Challenges in the Future of Long-Term Care

Testimony for the Senate Special Committee on Aging

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Chairman Kohl, Ranking Member Corker, and Members of the Committee thank you for the opportunity to be here today to discuss the demand for, cost, and financing of long-term care (LTC) services. Long-term care is the personal assistance that enables people who are physically or mentally impaired to perform daily routines (called Activities of Daily Living or ADLs) such as eating, bathing, and dressing. LTC is a pervasive part of the life cycle; an individual who turned 65 in 2005 has a nearly 70 percent chance of needing long-term care at some point in their lifetime.[1]

The provision of LTC will like increase, both absolutely and as a fraction of our economy, over the next 40 years. According to estimates of the Census Bureau, the number of elderly people (those ages 65 and older) in the United States will increase by two and a half times between 2000 and 2050. This is significant for LTC as 19 percent of seniors have some degree of chronic impairment. Among those aged 85 and older, impairment is even higher, 55 percent are impaired and need assistance with ADLs.[2]

Currently much of the LTC in the United States is supplied by spouses and adult children and labeled donated, or informal, care. However, demographic changes will reduce the supply of informal care. Smaller families, lower fertility rates, and increasing divorce rates may make donated LTC services less common in the future. The size of the average family has declined, reducing the number of adult children available to care for their elderly parents. Family size fell from 3.8 members in 1940 to 3.1 members in 2000; if current trends continue, it will decline to 2.8 people by 2040. At the same time, the rate at which women participate in the labor force will probably continue to grow, further reducing the availability of donated care. Those family-related trends, in sum, could further stimulate the demand for formal, or paid, services.

Paid LTC is very expensive. Although there is wide geographical variation for all long-term care costs, the 2012 Genworth Cost of Care Survey provides the most recent average costs: in 2012, nursing homes cost $81,030 for private rooms. Assisted living averages $39,600. Unskilled home health aides cost an average of $19 per hour and, for the average care time of 17 hours per week, annual costs are $16,800.

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[1] *Kemper, Komisar, and Alecxih, 2005-2006*

[2] Congressional Budget Office, *Financing Long-Term Care for the Elderly* (April 2004)

Paying for Long-Term Care

Because the informal caregivers are essentially payers as well as providers, they are an important source of financing costs. The donated care is very hard to quantify- but estimates range from $50 billion to $350 billion. The informal caregivers not only forego wages and therefore investment and retirement income for themselves, caregivers also suffer from higher rates of depression and other potentially expensive health problems.

Turning to formal care, Medicaid accounts for the highest percentage of paid care- roughly 50 percent.[3] Jointly funded by the federal and state governments, Medicaid is a means-tested program that pays for medical care for certain groups of people, including seniors with impairments who have low income or whose medical and LTC expenses are high enough that they allow those seniors to meet Medicaid's criteria for financial eligibility. Within broad federal guidelines, the states establish eligibility standards; determine the type, amount, duration, and scope of services; set the rate of payment; and administer their own programs. The share of each state's Medicaid expenditures that is paid by the federal government is determined by a statutory formula. Medicaid generally pays for services provided both in nursing facilities and in the home, although the specific benefits that the program provides differ from state to state, as do patterns of practice, the needs and preferences of beneficiaries, and the prices of services.

Many people who are not eligible for Medicaid while they live in the community become so immediately or shortly after being admitted to a nursing facility because of the high cost of institutional care. One study demonstrated that one-third of discharged nursing home patients who had been admitted as private-pay residents became eligible for Medicaid after exhausting their personal finances; nearly one-half of current residents had similarly qualified for coverage.[4] Medicaid coverage is especially common among nursing home patients who have been institutionalized for long periods.

State Medicaid directors have been given more flexibility in recent years to design their long-term care programs to help seniors stay in their homes as long as possible, by allowing payment for non-traditional services such as home modifications. This has caused spending on home-based services to rise faster than spending on institutional services but leads to lower aggregate spending and patients generally prefer to stay in their homes as long as possible.

