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Financing Long-Term Care for the Elderly

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PAPER

Financing Long-Term Care for the Elderly

April 2004

The Congress of the United States ■ Congressional Budget Office

Notes

Numbers in the text and tables of this report may not add up to totals because of rounding.

All years are calendar years unless otherwise noted.

Preface

Over the next several decades, the population of U.S. seniors—people aged 65 and older—is expected to grow rapidly, more than doubling by 2040 while the population as a whole grows by about one-third. That surge will probably produce a similar increase in the demand for long-term care (LTC) services—the personal assistance that enables people who are impaired to perform daily routines such as eating, bathing, and dressing. Today, seniors finance such services from a variety of sources, including personal savings, care donated by friends and family, private insurance, and public programs such as Medicaid and Medicare. This Congressional Budget Office (CBO) paper—prepared at the request of the House Budget Committee—summarizes the current state of financing for long-term care, identifies some of the issues affecting it both now and in the future, and considers policy alternatives that address the mix of private and governmental sources of financing for LTC costs. In keeping with CBO's mandate to provide objective, impartial analysis, this report contains no recommendations.

Stuart Hagen of CBO's Health and Human Resources Division prepared the paper under the supervision of Steve Lieberman and James Baumgardner. The paper benefited from comments by Carol O'Shaughnessy and Julie Stone of the Congressional Research Service, Brenda Spillman and Joshua M. Wiener of the Urban Institute, Harriet Komisar of Georgetown University, and Jeffrey R. Brown of the University of Illinois at Urbana-Champaign.

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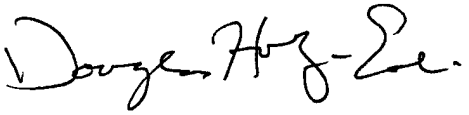


Douglas Holtz-Eakin
Director

April 2004

CONTENTS

Summary *ix*

1

The Current Context of Long-Term Care Financing *1*
Personal Resources *2*
Public Long-Term Care Insurance Programs *5*
The Income Standard *6*
The Asset Standard *7*
Income and Asset Rules for Married Couples *7*

2

Major Issues in the Financing of Long-Term Care *13*
Demographic Trends Affecting the Demand for Long-Term Care Insurance *13*
Factors Affecting the Demand for Private Insurance *16*

3

Policy Approaches to Long-Term Care Financing *23*
Restrict Growth in Long-Term Care Spending by Medicaid and Medicare *23*
Expand Medicaid Eligibility *24*
Expand Benefits Under Medicare *24*
Establish Tax Credits for Impaired People *25*
Improve the Functioning of the Market for Private Long-Term Care Insurance *27*

A **An Overview of Long-Term Care Services** *33*

B **Recent Policy Initiatives Affecting Long-Term Care Financing** *37*

Tables

S-1.	Primary Financing Sources for Care of Elderly Nursing Home Residents, 1997	xi
1-1.	Impaired Elderly People, by Level of Impairment and Sources of Assistance, 1994	4
1-2.	Long-Term Care Expenditures for the Elderly, by Source of Payment, 2004	5
1-3.	Average Annual Premiums for Private Long-Term Care Insurance, 2002	8
2-1.	Probability of Nursing Home Use by Elderly People Over Their Remaining Lifetime	15
3-1.	Average Annual Premiums for Policies of the Partnership for Long-Term Care, 2004	30
A-1.	Elderly Nursing Home Residents, by Age and Sex, 1997	34
A-2.	Average Length of Stay of Current Elderly Nursing Home Residents, by Age and Sex, 1997	34
A-3.	Average Length of Stay of Discharged Elderly Nursing Home Residents, October 1996 to September 1997	35
A-4.	Average Duration of Care of Elderly Home Health Care Patients, 1996	35
A-5.	Elderly Home Health Care Patients, by Age and Sex, 1996	36

Figures

S-1	Estimated Percentage Shares of Spending on Long-Term Care for the Elderly, 2004	x
S-2	Percentage of Households with Seniors, by Seniors' Nonhousing Net Worth, 2000	xii
1-1.	Estimated Percentage Shares of Spending on Long-Term Care for the Elderly, 2004	3
1-2.	Long-Term Care Insurance Policies Sold, 1988 to 2001	5
1-3.	Average Medicaid Payments for Long-Term Care, Selected States, Fiscal Year 2000	9
1-4.	Medicaid's Expenditures on Long-Term Care for Elderly Beneficiaries, Fiscal Years 1992 to 2004	10
1-5.	Medicare's Expenditures on Long-Term Care for Elderly Beneficiaries, Fiscal Years 1992 to 2004	11

1-6. Average Medicare Payments for Long-Term Care, Selected States, Fiscal Year 2001 12

2-1. People Aged 65 and Older as a Share of the U.S. Population, Selected Years, 1900 to 2050 14

2-2. CBO's Projections of Impaired Seniors as a Share of the Elderly Population, 2000 to 2040 15

2-3. Average Family Size, 1940 to 2040 18

Boxes

1-1. Activities of Daily Living and Instrumental Activities of Daily Living 2

1-2. Financial Eligibility Requirements for Medicaid Coverage 6

2-1. Long-Term Care Expenditures for Nonelderly People 16

3-1. Expanding Public Programs That Finance Long-Term Care 24

3-2. Comparing the Financial Impacts of a Partnership Policy and Other Insurance Options 28

Summary

Preparing for the possible costs of future impairment and long-term care is a task that everyone faces as they age. The probability of losses in physical functioning increases with age—dramatically so for the population aged 65 and older. About 19 percent of seniors experience some degree of chronic physical impairment. Among the very old, those aged 85 or older, the proportion of people who are impaired and require long-term care (LTC)—the personal assistance that enables impaired people to perform daily routines such as eating, bathing, and dressing—is about 55 percent.

Losses in a person's ability to function day to day is a natural part of the aging process, and those losses become more severe as people get older. Impaired people who need long-term care usually need it for a long time—in some cases, until they die. But people may also use the same kinds of services constituting long-term care for relatively short periods, such as during their convalescence from a hospitalization or from an injury or illness. That characteristic of LTC services tends to complicate an understanding of the issues related to LTC financing. For example, health insurers cover certain long-term care services, such as home health care, to aid beneficiaries in recovering from specific medical events. But they generally do not cover LTC services that are needed because of either nonspecific causes related to old age or as a result of chronic, or "long-term," impairment.

Currently, elderly people finance LTC services from a variety of sources including private resources—personal savings, care donated by friends and family, and LTC insurance—and with assistance from public programs such as Medicaid and Medicare. Incentives inherent in that financing structure have led to increased reliance on—and spending by—those public programs and may have discouraged seniors and younger Americans from purchasing LTC insurance to pay for their care. In recent years, lawmakers have implemented various policies (for example, tax-advantaged treatment of the premiums for LTC insurance) to help people pay for their long-term care; they have also instituted incremental reforms of public LTC financing programs to control costs and improve the programs' effectiveness. But the demographic changes projected for the coming decades—in particular, the growing shares of the population accounted for by seniors and the very old as well as alterations in the structure of families—raise doubts about whether the current distribution of LTC financing and the incentives those financing sources include can support increased demand for long-term care without heightening budgetary strains.

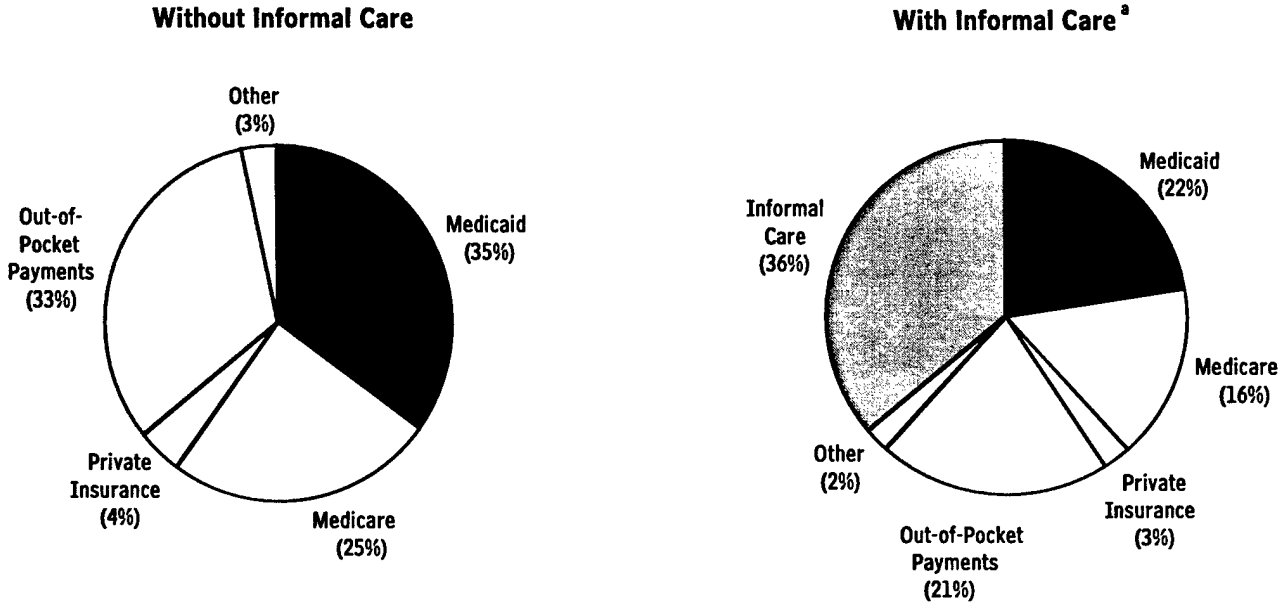
The Current Context of Long-Term Care Financing

A person preparing for possible future long-term care needs has several options from which to choose. One alternative is to "self-insure" by setting aside personal savings and assets and then supplementing those personal resources with the donated, or free, care of family and friends. In fact, the majority of impaired seniors rely solely on donated care and their own savings. The value of donated care probably exceeds that of any other category of LTC financing but is difficult to quantify in dollar terms. In 2004, out-of-pocket spending (excluding donated care) is expected to account for about one-third of total estimated LTC expenditures (see Summary Figure 1). The Congressional Budget Office (CBO) estimates that total expenditures for LTC services for the elderly in 2004—excluding the value of donated care—will total about $135 billion, or roughly $15,000 per impaired senior.

