOURCES OF FINANCING FOR LONG-TERM SERVICES AND SUPPORTS
Most people are not insured for LTSS

- Unpaid care (family and friends): Large role
- Private long-term care insurance: Few have it
- Medicare: Does not cover LTSS
  - Limited coverage of skilled nursing facility and home health for “post-acute” care
- Medicaid: Covers LTSS but is a “safety net”
  - Must meet income and asset criteria
When extensive services are needed, it can be costly

- Nationwide average prices (in 2009)
  - Nursing home (private room): $79,900 per year
  - Assisted living: $38,000 per year
  - Home care aide: $21 per hour (20 hrs/week = $21,900 per year)
  - Adult day services: $67 per day

- Prices vary among, and within, locations

Source: The 2009 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs.
Medicaid and out-of-pocket are the main payers of LTSS

- Medicaid ($119.0 billion) 62%
- Out-of-Pocket ($43.5 billion) 23%
- Private Health and Long-Term Care Insurance ($22.3 billion) 12%
- Other Public ($6.2 billion) 3%

Total in 2008 = $191.1 billion

Source: O’Shaughnessy 2010.
Medicare covers post-acute services (not LTSS)

- Area of considerable confusion

- Home health care benefit
  - Emphasis on skilled nursing and therapy services
  - Provides part-time or intermittent services
  - Must be homebound & need periodic skilled nursing or therapy

- Skilled nursing facility care benefit
  - Covered after a 3-day hospital stay
  - Must need daily skilled nursing or therapy service
  - 100-day maximum
Many people go without needed LTSS

Among community adults who need LTSS

Met Need 80%
Unmet Need 20%

How LTSS is financed is important

- Lack of insurance means people are at risk financially

- Reliance on out-of-pocket and Medicaid affects access to care
  - Determines whether and what types of care can be obtained

- Affects supply
  - Nursing home industry shaped by Medicaid

- Results in fragmented and uncoordinated care
PRIVATE LONG-TERM CARE INSURANCE
Few people have private long-term care insurance

- About 7 million people have private LTCl
  - About 3% of people age 20+; about 10% of people age 65+

- Most policies pay for home-based & nursing home care; some also cover assisted living & adult day

- Price depends on features and age when first purchased

- Typically sold as individual policies
Why is the private long-term care insurance market limited?

- “Underwriting” means many people can’t purchase it
  - One study estimated 28% of people age 65-69

- Demand is low
  - Consumer confusion, lack of knowledge
  - Difficult to navigate individual market
  - Expensive
  - Concerns about stability of premiums and insurer, benefit adequacy
Federal efforts to increase the number of purchasers

- Federal tax incentives, e.g.,
  - Itemized deduction of medical expenses, deduction for self-employed
  - Benefits exempt from taxation for qualified policies

- Information: Own Your Future campaign and National Clearinghouse for Long-Term Care website

- The Partnership for Long-Term Care program
  - “Partnership” policyholders have a higher Medicaid asset eligibility threshold after receiving their policy’s benefits

- Have had little effect on number of purchasers
MEDICAID
Medicaid’s coverage of LTSS varies by state

- Benefits
  - Nursing home services: all states must provide
  - Home and community based services (HCBS)
    - Home health: all states must provide
    - Personal care: optional (30 states)
    - HCBS waivers: optional (all states use to varying degrees)

- Eligibility
  - Income and assets criteria; functional criteria

- “Nursing home bias” in Medicaid
HCBS share of Medicaid LTSS spending has been growing.

<table>
<thead>
<tr>
<th>Year</th>
<th>Institutional Services</th>
<th>Home and Community Based Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>87%</td>
<td>13%</td>
</tr>
<tr>
<td>1997</td>
<td>76%</td>
<td>24%</td>
</tr>
<tr>
<td>2008</td>
<td>57%</td>
<td>43%</td>
</tr>
</tbody>
</table>

Institutional Services: $30 billion to $56 billion to $106 billion
Home and Community Based Services: $30 billion to $56 billion to $106 billion

Source: Burwell, Sredl & Eiken 2009. Years are fiscal years.
Medicaid spending for LTSS, by type of service

- Nursing Home: 46%
- Home and Community Based Services: 43%
- ICF-MR: 11%
- Personal Care: 10%
- Home Health: 4%
- HCBS Waivers: 29%

ICF-MR = intermediate care facilities for people with intellectual or developmental disabilities.
Source: Burwell, Sredl & Eiken 2009; data are from fiscal year 2008.
Medicaid HCBS Waivers

- Account for most Medicaid HCBS spending
  - All states use, but vary greatly in extent, target populations

- Allow states to provide range of services to individuals who meet state’s eligibility criteria for institutional care

- Allow states to control waiver spending
  - Can limit waiver enrollment, offer in specified geographic areas

- Typically designed for target populations
  - Older adults and people with disabilities (“aged and disabled”)
  - People with intellectual or developmental disabilities (“MR/DD”)
  - Other (e.g., HIV/AIDS, brain injury, mental illness, children)
Medicaid HCBS Waiver spending varies by enrollment groups

<table>
<thead>
<tr>
<th>Enrollees</th>
<th>Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older adults</td>
<td>50%</td>
</tr>
<tr>
<td>and people with disabilities</td>
<td>21%</td>
</tr>
<tr>
<td>People with intellectual/disdevelopmental disabilities</td>
<td>40%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: Ng, Harrington & O'Malley 2009; data are from fiscal year 2007.
Medicaid LTSS programs vary widely among states

Medicaid LTSS Spending per State Resident with Income Below 200% of Poverty Level

<table>
<thead>
<tr>
<th>Category</th>
<th>Average of 5 Highest States</th>
<th>U.S. Total</th>
<th>Average of 5 Lowest States</th>
<th>U.S. Total</th>
<th>Average of 5 Lowest States</th>
</tr>
</thead>
<tbody>
<tr>
<td>All LTSS</td>
<td>$2,478</td>
<td>$1,031</td>
<td>$508</td>
<td>$1,137</td>
<td>$383</td>
</tr>
<tr>
<td>Home and Community Based Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Feder, Komisar & Friedland 2007. Amounts shown are for fiscal year 2005.
Medicaid issues going forward

- Continued interest in expanding HCBS
  - Better “balance” between institutional services and HCBS
  - Consumer-directed care
  - Health reform law provides new options and financial incentives to states for expanding HCBS

- Tight state budgets
Sources


Sources continued


About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized research center dedicated to improving the health and social outcomes of vulnerable populations. Hilltop conducts research, analysis, and evaluation on behalf of government agencies, foundations, and other non-profit organizations at the national, state, and local levels.

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