



The Hilltop Institute

analysis to advance the health of vulnerable populations

Financing for Long-Term Services and Supports

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and the CLASS Act*
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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

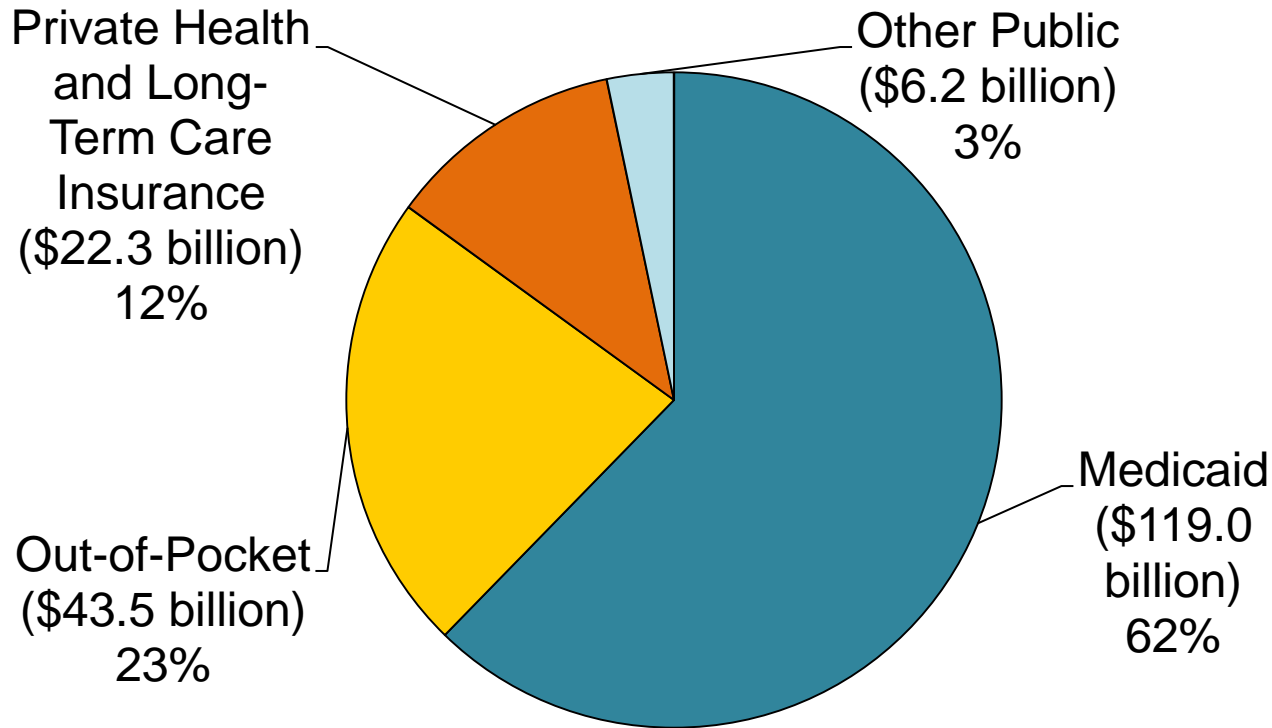
- Unpaid care (family and friends): Large role
- Private long-term care insurance: Few have it
- Medicare: Does not cover LTSS
 - Limited coverage of skilled nursing facility and home health for “post-acute” care
- Medicaid: Covers LTSS but is a “safety net”
 - Must meet income and asset criteria