An individual who self-insures retains maximum flexibility and control over his or her savings and assets but must bear the full financial risk of impairment, which will depend on the extent and duration of functional losses. Sig-

Summary Figure 1.

Estimated Percentage Shares of Spending on Long-Term Care for the Elderly, 2004



Source: Congressional Budget Office.

a. Values are calculated on the basis of how much such care would cost if it were provided through formal means. Estimates are from Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Administration on Aging, *Informal Caregiving: Compassion in Action* (June 1998), inflated to 2004 dollars.

nificant impairment can leave little, if any, wealth for bequests or other uses. Nursing home care in 2003, for example, cost an average of $181 per day for a private room (or about $66,000 annually); a visit by a home health aide averaged $18 per hour.

Seniors in general are not well prepared to pay for their long-term care needs. In 2000, for instance, only about 7 percent of seniors had income in excess of $50,000 (about the cost then of a year's stay in a nursing home).[1] In 1997, more than half of nursing home residents were poor enough to qualify for Medicaid coverage (see Summary Table 1). Apart from their housing wealth, most seniors have only a modest amount of savings (see Summary Figure 2).

Given the financial consequences of impairment, some people may prefer to pay a certain, smaller amount rather than bear the risk of a potentially large financial loss, and they can do so by purchasing private long-term care insurance. Purchasing insurance allows people to share the risk of needing long-term care with other people who have a similar "risk profile" (a generally similar likelihood of requiring care). In 2004, spending from private LTC insurance, which is a relatively new insurance product, is expected to account for about $6 billion, or 4 percent, of total LTC expenditures. That share could grow in the future as more people purchase private coverage and current policyholders become impaired and draw on their benefits.

Underlying the set of decisions a person makes in preparing financially for future long-term care needs is the availability of publicly funded programs for long-term care, primarily Medicare and Medicaid. In 2004, the portion of total LTC expenditures attributable to those two programs together is likely to reach nearly 60 percent. Medicare does not cover long-term care per se but has become a de facto LTC financier through its coverage of care in skilled nursing facilities (following hospitalization) and its home health care benefit. Medicaid is the dominant

1. CBO's calculations were based on U.S. income tax data for 2000. See also CBO's publication *Baby Boomers' Retirement Prospects: An Overview* (November 2003).

Summary Table 1.

Primary Financing Sources for Care of Elderly Nursing Home Residents, 1997

Payment Source[a]	As a Percentage of All Residents
Medicaid	56.1
Medicare	15.1
Other Government Assistance and Charity	2.0
Private Insurance and Other Personal Sources	26.0
Unknown	0.9

Source: Congressional Budget Office based on Celia S. Gabrel, *Characteristics of Elderly Nursing Home Current Residents and Discharges: Data from the 1997 National Nursing Home Survey,* Advance Data no. 312 (Centers for Disease Control and Prevention, National Center for Health Statistics, April 25, 2000).

a. Residents' financing as of one month before being interviewed.

public insurance program for long-term care. Not only does it cover the care of people with very low income, but its eligibility rules permit middle-income people—even seniors whose income in retirement leaves them fairly comfortable—to qualify for coverage by exhausting, or "spending down," their income and assets. Thus, people who fail to make their own preparations for long-term care needs can eventually qualify for Medicaid if they become impaired.

Major Issues in the Financing of Long-Term Care

Future demographic changes are likely to result in increased demand for long-term care, placing growing fiscal pressure on the public programs that pay for much of it today. Those changes may also indirectly affect informal care by reducing the number of people who might provide LTC services. In addition, the current financing structure creates incentives that discourage people from preparing to finance their own care, encouraging them to rely instead on public LTC insurance.

Demographic Factors Affecting the Demand for Long-Term Care Insurance

As the aging of the baby-boom generation causes seniors' share of the population to rise from 12.6 percent in 2000 to 20.5 percent in 2040, the demand for long-term care services is virtually certain to increase. Part of the basis for that expectation is that the share of people aged 85 and older—those with the greatest probability of using long-term care—is projected to grow from 1.6 percent in 2000 to 3.8 percent in 2040. The population's aging will also cause a decline in the share of the population who are of working age—and who pay the bulk of the taxes that support public programs for the elderly. In 2000, the ratio of people of working age to people of retirement age was 4.7. In 2040, that ratio is forecast to fall to 2.6.

Other projected demographic changes may also influence aspects of private LTC financing. Life expectancy is continuing to rise, which implies that people may require long-term care for longer periods. Also, families are expected to be smaller in 2040 than they are today, and if current trends continue, a greater proportion of women may be in the labor force. That change could make informal care less available (women provide the majority of such care) and thus place additional pressure on public and other private sources of LTC services.

Factors Affecting the Demand for Private Long-Term Care Insurance

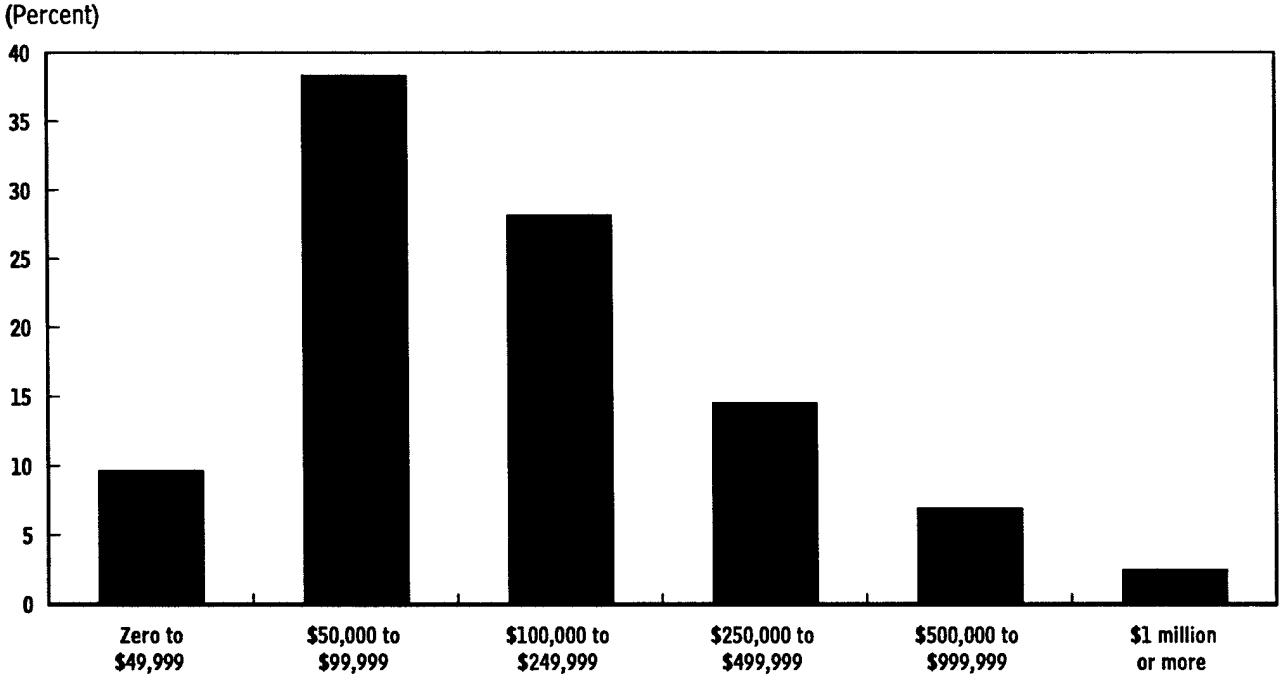
Several factors may be contributing to the relatively modest share of LTC financing provided by private insurance. The availability of Medicaid is a significant element; other factors include the inability to insure against certain risks associated with long-term care and potential adverse selection in the LTC insurance market.

The availability of Medicaid benefits for long-term care skews people's decisions about purchasing private coverage. Many people who believe that they could meet the financial qualifications for Medicaid may view it as a substitute for private insurance. The public coverage that Medicaid provides is not a perfect substitute; for example, it does not protect a person's wealth (people are generally obliged to exhaust their own resources before becoming eligible for coverage) and may not be able to provide the same quality of care and array of choices that would be available to someone with private LTC insurance. But many people may prefer to accept those drawbacks rather than pay premiums for private insurance.

Medicaid's free coverage may also deter people from purchasing private insurance even if they do want to protect their assets or secure higher-quality care than they could receive through Medicaid. Medicaid is a means-tested program; people who set aside savings or obtain private insurance cannot qualify for benefits for as long as their

Summary Figure 2.

Percentage of Households with Seniors, by Seniors' Nonhousing Net Worth, 2000



Source: Congressional Budget Office based on the Census Bureau's 1996 Survey of Income and Program Participation (updated to 2000 dollars).

private resources last. The more people save or the more insurance they purchase, the less likely they are ever to qualify for Medicaid benefits. Thus, people who buy insurance pay more than just the premiums; they also give up the value of future Medicaid benefits for which they might have been eligible.

People may find private LTC insurance unattractive because it does not protect them against certain kinds of risks pertinent to long-term care. Most important, a typical policy does not guarantee that policyholders' benefits will be large enough to allow them to purchase the services they desire if they need care at some point in the future. Insurers cannot accurately forecast LTC costs 20 or 30 years from now. Consumers can obtain a degree of protection from inflation in medical costs by purchasing coverage that increases annually at a specified rate—typically 5 percent. But there is no insurance against the additional risk that prices might grow at a faster pace. Another risk that insurance cannot protect consumers from is the possibility that the insurance carrier itself will not be in business in the future, when the benefits may be needed. (The states afford some protection against that risk by requiring insurance carriers to meet certain financial criteria intended, in part, to reduce the risk of future insolvency.) In both those respects, Medicaid may compare favorably with private insurance: it pays for a defined set of LTC services instead of providing a monetary benefit and, in spite of future budgetary pressures, many people may perceive the risk of its not providing services many years into the future as less than that of private insurance. A drawback to Medicaid coverage, however, is that its benefits could be reduced if budgets are strained.