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[3] Congressional Research Service. "*Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress"(2011)*

[4] Joshua M. Wiener, Catherine M. Sullivan, and Jason Skaggs, *Spending Down to Medicaid: New Data on the Role of Medicaid in Paying for Nursing Home Care* (Washington, D.C.: AARP Public Policy Institute, June 1996)

Medicare, the health insurance entitlement for those ages 65 and over, covers some services considered LTC as well. Medicare pays roughly 23 percent of aggregate long-term care costs.[5] However, while Medicare pays for nursing home stays after acute episodes and has home health benefit providing post-acute care and skilled services to homebound seniors, it does not cover the ongoing, unskilled care and assistance with the Activities of Daily Living that many seniors need for an indefinite period of time.

The remainder of paid long-term care is provided by out of pocket spending (20 percent) and private long-term care insurance (7 percent).[6] The data on private LTC insurance generally capture payments that insurers make directly to providers but do not always pick up insurers' reimbursements to policyholders for covered services that policyholders initially pay for out of pocket. Thus, estimates of LTC insurance payments—and of out-of-pocket spending—should be interpreted with caution because the former may be underestimated and the latter overestimated.

The Future of Financing LTC

The picture that emerges is one in which an increasing demand for LTC services will arise over the next several decades. At the same time, the dominant form of provision and payment – informal care – will be squeezed by demographic and labor market trends. The result will be a relative shift toward paid care.

But who will pay?

To date, the answer has not been private LTC insurance. Exactly why is a bit of a mystery since since insurance is used as the dominant solution for both health care and disability costs. While a large part of that may have to do with "crowd-out" from Medicaid (see below), there may be as well a disconnect between the likelihood of needing long-term care and people's beliefs about their risk. Adults are largely unaware of their future LTC needs and do not adequately prepare for them. They are also surprised to find out just how expensive it is. Other adults are under the false impression that if they get sick and need constant care, that Medicare will cover it.

At the same time, it appears unwise to reflexively add a new LTC payment stream to the demands facing the U.S. taxpayer. At present, we face both a sluggish economy and rapidly escalating health care costs. The US currently runs annual deficits of over one trillion and

[5] Congressional Research Service. "*Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress"(2011)*

[6] Congressional Research Service. "*Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress"(2011)*

our national debt is over $15 trillion. This is not the time when we can afford to dramatically expand our health insurance entitlement programs. The current mix of financing for LTC, in which a significant share of financing comes from government programs, already adds to the pressures that the federal budget will experience with the aging of the baby-boom generation. Contributing to the strains that government LTC programs will face are incentives created by those programs that diminish the attractiveness of using private resources—especially private insurance—as a means for seniors to finance their care.

Medicare is quickly becoming insolvent and there is substantial concern about how the program will cover just the medical care needs of the baby boomers, let alone their LTC needs. Medicaid, which is scheduled to dramatically expand enrollment as a result of the Affordable Care Act, is already placing more and more pressure on state budgets and eating into funding for education, infrastructure and other necessary programs.

In addition, because Medicaid and Medicare both generally pay lower fees for services than those paid by private payers, beneficiaries may not receive the same quality of care that private policyholders receive. Both entitlement programs are less flexible in the types of services they cover as private insurance would be; a person who has private coverage has a broader choice of providers and types of care than an individual on Medicare or Medicaid. Furthermore, both Medicare and Medicaid do not make adequate use of lower cost settings to provide care. Generally home health is less expensive and preferred by patients; however we continue to spend billions on institutional care.

In contrast, private long-term care insurance (LTCI) pays out a daily benefit and the beneficiary can choose to spend that money on the care that best meets their needs. 43 percent of private LTCI beneficiaries choose to spend their benefits on home care, 35 percent use the benefits for assisted living and only 25 percent chose nursing homes.[7] Seniors with functional limitations are not a one-size-fits-all population. They have diverse health needs, differing abilities, and varying amounts of support from their spouse, family or community. LTCI not only offers many options, these are also associated with care management that assists caregivers in implementing and monitoring an individualized plan of care. The individual is best served by a flexible program tailored to their unique situation.