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



Total in 2008 = \$191.1 billion

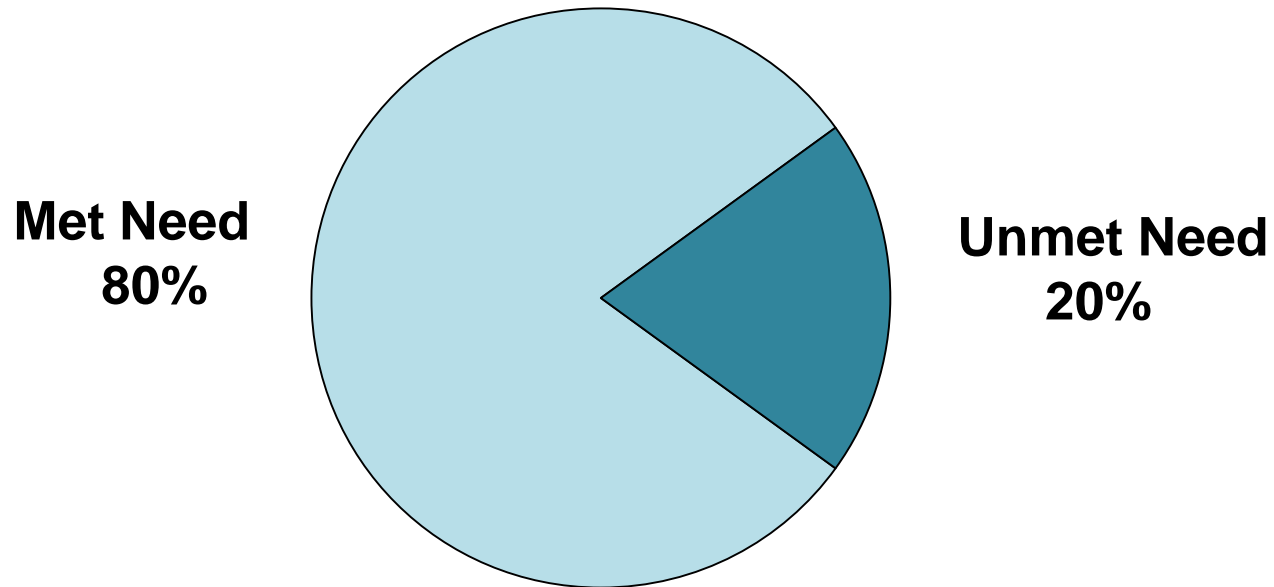
Source: O'Shaughnessy 2010.

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



Source: Feder, Komisar & Friedland 2007; based on data from 1994-1997.

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 LTCI
 - 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

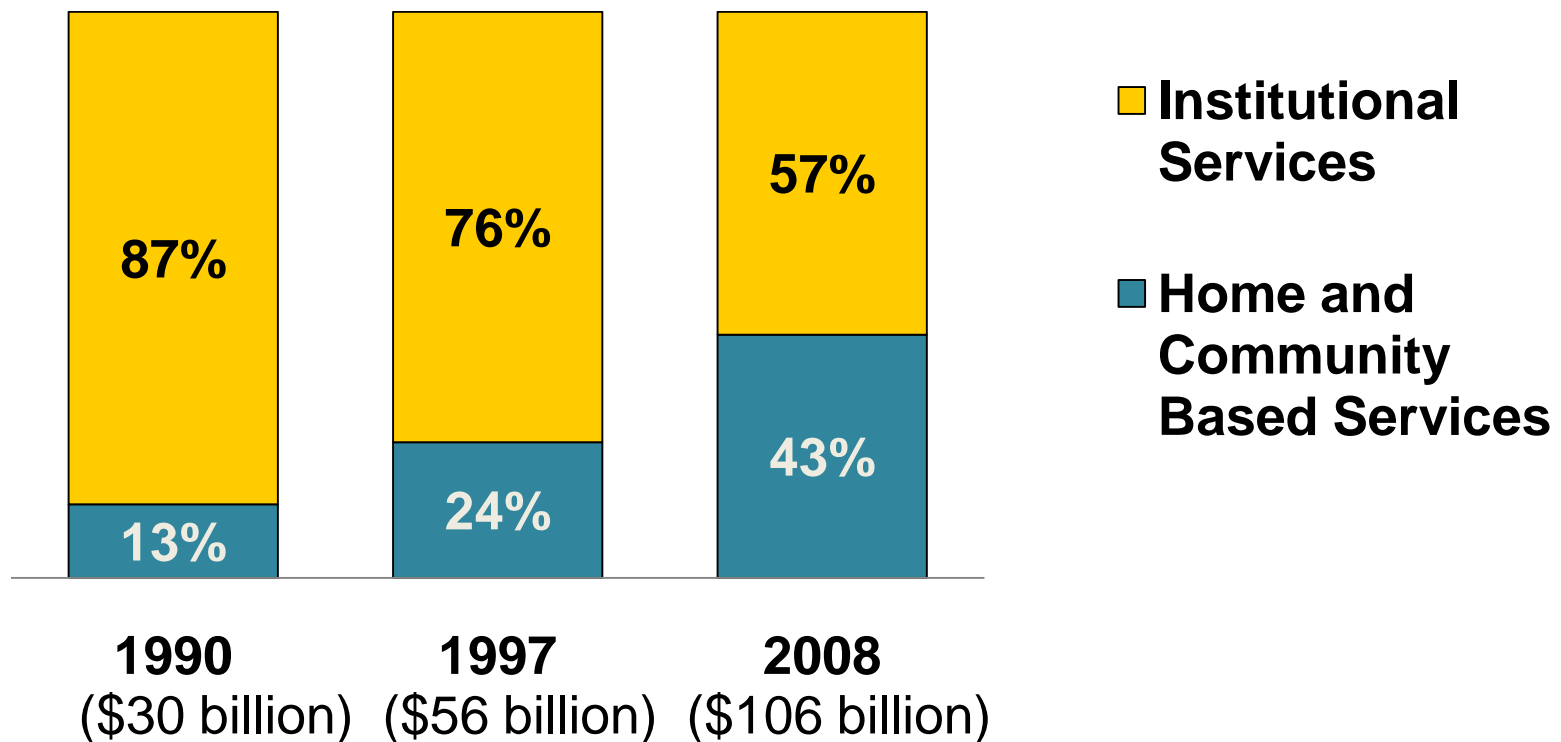
- Federal tax incentives, e.g.,
 - Itemized deduction of medical expenses, deduction for self-employed
 - Benefits exempt from taxation for qualified policies
- Information: Own Your Future campaign and National Clearinghouse for Long-Term Care website
- The Partnership for Long-Term Care program
 - “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