Finally, the consequences of adverse selection may also discourage people from purchasing private insurance. Many people who buy private LTC policies in today's market do so because they expect to use LTC insurance someday, and policies' premiums might reflect that probability. If premiums are higher because of adverse selection, they could dissuade individuals who expect to have relatively good health in the future from purchasing coverage, even though those individuals may wish to do so.

Policy Approaches to Long-Term Care Financing

Policy approaches are available that could address the structure of LTC financing in the face of expected demographic trends and alter incentives that negatively affect the market for private LTC insurance. Alternatives include restricting growth in spending for long-term care by federal programs and improving the functioning of the market for private insurance. Although those policies would affect the future distribution of expenditures for long-term care, including federal spending, they are not likely to significantly affect the total resources, both private and public, that are devoted to LTC services. Some modest savings in total expenditures might be achieved by improving the efficiency with which services are provided, and many such efforts have been made in public-sector programs. Those efficiencies, however, are likely to be overshadowed by future demographic changes.[2]

Restrict Growth in Long-Term Care Spending by Medicaid and Medicare

Growth in future LTC expenditures by the major federal health financing programs could be constrained by placing additional limits on eligibility for Medicaid coverage and restricting the services covered under Medicare's home health care benefit. Restricting growth in those programs' LTC expenditures would address both the fiscal strain on government budgets brought about by the population's aging and the low levels of participation in the private LTC insurance market. As people's expectations about federal assistance changed, they might purchase private LTC insurance or set aside additional savings to prepare for the possibility of future long-term care needs. The adjustments in the program's benefits could be phased in over an extended period to allow people time to appropriately adjust their long-range financial plans.

Restricting growth in Medicaid and Medicare spending would shift some costs from the public to the private sector, although such constraints would probably not have more than a marginal effect on total spending for LTC-services. If people either had to wait longer to qualify for Medicaid than they would under current law or could not get coverage from either Medicaid or Medicare for the cost of their care, they would probably monitor the cost of their services more closely and limit the number and kinds that they purchased. Reducing the amount of public assistance might also shift some of the cost of care to LTC providers, primarily nursing homes, in the form of charity care and bad-debt expense, and perhaps to friends and relatives, who would either have to pay for the care themselves or provide it informally.

Improve the Functioning of the Market for Private Long-Term Care Insurance

Improving the private market's functioning could offer better alternatives for financing possible long-term care needs as people prepared for old age. Private insurance could be made more attractive to consumers by standardizing insurance policies to allow competing policies to be more easily compared and by taking steps to remove or lessen what is sometimes termed Medicaid crowd-out—the dampening effect that the availability of Medicaid's LTC benefits has on sales of private LTC insurance policies.

State insurance regulations do not require insurance carriers to offer policies that conform to particular design standards, except to the extent that the policies must comply with certain consumer protection requirements. Moreover, insurance companies offer a variety of policies with differing features so that consumers frequently find it difficult to compare the premiums of one carrier with those of any other. On the one hand, requiring carriers to offer policies that met a set of standard designs to enable consumers to compare them could stimulate price competition among insurers and help keep premiums lower than they would otherwise be. On the other hand, imposing standard policy designs on the private LTC insurance market could backfire if it hampered carriers' flexibility in adapting to changes both in the provision of long-term care and in the varying preferences of consumers who are considering buying coverage.

One method for reducing Medicaid's impact on sales of private LTC insurance would be to allow consumers to purchase a policy that supplemented Medicaid coverage and thus obtain the advantages of both private and public financing. The Partnership for Long-Term Care, which currently operates in four states does just that. In those states, consumers may purchase private insurance policies

2. Specific initiatives aimed at improving the efficiency of LTC services financed through federal programs are not a major focus of this paper, although they are described in Appendix B.

to cover the first one to three years of LTC benefits. When their private coverage expires, they apply for Medicaid coverage—just as they would have if they had had no coverage—but they do not have to spend down their assets except to the extent that the assets exceed the value of their LTC insurance benefits.

Supplemental coverage would enable purchasers to improve the quality of their LTC coverage without having to surrender their Medicaid benefits. However, private insurance that supplemented Medicaid coverage would not be likely to reduce the federal government's expenditures and might instead increase them.

CHAPTER

1

The Current Context of Long-Term Care Financing

With the aging of the baby-boom generation, the United States' elderly population is expected to grow rapidly over the next several decades, more than doubling by 2040 while the population as a whole grows by about one-third. As people age, the likelihood increases—dramatically so for people aged 65 and older—that their ability to carry out certain basic physical functions will become impaired. (Impairment is measured on the basis of such activities; see Box 1-1.) The surge in the population of seniors is thus expected to increase the number of impaired people and in turn the demand for long-term care (LTC) services. Long-term care is the personal assistance that enables impaired people to perform daily routines such as eating, bathing, and dressing. Such services may be provided at home by family and friends, through home and community-based services such as home health care, personal care, and adult day care; or in institutional settings, such as nursing or residential care facilities (see Appendix A for more details).

The need for long-term care is already substantial, even without the coming demographic wave of elderly people. (Nonelderly people may also require such services; however, this report focuses on LTC services for seniors.) About 19 percent of seniors experience some degree of chronic physical impairment. Among the very old, those aged 85 or older, the proportion of people who are impaired is 55 percent.

Expenditures for LTC services are substantial as well: the Congressional Budget Office (CBO) estimates that spending on long-term care for the elderly in 2004 will total about $135 billion—or approximately $15,000 per impaired senior. Those funds come from two broad sources of financing: personal resources (consisting of out-of-pocket spending and private LTC insurance) and government programs—primarily Medicare and Medicaid.[1] Another significant source of financing is donated, or informal, care—significant, because most impaired seniors rely solely on services donated by family and friends and not on purchased services. If only services in which dollars change hands are taken into account, Medicaid and Medicare together are responsible for the majority of LTC expenditures (see Figure 1-1). If the total includes the dollar value of donated care, then personal resources are the main source of seniors' LTC financing.

That financing framework will experience pressures in coming years not only as a result of the rising number of impaired seniors but also because of other demographic trends—such as declining numbers of informal caregivers willing to donate their services. The current mix of LTC financing—and in particular the rules governing public programs—include incentives that both discourage people from making their own financial preparations for long-term care and encourage them to rely on that public LTC coverage. If left unchanged, those incentives will bring even more fiscal pressure to bear at a time when government programs for retirees are already facing potentially overwhelming forces.

This Congressional Budget Office paper summarizes the current sources of financing for long-term care and identifies some of the issues that arise under the current financing structure, in particular the factors that discourage people from securing private LTC insurance coverage. It also considers policy alternatives that address the mix

1. For a brief review of the history of federal policy for financing long-term care, see Richard Price, Carol O'Shaughnessy, and Bob Lyke, *Long-Term Care for the Elderly: Themes of Financing Reform,* CRS Report for Congress RL30062 (Congressional Research Service, January 15, 1999), pp. 4-6.

Box 1-1.

Activities of Daily Living and Instrumental Activities of Daily Living

The activities of daily living (ADLs) and the instrumental activities of daily living (IADLs) describe a broad array of physical functions that is used to determine whether a person can live without assistance. ADLs represent basic physical abilities—eating, getting in and out of bed, getting around inside the home, dressing, bathing, and using the toilet. IADLs represent functions necessary for living independently; they include doing heavy housework and laundry, preparing meals, shopping for groceries, getting around outside, getting to places that require either driving or taking public transportation, managing money, using the telephone, and taking medications.

State Medicaid programs, private long-term care insurers, and other programs that provide long-term care benefits typically use ADLs and IADLs to define losses in ability that may qualify an enrollee or policyholder for benefits. Usually, if people are unable to perform three or more ADLs, they qualify for benefits. Losses in the abilities measured by IADLs are part of the general clinical picture of whether people can function on their own but by themselves are not used to trigger benefits. IADLs indirectly measure cognition; however, they are not generally used to gauge cognitive impairment. Instead, insurers commonly pay benefits when an individual's cognitive impairment is so severe that supervision is required to protect the person's health and safety.

of private and governmental sources of financing for LTC costs.

Personal Resources

Most long-term care is provided through the personal resources of the impaired person who receives it. Many elderly people receive long-term care without exchanging formal payment for those services—that is, through care donated by family and friends. They also pay for a substantial amount of care out of pocket—such spending accounts for about one-third of total LTC payments.[2] Private insurance accounts for a very small share of spending today, but with the growing number of policies being purchased, that source of financing is likely to account for a larger proportion of expenditures in the future.

Informal Care

Most functionally impaired seniors who reside in the community, including those who are severely impaired (unable to perform at least four activities of daily living, or ADLs), rely entirely on donated care from friends and family (see Table 1-1). And even many people who do pay for care in their home rely on some informal services as well. Donated care is most common among lower-income groups and among seniors who live close to people willing to provide it, such as family members.