[7] American Association for Long-Term Care Insurance, 2008 LTCi Sourcebook.

Long-Term Care Insurance

As mentioned above, LTCI pays only 7 percent of aggregate long-term care costs in the US, as fewer than 10 percent of adults hold a policy.[8] Policyholders typically become eligible to collect benefits when they reach a specific minimum level of impairment, usually defined as being unable to perform two or three Activities of Daily Living (ADLs) or having a cognitive impairment significant enough to warrant substantial supervision. The vast majority of plans pay over $100 per day and 21.5 percent pay over $200 per day.[9]

The majority of Americans with health insurance coverage are insured on group policies provided by their employer. Unlike health insurance, LTCI is largely an individual market although employers are increasingly offering employees LTCI benefits. In the 1990's, employer-sponsored LTCI represented less than 3 percent of all policies but by 2007 they had grown to one-third of the market.[10] Federal government employees are one of the largest purchasers of large group LTCI through an employer-sponsored group LTCI plan. Indeed, employer-sponsored is a somewhat misleading term as employers usually do not contribute to the premiums. Employees can take advantage of the larger group pooling for discounted premiums but most often pay 100 percent of the cost.

The LTCI market has been consolidating rapidly in the last decade. While previously there were over 100 firms selling LTCI, the market dropped to 45 companies in 2006, with only 10 firms selling over 80 percent of all new policies.[11] The LTCI companies are diversifying their products and creating new hybrid policies that combine with annuity income or life insurance. Long-term care insurance is not a one-sized fits all market. In fact, the Pension Protection Act of 2006 created tax incentives permitting long term care coverage to be offered as a component of life insurance and annuities. Such products are expected to have strong appeal with retiring members of the baby-boom generation.

Challenges for the LTCI Market:

Challenges exist for LTCI market on both the supply and demand side. On the supply side, the key appears to be broader use of purchase through employers. The costs of marketing to and enrolling groups are about half those for individuals. On average, administrative costs as a percentage of premiums are likely to fall in the future as group policies make up a

[8] Congressional Research Service. "*Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress"(2011)*
[9] American Association for Long-Term Care Insurance, 2008 LTCi Sourcebook.
[10] Congressional Research Service. "*Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress"(2011)*
[11] Congressional Research Service. "*Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress"(2011)*

larger share of the private LTC insurance market. A second challenge in the current environment is the low rate of return on reserves, which is likely to be resolved only through better macroeconomic performance.

There are also significant issues with demand for LTCI. Certainly, cost is a factor. Additionally, LTCI may be unattractive to some consumers because it does not, in general, insure against the risk of significant price increases for long-term care. Most policies promise to provide contractually specified cash benefits in the event that a policyholder becomes impaired. To protect themselves against LTC price inflation, consumers can purchase a rider to their policy under which the policy's benefits grow at a specified rate each year (usually 5 percent); however, such riders offer no protection against additional costs if prices rise at a faster pace. Concerns about price increases of that kind are not unjustified: Medicaid's average reimbursement rates for nursing facilities grew at an average annual rate of 6.7 percent from 1979 to 2001.[12]

Although Medicaid's coverage differs in many respects from that of private insurance, it nevertheless reduces the demand for private policies. Research has shown that the availability of Medicaid constitutes a substantial deterrent to the purchase of private insurance, even for people at relatively high income levels.[13] Medicaid's rules for financial eligibility affect people's decisions to purchase private LTC insurance as well as how much insurance they buy because the rules offer a low-cost alternative (by allowing people to qualify for the program's benefits) to making personal financial preparations for possible future impairment. People who buy private insurance or accumulate savings substantially reduce the probability that they will ever qualify for Medicaid's benefits, thereby forgoing the value of the government provided benefits that they might otherwise have obtained. Thus, the availability of Medicaid raises the perceived cost of purchasing private insurance or of saving. That increase is small for relatively wealthy people who have little likelihood of ever qualifying for Medicaid coverage, but it can be substantial for others. One study in particular found that the availability of Medicaid was a key factor for why two-thirds of the wealth spectrum did not hold a LTCI policy.[14]