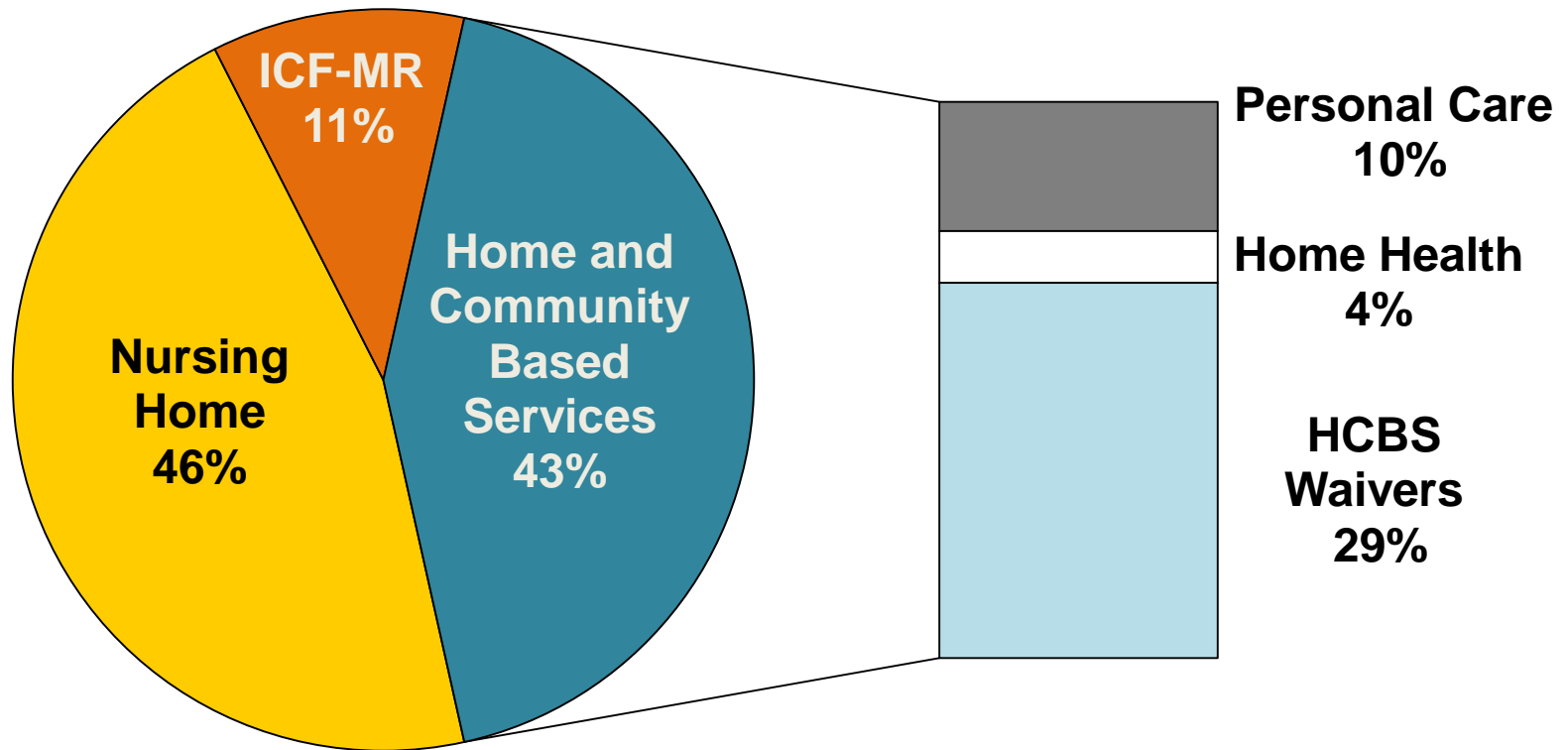
- Benefits
 - Nursing home services: all states must provide
 - Home and community based services (HCBS)
 - Home health: all states must provide
 - Personal care: optional (30 states)
 - HCBS waivers: optional (all states use to varying degrees)
- Eligibility
 - Income and assets criteria; functional criteria
- “Nursing home bias” in Medicaid