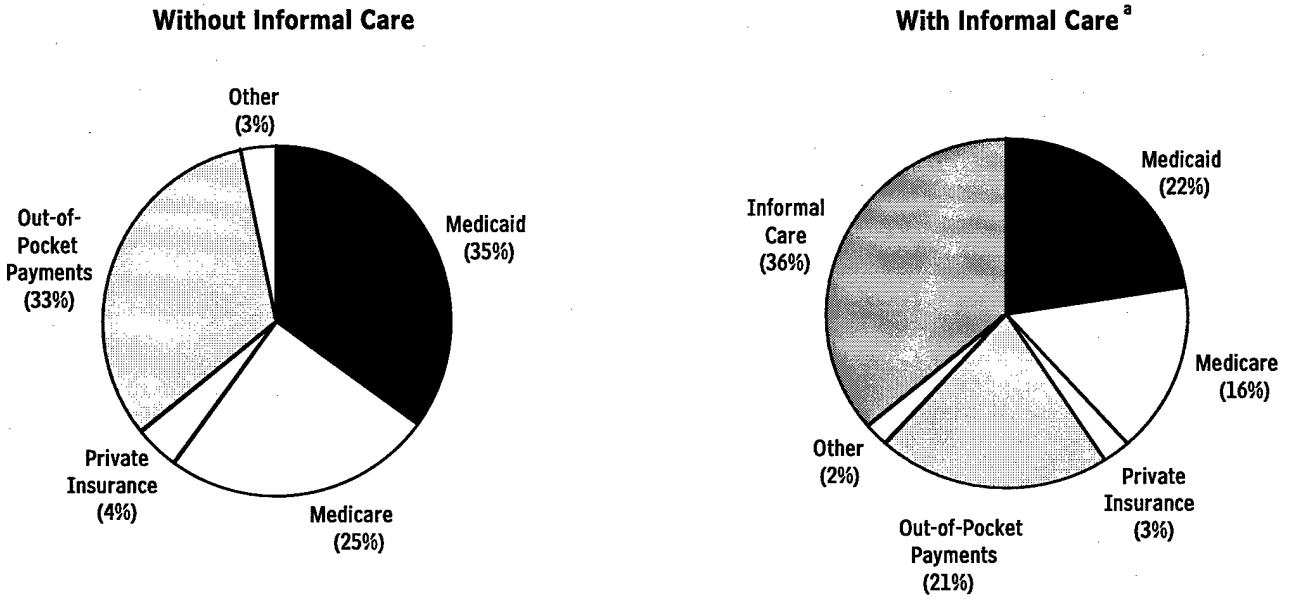
As mentioned earlier, the economic value of informal care is significant, although—as the following ranges imply—estimates of it are highly uncertain. In 1998, the Department of Health and Human Services estimated that replacing donated LTC services for seniors with professional care would cost between $50 billion and $103 billion.[3] Another recent analysis estimated the value of informal care for impaired people of all ages in 1997—measuring it as the forgone wages of caregivers—at

2. By comparison, out-of-pocket spending for acute, or general, health care for the elderly—such as hospital care and physicians' visits—makes up a much smaller share of those total costs (about 13 percent). For more information, see Joel W. Cohen and others, *Health Care Expenses in the United States, 1996,* Research Findings 12, AHRQ Pub. No. 01-0009 (Rockville, Md.: Agency for Healthcare Research and Quality, 2000). The data on which that publication draws are for the civilian noninstitutionalized population only and exclude dental expenses.

3. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Administration on Aging, *Informal Caregiving: Compassion in Action* (June 1998). CBO has updated the department's figures to 2004 dollars.

Figure 1-1.

Estimated Percentage Shares of Spending on Long-Term Care for the Elderly, 2004



Source: Congressional Budget Office.

a. Values are calculated on the basis of how much such care would cost if it were provided through formal means. Estimates are from Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Administration on Aging, *Informal Caregiving: Compassion in Action* (June 1998), inflated to 2004 dollars.

$196 billion.[4] Those forgone wages are the "opportunity cost" of informal care—the value of the caregivers' time that could have been used for other activities, such as working more, doing household chores, or enjoying leisure activities.

Out-of-Pocket Spending

Out-of-pocket spending in 2004 will account for about one-third of total LTC expenditures, CBO estimates, or roughly $5,000 per impaired senior. The federal government reduces the cost of some long-term care through the tax code's advantageous treatment of certain LTC expenses. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows a taxpayer (or his or her dependent) who incurs such expenses and has a specified degree of physical or cognitive impairment to deduct them from taxable income along with other medical and dental costs. Qualifying expenses include expenditures for nursing home care; home-based care; medical equipment and supplies, such as oxygen; and alterations to a home, such as grab bars in the bathroom. (However, only the portion of the alterations that does not add to the market value of the home is eligible for the deduction.)

Private Long-Term Care Insurance

Private insurance for long-term care is a relatively recent development and pays for only a small amount of care at present. Few elderly people currently maintain private-coverage.[5] However, that source of financing is growing—although the precise extent of the growth is difficult to measure accurately. The data on private LTC insurance generally capture payments that insurers make directly to providers but do not always pick up insurers' reimburse-

4. Peter S. Arno, Carol Levine, and Margaret M. Memmott, "The Economic Value of Informal Caregiving," *Health Affairs*, vol. 18, no. 2 (1999), pp. 182-188.

5. In 2001, William J. Scanlon, Director of Health Care Issues for the General Accounting Office, noted that less than 10 percent of seniors had such coverage. For more details, see his statement before the Senate Committee on Finance, published as General Accounting Office, *Long-Term Care: Baby Boom Generation Increases Challenge of Financing Needed Services*, GAO-01-563T (March 27, 2001), p. 12.

Table 1-1.

Impaired Elderly People, by Level of Impairment and Sources of Assistance, 1994

Impairment Level	Number of Impaired People (Thousands)	Percentage of Impaired People with		
		Paid Helpers Only	Informal Helpers Only	Both Paid and Informal Helpers
IADL Only	1,488	9.5	78.3	12.2
One ADL	1,114	10.7	64.9	24.4
Two ADLs	745	7.3	62.8	30.0
Three ADLs	443	5.4	57.4	37.2
Four ADLs	434	2.6	51.1	46.2
Five ADLs	512	3.3	41.4	55.3
Total	**4,737**	**7.8**	**64.3**	**28.0**

Source: Congressional Budget Office based on K. Liu, K.G. Manton, and C. Aragon, "Changes in Home Care Use by Disabled Elderly Persons: 1982-1994," *Journal of Gerontology,* vol. 55B, no. 4 (2000), pp. S245-S253.

Note: The instrumental activities of daily living (IADLs) and the activities of daily living (ADLs) describe a broad array of physical functions used to determine whether a person can live without assistance. ADLs represent basic physical abilities—eating, getting in and out of bed, getting around inside the home, dressing, bathing, and using the toilet. IADLs represent functions necessary for living independently—for example, preparing meals, shopping for groceries, and getting around outside.

ments 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.

In 1995, private insurance paid about $700 million for LTC services for seniors, or 0.8 percent of all such expenditures. In 2004, such spending will be about $6 billion, CBO estimates, or about 4 percent of total expenditures (see Table 1-2). The number of policies written yearly increased from about 300,000 in 1988 to more than 700,000 in 2001. According to America's Health Insurance Plans (formerly the Health Insurance Association of America), about 8.3 million policies were sold from 1987 through 2001; about 70 percent of them are still in force (see Figure 1-2).

Benefits. A typical LTC insurance policy pays the cost of nursing home care and home and community-based care but specifies a maximum daily benefit (such as $100 or $150) and may impose other limits. Policies with so-called inflation protection increase the dollar value of their benefits by a contractually specified percentage each year, usually 5 percent. Although some policies offer coverage for an unlimited period, most commonly cover services for a shorter time, such as four years, or until benefit payments for a policyholder reach a preestablished maximum lifetime amount. 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 ADLs or being cognitively impaired to a degree that warrants substantial supervision (see Box 1-1 on page 2).

Premiums. Premiums for LTC insurance reflect the cost of services and the risk that a policyholder will require long-term care as he or she ages. In 2002, the average annual premium for a typical policy was $2,014 if the policy was purchased at age 65; the premium more than doubled if the policy was purchased at age 75 (see Table 1-3 on page 8). The lower premiums offered to younger people reflect the lower risk of their requiring LTC services at younger ages and the expectation that younger policyholders will pay premiums over a longer period than will people who purchase coverage when they are older. Thus, the average annual premium for the same policy purchased by a 30-year-old would be only $622 and for a 50-year-old, $925.

In fact, fixed premiums are a key feature of LTC insurance policies—that is, the premiums do not increase as the policyholder grows older or as his or her health deteri-

Table 1-2.

Long-Term Care Expenditures for the Elderly, by Source of Payment, 2004

(Billions of dollars)

Payment Source	Institutional Care	Home Care	Total
Medicaid	36.5	10.8	47.3
Medicare	15.9	17.7	33.6
Private Insurance	2.4	3.3	5.6
Out of Pocket	35.7	8.3	44.0
Other	2.0	2.5	4.4
Total	92.4	42.5	134.9

Source: Congressional Budget Office.

orates, even though the risk of requiring services rises. Instead, insurers calculate premiums to ensure that the premiums' total, paid over the life of a policy, plus the interest that accrues from investing them will be sufficient to cover both the claims of the policyholder and an insurer's profit and overhead costs. However, insurers reserve the right to increase premiums for a specific group, or rating class, of policyholders—such as all policyholders in a state—if new data indicate that expected claims will exceed the class's accumulated premiums and their associated investment returns.

Some premiums for private LTC insurance are tax-deductible; any policy purchased before HIPAA was enacted qualifies for such a deduction, but policies purchased afterward must conform to the law's requirements for their premiums to be tax-deductible. The tax benefit is limited to people who itemize their deductions and whose total medical and dental expenditures exceed 7.5 percent of their adjusted gross income. The President in his 2005 budget has proposed creating an "above-the-line" tax deduction (the amount is deducted from gross income) for qualified LTC insurance premiums.

Public Long-Term Care Insurance Programs

Medicaid is the biggest public source of payment for long-term care, covering costs for services provided to beneficiaries who are institutionalized as well as those who remain in the community. Medicare covers care provided in skilled nursing facilities (SNFs) and at home; its benefits are designed primarily to help beneficiaries recover from acute episodes of illness rather than to provide care for long-term impairment. The stays in nursing facilities that Medicare covers are only for skilled care, not the more custodial nursing home care typically covered by Medicaid, and stays in SNFs tend to be relatively short. But Medicare's home health benefit, originally conceived to finance short-term rehabilitation, has evolved into what some observers have described as a de facto LTC benefit. As a result, Medicare's spending for both kinds of care is generally included in estimates of LTC expenditures.