Since private LTCI insurance is largely an individual market, it is not a tax-free benefit like employer provided health insurance. While employer provided LTCI benefits are treated by the federal tax code as untaxed income, very few employers who offer LTCI plans

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[12] Congressional Budget Office, *Financing Long-Term Care for the Elderly* (April 2004)

[13] Jeffrey R. Brown and Amy Finkelstein, *The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market*, Working Paper No. 10989 (Cambridge, Mass.: National Bureau of Economic Research, December 2004).

[14] Jeffrey R. Brown and Amy Finkelstein, *The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market*, Working Paper No. 10989 (Cambridge, Mass.: National Bureau of Economic Research, December 2004).

contribute to them. States vary in their tax treatment, with some providing tax deductions or credits to individuals or tax credits to employers who offer policies. However, with state income tax being generally low, these benefits do not appear to make a large difference in the decision to purchase or forego long-term care insurance.

Reform Options

There are several options for increasing LTCI participation rates. One program that has been successful is the "Long-Term Care Partnership Program." It was originally crafted in the 1980s, halted in 1993 and re-started in 2006.[15] This demonstration project was designed to make private LTCI more desirable by altering Medicaid eligibility rules for those holding policies that cover up to a certain dollar-amount of benefits. If further benefits were needed, the policyholder became eligible for Medicaid without the stringent spend-down requirements. For example, the program allows individuals who hold a policy with $150,000 to become eligible for Medicaid with $150,000 of their assets protected from the traditional asset test.[16]

Another option would be to incentivize LTCI via the tax code. While states have had modest success, a federally implemented tax deduction or tax credit may be more effective at incentivizing individuals to purchase policies. These options included cafeteria plans and the use of flexible spending accounts to cover LTCI. Additionally, as the market has been so limited by Medicaid crowd-out, tightening the limits for Medicaid eligibility may drive more demand for private policies.

In any case, the public clearly needs additional information about this issue. The public is woefully unaware of their likelihood of needing LTC at some point in their life. Among those that acknowledge that they may need ongoing care, many mistakenly assume they are covered by Medicare or supplemental insurance or believe their families will be able to care for them. Generally the country is uneducated about the costs of paid care and is likely to be unaware of what LTCI products exist and how the benefits work. Thus education and better retirement planning resources are an integral part of any reforms that aim to boost LTCI use. The LTC Information Clearing House is the only federal funding for LTC awareness and planning; spending only $3 million annually.

Conclusion

[15] The National Conference of State Legislatures, *A Guide to Long-Term Care for State Policy Makers: The Long-Term Care Partnership Program* http://www.ncsl.org/issues-research/health/archive-the-long-term-care-partnership-program.aspx

[16] The National Conference of State Legislatures, *A Guide to Long-Term Care for State Policy Makers: The Long-Term Care Partnership Program* http://www.ncsl.org/issues-research/health/archive-the-long-term-care-partnership-program.aspx

Currently, elderly people finance LTC services from various sources, including both private resources and government programs. Incentives inherent in the current financing structure have led to increased reliance on and spending by government programs and may have discouraged people from relying on private resources (savings, private LTC insurance, and donated care) to prepare for potential future impairment. The demographic changes projected for the coming decades will bring increased demand for long-term care and heightened budgetary strains.

Expanding the entitlement programs is not the answer-instead we need to look to the potential of a larger and more robust private long-term care insurance market, a mechanism we rely on for nearly all other healthcare financing. A LTCI market allows for both flexibility in the plan selection and, if needed, utilization of plan benefits to their unique medical needs, financial reality and family situation. A successful solution in this vein would return Medicare and Medicaid to their original functions, to provide medical care and a safety net, respectively.