HCBS share of Medicaid LTSS spending has been growing



Source: Burwell, Sredl & Eiken 2009. Years are fiscal years.

Medicaid spending for LTSS, by type of service



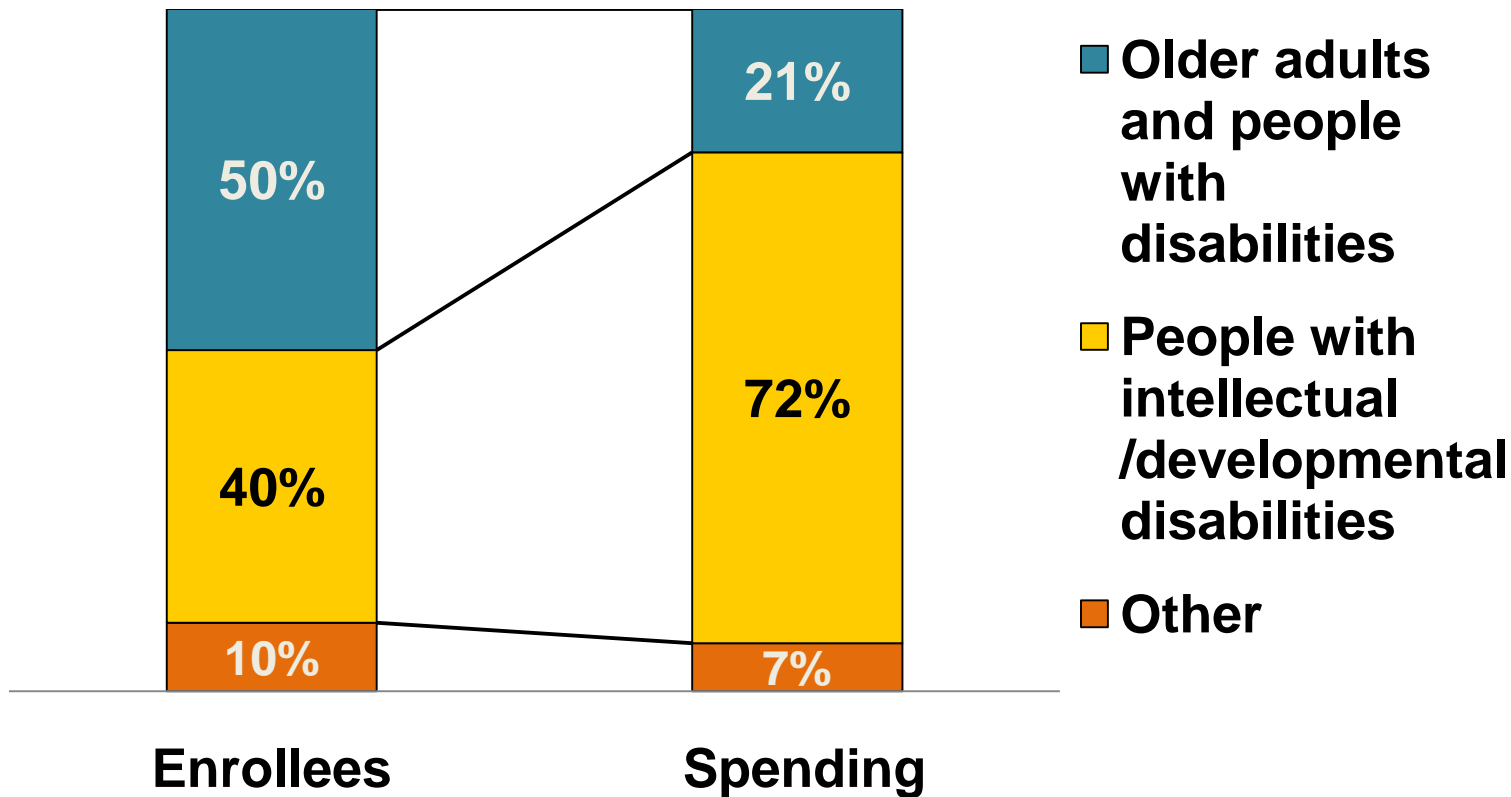
ICF-MR = intermediate care facilities for people with intellectual or developmental disabilities.