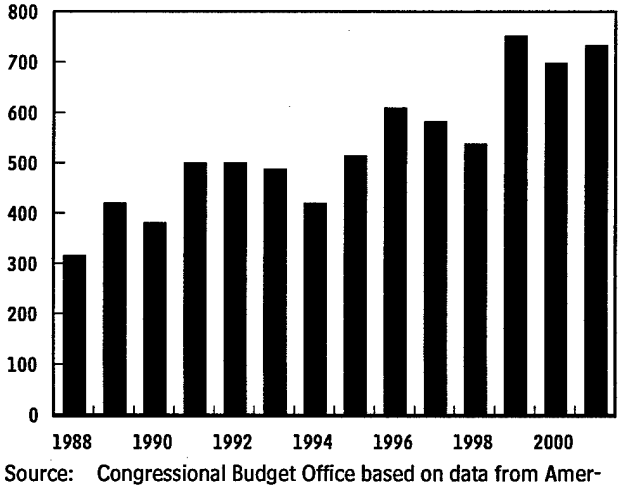
Medicaid

Medicaid is a means-tested program, jointly funded by the federal and state governments, that pays for medical care for certain groups of people, including impaired seniors who have low income or whose expenses are high enough that they allow those seniors to meet Medicaid's criteria for financial eligibility (see Box 1-2). Within broad national guidelines that the federal government provides, each of the states establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. The share of each state's Medicaid expenditures that is paid by the federal government is determined by a statutory formula; the average share is about 56 percent.

Figure 1-2.

Long-Term Care Insurance Policies Sold, 1988 to 2001

(Thousands)



Source: Congressional Budget Office based on data from America's Health Insurance Plans (formerly, the Health Insurance Association of America).

Box 1-2.

Financial Eligibility Requirements for Medicaid Coverage

The high cost of institutional care ($66,000 per year in 2003 for a private room) leads many seniors to try to qualify for public coverage of long-term care (LTC) costs through Medicaid. As a means-tested program, Medicaid is governed by financial eligibility rules that restrict its benefits to applicants whose income and assets do not exceed certain "ceilings," which are established by the states subject to federal guidelines. Separate ceilings apply to income and assets; an applicant must meet both to qualify for benefits. To become eligible for Medicaid's long-term care coverage, applicants must also meet certain state-set criteria involving the degree of their impairment. Seniors with very low income who become impaired may meet the program's financial eligibility requirements almost immediately, but others may eventually qualify—even people with fairly substantial assets and income—by exhausting, or "spending down," those funds to pay medical expenses.

The Income Standard

States have several options for setting an income standard for Medicaid coverage. In most states, seniors who are eligible for Supplemental Security Income (SSI) under the Social Security Act are automatically eligible for Medicaid.[1] To receive SSI benefits in 2004, individuals may have no more than $564 per month in so-called countable income; couples are limited to $846 per month. States may also extend Medicaid coverage to elderly and disabled individuals whose income exceeds the SSI limits; the rules allow states to qualify people who have income as high as 100 percent of the federal poverty level ($9,310 for a single person and $12,490 for a couple in 2004). States establish their own limits within that range. Florida's eligibility criterion, for example, is income that is less than or equal to 90 percent of the poverty level.

Medicaid's eligibility rules also give states two options, not mutually exclusive, under which people who have excessive health care costs and income above the usual Medicaid limit may nevertheless qualify for coverage. Under the first alternative, known as the "medically needy" option, seniors may qualify for Medicaid coverage if what remains of their income after subtracting their medical costs falls below a set amount. (Again, states establish that limit.) Once elderly people qualify, all of their income except a small allowance to cover nonmedical costs must be applied to their medical expenses.[2] In 2002, 35 states and the District of Columbia used the medically needy rule.

The second option that states may use to qualify people whose income exceeds the state-specified ceiling is known as the special income, or "300 percent," rule. That approach is only for people who need long-term care; applicants must meet the physical criteria for receiving Medicaid-covered nursing home

1. Policymakers have allowed some states, known as 209(b) states, to apply more-restrictive criteria for income, assets, and disability than those that apply for SSI eligibility. However, policymakers have also required those states to give people options for spending down their assets to become eligible.

2. The allowance may be as low as $30 per month for nursing home residents. It may be much higher—as much as three times the SSI income standard—for people who receive long-term care in the community.

Box 1-2.

Continued

care, and once they are enrolled, Medicaid pays for their medical care in addition to their long-term care. As is the case with the medically needy rule, people who qualify for coverage under the special income rule must use all of their income to pay for care, except for the small allowance noted above.

Under the special income option, the state sets an income cap of no more than 300 percent of the federal SSI benefit level. Regardless of their medical expenses, people in states that use this rule (38 in 2002) must have income below the state-set level for qualifying for Medicaid. However, applicants who have income that exceeds the cap may place the excess portion in special trusts to reduce their countable income and so become eligible. Under federal law, the money set aside in those so-called Miller Trusts must be used to pay for the beneficiary's care. When the beneficiary dies, the state Medicaid program is entitled to any residual funds in the trust to pay for costs it incurred in providing the person's care.[3]

The Asset Standard

The states also limit, subject to federal law, the amount of countable assets a person may hold and still qualify for Medicaid coverage. In that count, all states exempt the value of certain items such as a person's primary residence and a car (of limited value). All other assets, or "countable resources"—such as cash, bonds, and stock—must be depleted until the person's assets meet the standard. Most states choose a standard for assets that equals the current SSI asset standard of $2,000 for a single person and $3,000 for couples. (The standard is generally the same for someone applying for nursing home residency or for home and community-based care.)

Income and Asset Rules for Married Couples

Special rules for Medicaid eligibility, set by federal law, apply to married couples when one spouse is institutionalized and the other remains in the community. All income of the so-called community spouse remains with that person and is not counted in determining the institutionalized spouse's eligibility for benefits. In addition, federal law requires states to allow the community spouse to retain enough of the institutionalized spouse's income to make up a monthly allowance for minimum living costs. The allowance is set by the state according to federal guidelines—in 2004, no less than $1,515 per month and no more than $2,319.

The community spouse also has rights with regard to the couple's assets. The community spouse is allowed to retain either an amount equal to one-half of the couple's resources at the time that his or her spouse enters the institution, up to a federally specified maximum ($92,760 in 2004) or the state standard—whichever is greater. Federal law requires that the state standard be no lower than a specified amount —$18,552 in 2004. (Such maximum and minimum resource allowances are adjusted annually for inflation.) If the community spouse's half of the couple's combined resources is less than the state standard, the institutionalized spouse may transfer up to that amount of his or her resources to the community spouse.

3. The state also uses the funds to reimburse the federal government for its share of the expenditures for the beneficiary's care.

Table 1-3.

Average Annual Premiums for Private Long-Term Care Insurance, 2002

(Dollars)

If Policy Is Purchased at Age	Policies with Terms Averaging Three to Six Years		Policy with Lifetime Term	
	No Inflation Protection	Inflation Protection of 5 Percent Compounded	No Inflation Protection	Inflation Protection of 5 Percent Compounded
30	284	622	437	1,016
35	299	667	467	1,089
40	336	743	515	1,171
45	375	822	592	1,319
50	427	925	687	1,499
55	537	1,140	874	1,839
60	740	1,474	1,170	2,345
65	1,086	2,014	1,675	3,160
70	1,771	2,987	2,700	4,647
75	3,015	4,607	4,461	7,029
80	4,822	6,791	7,077	10,378
85	6,528	7,718	10,700	13,869

Source: Congressional Budget Office based on Weiss Ratings, Inc., *Weiss Ratings' Consumer Guide to Long-Term Care Insurance* (Palm Beach Gardens, Fla.: Weiss Ratings, Inc., 2003).

Note: The table reflects policies offering comprehensive benefits (nursing home care, in-home care (including respite care), and community-based care (for example, hospice or adult day care) with a $100 daily benefit for a three- to six-year period, a 30- to 100-day elimination period, and a pool-of-money contract.

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. That variation produces substantial differences in states' Medicaid spending (see Figure 1-4). In total, however, Medicaid's expenditures for long-term care for elderly people since 1992 have grown at an average annual rate of about 5 percent (see Figure 1-3). CBO estimates that in 2004, Medicaid's payments for institutional care for seniors, including both state and federal expenditures, will total $36.5 billion, or about 77 percent of all Medicaid LTC spending. Accounting for about 40 percent of total expenditures on nursing facilities, those payments will cover the care of more than half of all elderly nursing home residents.[6]

Medicaid's expenditures for home and community-based services (HCBS), which include home health care, personal care services, and spending under HCBS waiver programs, are much smaller than its spending for nursing homes—HCBS expenditures constitute only about 23 percent of total Medicaid LTC spending. (Under the waiver programs, which are discussed in more detail in Appendix B, states have the option of providing impaired people with enhanced community support services not otherwise authorized by the federal statutes.)