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)

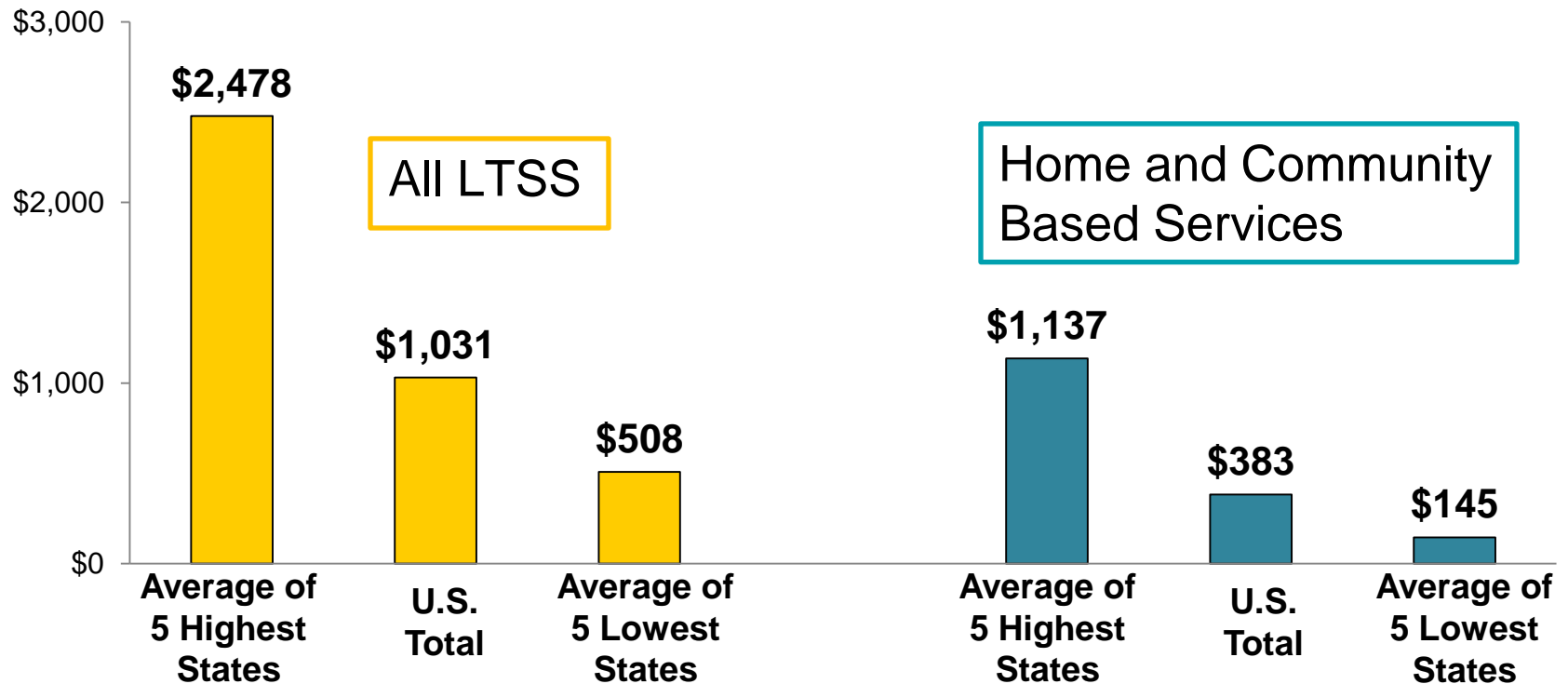
Medicaid HCBS Waiver spending varies by enrollment groups



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



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

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http://www.hcbs.org/moreInfo.php/nb/doc/2793/Medicaid_Long_Term_Care_Expenditures_FY_2008
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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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