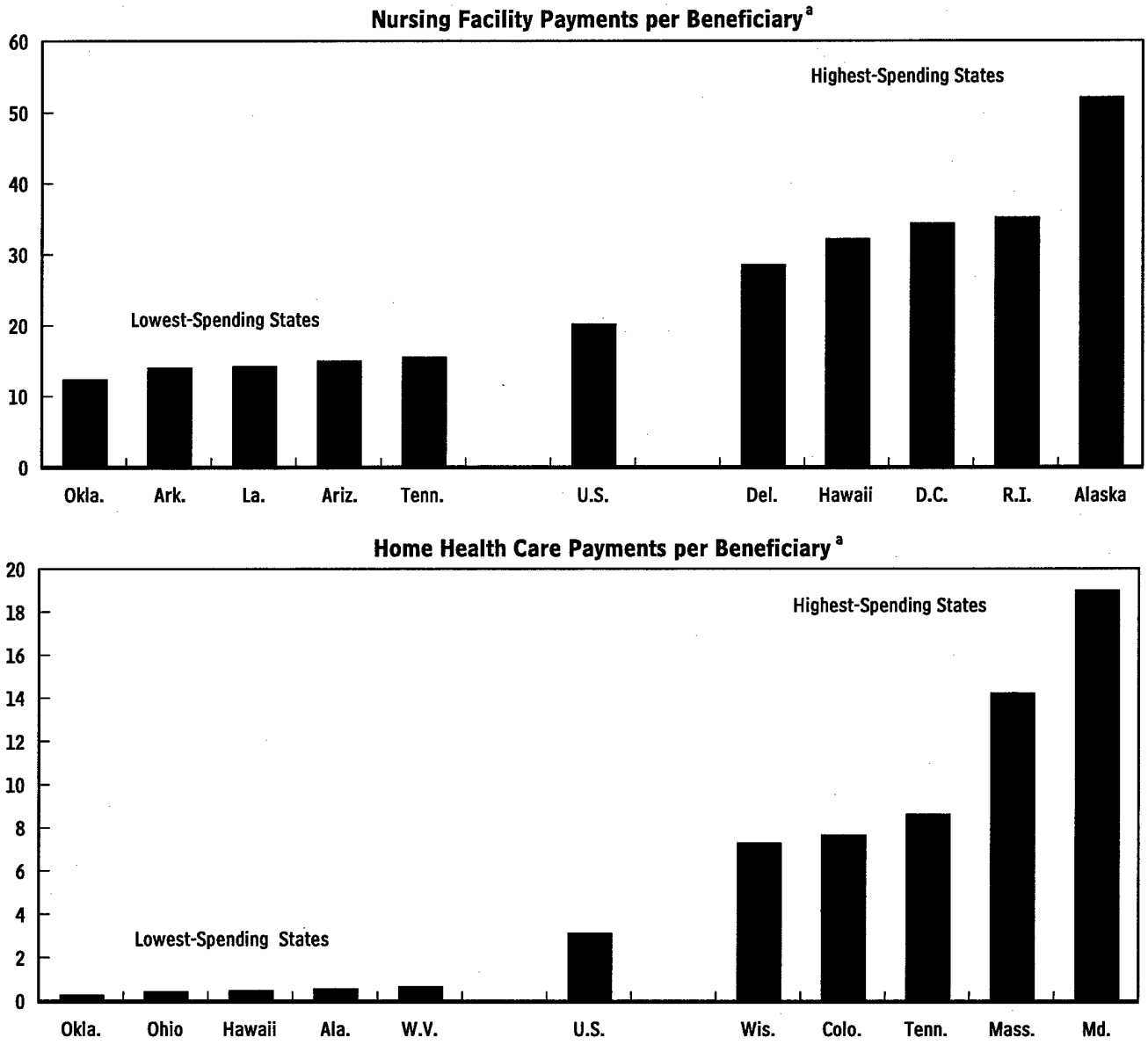
Since 1992, spending for home-based care has grown faster than spending for nursing home care, rising by about 11 percent annually on average compared with about 3 percent growth for care in nursing facilities. Potential causes of the higher rate include the growth of HCBS waiver programs and a 1999 decision by the

6. See Celia S. Gabrel, *Characteristics of Elderly Nursing Home Current Residents and Discharges: Data from the 1997 National Nursing Home Survey*, Advance Data no. 312 (Centers for Disease Control and Prevention, National Center for Health Statistics, April 25, 2000). The disparity between Medicaid's share of total spending on nursing facilities (40 percent) and the proportion of patients covered by Medicaid (56 percent) may result from one or more factors: Medicaid's low average reimbursement rates; differences between the severity of Medicaid enrollees' conditions and the conditions of patients using other sources of payment; or enrollees' cost sharing, which counts as out-of-pocket spending.

Figure 1-3.

Average Medicaid Payments for Long-Term Care, Selected States, Fiscal Year 2000

(Thousands of dollars)



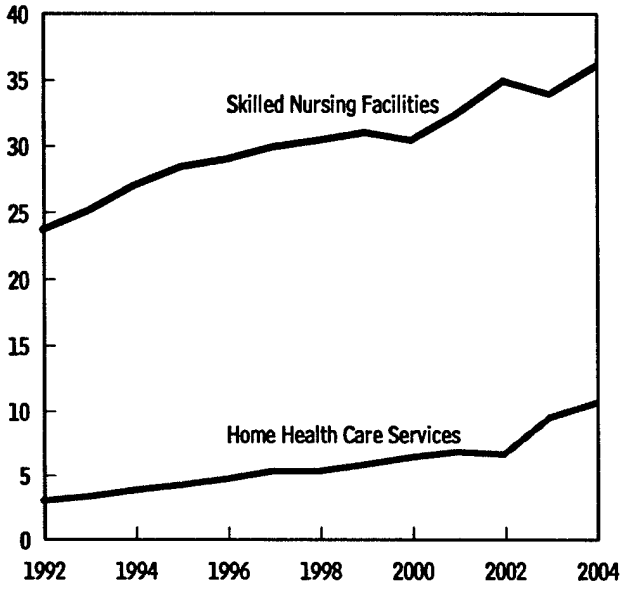
Source: Congressional Budget Office based on unpublished data from the Centers for Medicare and Medicaid Services, Office of Research, Development, and Information.

a. Beneficiaries aged 65 and older only.

Figure 1-4.

Medicaid's Expenditures on Long-Term Care for Elderly Beneficiaries, Fiscal Years 1992 to 2004

(Billions of dollars)



Sources: Congressional Budget Office and personal communication from Brian K. Bruen, Research Associate, Urban Institute.

Note: Expenditures for 2004 are projected.

Supreme Court requiring states, where possible, to provide community-based care to disabled Medicaid beneficiaries.[7]

Medicaid's involvement in LTC financing is consistent with the correlation between functional impairment and impoverishment. Lower-income groups—at any age—have higher rates of impairment than do higher-income groups, so people who are more likely to be impaired are also more likely to be eligible for assistance. But not all people who obtain Medicaid coverage for long-term care come from low-income households. Middle-income people may qualify for Medicaid if the cost of impairment drains their financial resources (see Box 1-2).

Many impaired 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. (As noted earlier, nursing home costs in 2003 averaged $66,000 for a private room.) According to a 1996 study, about 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.[8] Medicaid coverage is especially common among nursing home patients who have been institutionalized for long periods because they are likely to have used up whatever Medicare benefits were available as well as any assets they might have had.

Medicare

Medicare finances a substantial share of LTC services for elderly people in skilled nursing facilities and at home. To be eligible for reimbursement, services must be provided by a licensed professional, such as a registered nurse or physical therapist. A further requirement is that the SNF care be preceded by a recent, related hospitalization lasting at least three days. In the case of coverage for home health care, services need not be related to a prior hospitalization. One study based on 1994 data observed that only about a quarter of home health visits followed the beneficiary's hospitalization sometime in the previous 60 days.[9]

By CBO's estimates, Medicare's LTC spending for seniors in 2004 will total about $16 billion for care in skilled nursing facilities and $17 billion for home health care. Although the program's outlays for those categories grew rapidly from the late 1980s to the mid-1990s, expenditures actually declined near the end of the past decade (see Figure 1-5). A combination of factors was responsible, including changes in reimbursement methods imposed by the Balanced Budget Act of 1997, increased federal activities to counter providers' fraud and abuse of the

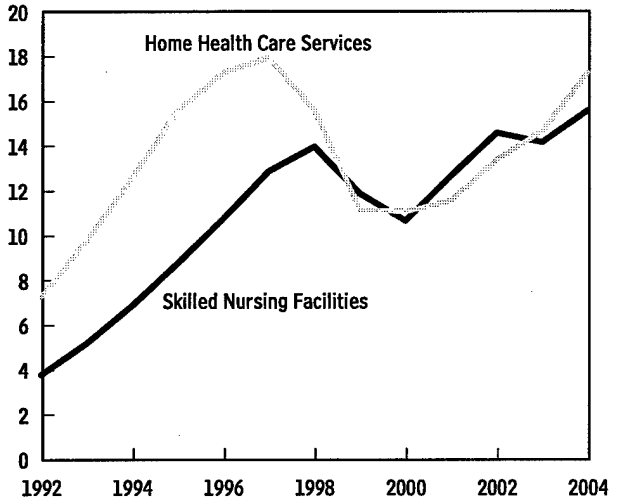
7. *Olmstead v. Georgia*, 527 U.S. 581 (1999). For details, see Nancy Lee Jones, *The Americans with Disabilities Act (ADA): Supreme Court Decisions*, CRS Report for Congress RL31401 (Congressional Research Service, June 19, 2002), p. 6. The growth attributable to that decision may be primarily among younger Medicaid beneficiaries rather than among seniors.

8. 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). Those proportions differ because discharged residents include people who were institutionalized for only a short time and the sample of current residents will include more people who stay for extended periods.

9. General Accounting Office, *Long-Term Care*, March 27, 2001.

Figure 1-5.

Medicare's Expenditures on Long-Term Care for Elderly Beneficiaries, Fiscal Years 1992 to 2004



Source: Congressional Budget Office.
Note: Expenditures for 2004 are projected.

program's payment systems, and delays in processing claims. CBO projects steady growth in spending for SNF and home health care over the 2005-2014 period, averaging approximately 5 percent annually. Although benefits are similar from state to state, Medicare spending, like spending for Medicaid, differs among the states and for many of the same reasons, such as variations in practice patterns and prices for services (see Figure 1-6).

Recent Reforms

Changes to Medicaid and Medicare LTC programs over the years have attempted to reduce costs, make service delivery more efficient, and improve the quality of LTC care. For example, to help control the growth of costs, Medicare recently switched from cost-based reimbursement to prospective payment systems for SNF stays and home health care. Prospective payment systems base reimbursement on the average costs of all providers—rather than on the costs only of the provider being reimbursed—and bundle those costs into a single payment for a specified unit of service. (In the case of SNFs, the unit is a day; for home health care, the unit is 60 days of visits.) The system thus rewards efficient providers who produce services at lower-than-average costs.

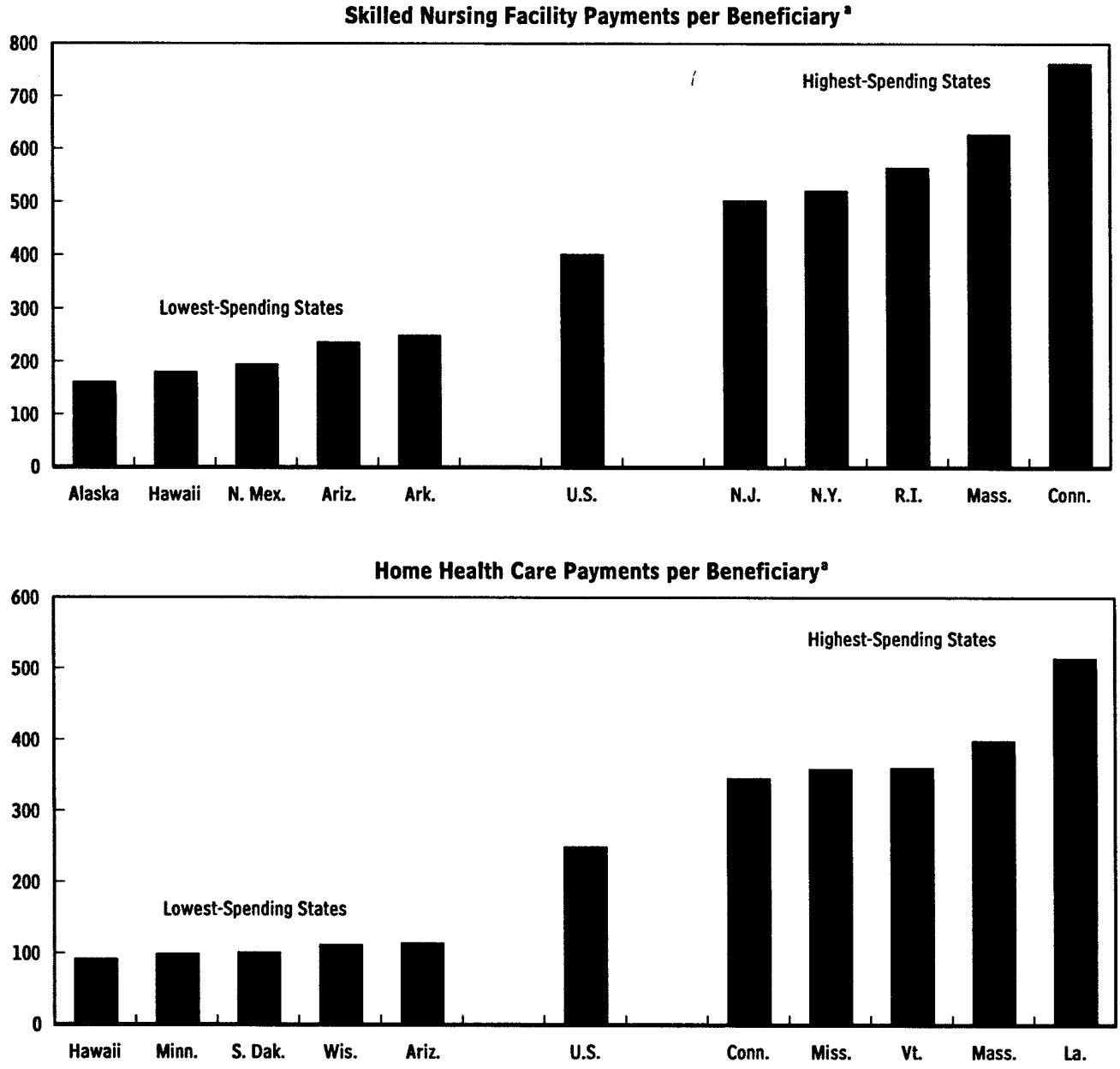
The HCBS waiver programs that most states now operate generally provide a more attractive living situation for beneficiaries because they enable Medicaid enrollees whose condition qualifies them for nursing home residency to remain in their homes. Moreover, for a few states, the waiver programs may have helped reduce their Medicaid costs. In addition, Medicare and Medicaid have initiated other policies to integrate acute and long-term care and better coordinate benefits for people enrolled in both programs. (Those initiatives, together with other reforms, are discussed in more detail in Appendix B.)

Nevertheless, despite the improvements in quality of care or efficiency that such changes may have elicited, there is little evidence to suggest that the new policies by themselves can rein in the projected surge in LTC spending that is likely to result from the demographic changes expected in the next several decades. How that spending is distributed among the various sources of LTC financing will depend in part on whether certain incentives present in the current financing structure remain in place.

Figure 1-6.

Average Medicare Payments for Long-Term Care, Selected States, Fiscal Year 2001

(Dollars)



Source: Congressional Budget Office based on unpublished data from the Centers for Medicare and Medicaid Services, Office of Research, Development, and Information.

Note: Medicare's home health benefit—though originally meant to cover only short-term rehabilitation—has evolved into what some observers describe as a de facto long-term care benefit. Consequently, the program's spending for both skilled nursing facility and home health care is generally included in estimates of long-term care expenditures.

a. Beneficiaries aged 65 and older only.

CHAPTER

2

Major Issues in the Financing of Long-Term Care

The current financing structure of long-term care, if carried forward into the coming decades, could add to the expected pressures that the federal budget is likely to experience with the aging of the baby-boom generation. As the proportion of older people in the population grows, the demand for long-term care will rise at the same time that other demographic forces (such as increased life expectancy and changes in the structure of families) are tending to reduce the availability of informal care. Contributing to the strains that public LTC programs will probably face is a series of factors that create incentives that in turn diminish the attractiveness of private insurance as a means for seniors to finance their care. Changes in those incentives could facilitate growth in the market for private LTC insurance.

Demographic Trends Affecting the Demand for Long-Term Care Insurance

The oldest members of the baby-boom generation become eligible for early retirement under Social Security in 2008, and their overall numbers drive the demographic trends that will affect the demand for long-term care services over the coming decades. According to estimates by the Bureau of the Census, the number of elderly people in the United States will double between 2000 and 2030; by 2050, the share of the population comprising people aged 65 or older will be 21.5 percent, up from 12.4 percent in 2000 and 8.1 percent in 1950 (see Figure 2-1). The most significant growth will be among the oldest seniors, those aged 85 or older—the people who have the greatest probability of using long-term care. Their share of the population will reach about 5.2 percent by 2050, more than triple the 1.5 percent share they claimed in 2000. By comparison, the proportion of the population accounted for by working-age people (aged 20 to 64)—who will in large part be paying the taxes that support public programs for retirees, including LTC programs—will grow by about 35 percent by 2050.[1]

Although the growth in the aged population may have the most powerful demographic effect on future demand for long-term care and in turn on LTC spending, other trends could also play a role. For example, a decline in the prevalence of functional impairment among elderly people (the percentage of people in the aged population who are impaired as measured by losses in the activities of daily living and the instrumental activities of daily living) could help slow the growth of LTC spending. Impairment among seniors appears to have waned significantly during the 20th century. From 1910 to the early 1990s, prevalence fell by about 6 percent per decade.[2] And some researchers found that in the early 1980s, it began to drop by just over 1 percent per year, primarily because of re-

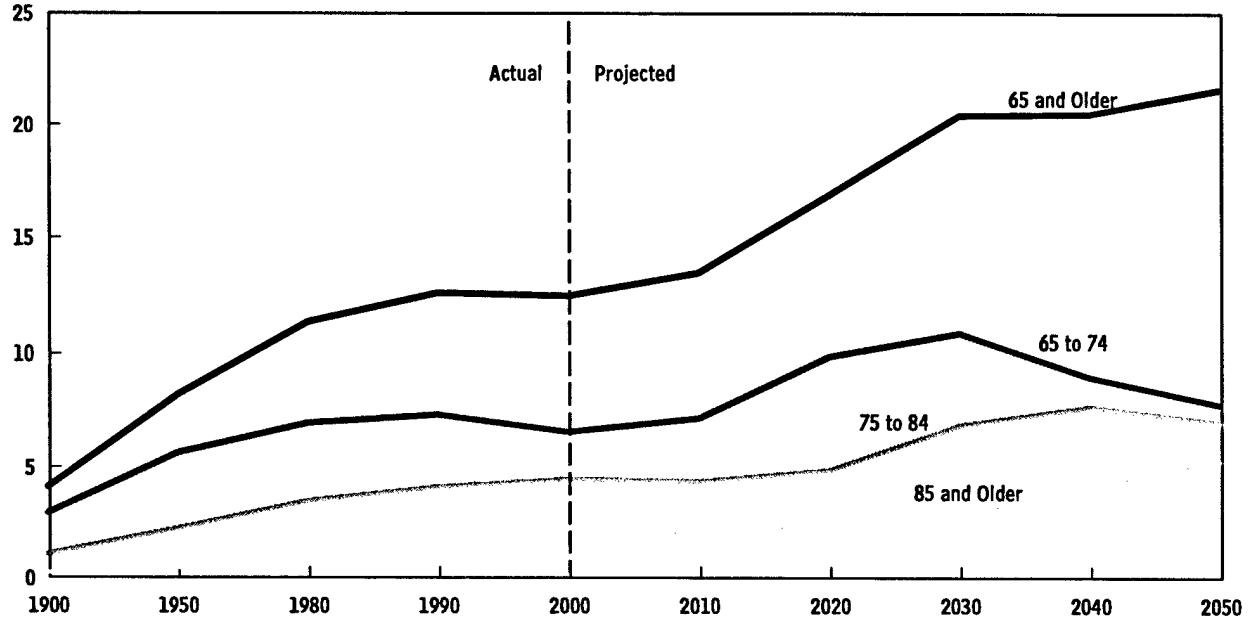
1. See Bureau of the Census, Population Division, *1980 Census of Population,* PC80-1-B1 (May 1983), and *U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin*, Table 2a. "Projected Population of the United States, by Age and Sex: 2000 to 2050" (March 2004), available at www.census.gov/ipc/www/usinterimproj/natprojtab02a.pdf.

2. Note that the decline in prevalence is a percentage drop, not a percentage-point drop. Of impairments among men at the beginning of the 20th century, difficulties in bending were the most prevalent at 50 percent. By the mid-1990s, the prevalence of such difficulties had fallen to 16 percent, a drop of 34 percentage points over eight decades, or a little more than 4 percentage points for each 10 years. Prevalence rates at the beginning of the last century for other types of impairment began at much lower levels and had very small percentage-point declines—but they still had relatively large percentage drops.

Figure 2-1.

People Aged 65 and Older as a Share of the U.S. Population, Selected Years, 1900 to 2050

(Percent)



Source: Congressional Budget Office based on Bureau of the Census, *U.S.. Interim Projections by Age, Sex, Race, and Hispanic Origin*, Table 2a, "Projected Population of the United States, by Age and Sex: 2000 to 2050" (March 2004), available at www.census.gov/ipc/www/usinterimproj/natprojtab02a.pdf.

duced impairment as measured by the instrumental activities of daily living.[3] (The Congressional Budget Office has projected that trend to 2040 in Figure 2-2.)

Not all measures show seniors' impairment rates as declining, however. Losses of functioning in the activities of daily living for which people require assistance only with equipment—such as walking canes—have been rising at a rate of about 4 percent per year since 1984 (although the prevalence of such impairment is still only about 3 percent of all seniors).[4] Impairment in general among people under age 65 may also be increasing, which could lead not only to higher current costs but also to higher future rates of impairment among seniors (see Box 2-1). In fact, one recent study projects that the currently declining trend in the prevalence of impairment among seniors will reverse in the future, leading to greater rates of institutionalization than those that prevail today.[5] As those conflicting trends suggest, projecting the prevalence of impairment in future years and basing estimates of spending on those projections are both difficult and subject to a high degree of uncertainty.

Yet despite that uncertainty, the expected increase in the number of seniors as the baby boomers age is so great that spending on long-term care is likely to rise over time because the number of impaired seniors will grow even if the prevalence of impairment declines. Moreover, life expectancy continues to grow—a trend that may increase the likelihood that a senior will use long-term care because, as noted earlier, the probability of being impaired

3. See Dora L. Costa, "Long-Term Declines in Disability Among Older Men: Medical Care, Public Health, and Occupational Change" (paper presented at the annual meeting of the American Economic Association, Boston, Mass., January 7-9, 2000); and Kenneth G. Manton, Larry Corder, and Eric Stallard, "Chronic Disability Trends in Elderly United States Populations: 1982-1994," *Proceedings of the National Academy of Sciences*, vol. 94, no. 6 (March 18, 1997), pp. 2593-2598.

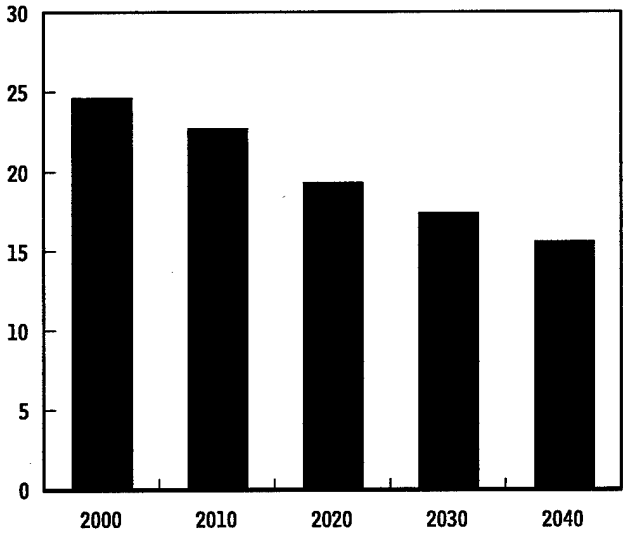
4. Brenda C. Spillman, *Changes in Elderly Disability Rates and the Implications for Health Care Utilization and Cost* (report prepared for the Department of Health and Human Services, Office of Aging and Long-Term Care Policy, 2002).

5. Darius Lakdawalla and others, "Forecasting the Nursing Home Population," *Medical Care*, vol. 41, no. 1 (2003), pp. 8-20.

Figure 2-2.

CBO's Projections of Impaired Seniors as a Share of the Elderly Population, 2000 to 2040

(Percent)



Source: Congressional Budget Office.

rises with age. Thus, the cohort of people turning 65 in 2020 may be more likely than the cohort turning 65 in 2000 to require nursing home care at some time before they die because that younger cohort will live longer (see Table 2-1).

In part because of the substantial opportunity costs of informal caregiving—as well as other factors, such as smaller families, lower fertility rates, and increasing divorce rates—donated LTC services may become 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 is likely to decline further, to 2.8 people by 2040 (see Figure 2-3 on page 18). At the same time, the rate at which women participate in the labor force will probably continue to grow, at least until 2010.[6] Women are more likely than men to provide LTC services for impaired people, and several studies have demonstrated that increases in the hours worked at paid em-

Table 2-1.

Probability of Nursing Home Use by Elderly People Over Their Remaining Lifetime

(Percent)

	People Turning 65 in		
	2000	2010	2020
Any Use	44	45	46
Three Months or Longer	32	33	34
One Year or Longer	23	24	25
Five Years or Longer	8	9	9

Source: Congressional Budget Office using data from Brenda C. Spillman and James Lubitz, "New Estimates of Lifetime Nursing Home Use: Have Patterns of Use Changed?" *Medical Care*, vol. 40, no. 10 (2002).

ployment reduce the number of hours spent in caregiving.[7] Those family-related trends, in sum, could further stimulate the demand for formal, paid services.

The increased demand for long-term care that is expected to emerge with the baby boomers' aging implies that if current patterns persist, public programs that finance such care—like all government programs serving large numbers of elderly people—will consume a growing share of the federal budget and of the national economy. In 1999, CBO projected that total LTC expenditures for seniors (including government and private spending but not the value of donated care) would rise from about $123 billion in 2000 (1.3 percent of GDP) to $346 bil-

6. According to the Bureau of Labor Statistics, the female civilian labor force participation rate will increase from 51.5 percent in 1980 to approximately 62.2 percent in 2010. However, the pace of that growth has been declining in recent years, shrinking from 6.0 percent during the 1980s to 2.7 percent during the 1990s. The rate of increase is projected to decline further, to 2.0 percent, over the 2000-2010 period. See Howard N. Fullerton Jr. and Mitra Toossi, "Labor Force Projections to 2010: Steady Growth and Changing Composition," *Monthly Labor Review Online*, vol. 124, no. 11 (November 2001), Table 3.

7. Richard W. Johnson and Anthony T. Lo Sasso, *The Trade-Off Between Hours of Paid Employment and Time Assistance to Elderly Parents at Midlife* (Washington, D.C.: Urban Institute, February 7, 2000). See also Rachel F. Boaz and Charlotte F. Muller, "Paid Work and Unpaid Help by Caregivers of the Disabled and Frail Elders," *Medical Care*, vol. 30, no. 2 (1992), pp. 149-158.

Box 2-1.

Long-Term Care Expenditures for Nonelderly People

Approximately one-third of the expenditures on long-term care in the United States go to pay for services for nonelderly people (see the table to the right). In 1994, about 3.3 million adults aged 18 to 64 and 400,000 children below the age of 18 used long-term care (LTC) services.[1] The majority of those people lived in the community—only about 100,000 nonelderly people lived in nursing homes.

In general, people who are younger than 65 use long-term care for different reasons than do people who are over 65. Impaired seniors who require long-term care generally suffer from physical problems, such as arthritis and coronary heart disease; younger adults are more likely to be impaired as a result of conditions such as mental retardation and mental illness (although they may also suffer the kinds of physical problems that older people experience). Common causes of impairment among children are respiratory problems and mental or neurological conditions.

Medicaid is by far the biggest funder of long-term care for impaired people under the age of 65, and the program's spending for that group has grown significantly over the past two decades. Taken together, Medicaid's payments to nursing homes, home health care providers, and Medicaid-run intermediate-care facilities for the mentally retarded (ICF/MRs) grew on average by about 4.8 percent annually between 1992 and today. However, examining the growth rate for each category of services separately reveals a shift over the period from institutional care to home and community-based services. Medicaid's expenditures for home health care grew at an average annual rate of more than 15 percent during the 1992-2004

1. The information in this box is drawn from the following sources: Judith Feder, Harriet Komisar, and Marlene Niefeld, "Long-Term Care in the United States: An Overview," *Health Affairs*, vol. 19, no. 3 (2000), pp. 40-56; General Accounting Office, *Long-Term Care: Diverse, Growing Population Includes Millions of Americans of All Ages*, GAO/HEHS-95-26 (November 1994); Darius Lakdawalla, Jay Bhattacharya, and Dana Goldman, *Are the Young Becoming More Disabled?* Working Paper No. 8247 (Cambridge, Mass.: National Bureau of Economic Research, April 2001); Paul W. Newacheck and Neal Halfon, "Prevalence, Impact, and Trends in Childhood Disability Due to Asthma," *Archives of Pediatric Adolescent Medicine*, vol. 154 (March 2000), pp. 287-293; and William D. Spector and others, *The Characteristics of Long-Term Care Users*, AHRQ Pub. no. 00-0049 (Department of Health and Human Services, Agency for Healthcare Policy and Quality, 1998).

lion (in 2000 dollars) by 2040, or 1.5 percent of GDP.[8] That estimate of a relatively modest increase in spending incorporated the assumption that the prevalence of impairment would decline at a rate of about 1.1 percent per year. If impairment levels instead remain about the same as they are today, expenditures will rise faster, to $484 billion by 2040, or about 2.0 percent of GDP. Spending could be even higher if, as some researchers believe, the prevalence of impairment actually increases in the future.

Another factor that could translate into higher spending levels is that the cost of LTC care is likely to increase at a faster rate than that of general price inflation since historically, the growth of health care costs has outpaced that of the economy in general.

Factors Affecting the Demand for Private Insurance

If the current framework of long-term care financing remained unchanged, the proportion of LTC spending that private insurance pays would rise to about 17 percent in 2020, by CBO's estimates, but that share of expenditures would still be smaller than those of Medicaid, Medicare,

8. Congressional Budget Office, *Projections of Expenditures for Long-Term Care Services for the Elderly* (March 1999). Long-range estimates are particularly prone to error and should be interpreted with caution.

Box 2-1.

Continued

Expenditures on Long-Term Care for Nonelderly People, 1998

(Billions of dollars)

Source	Amount
Third-Party Payers	
Medicaid	24.4
Private insurance	5.1
Medicare	2.1
Out-of-Pocket Spending	3.2
Other	5.6
Total	**40.4**

Source: Congressional Budget Office.

period, whereas its spending on institutional care grew by less than 5 percent.[2]

Although the percentage of elderly people who are impaired appears to be decreasing, the corresponding percentage of nonelderly individuals may be increasing. Several factors might explain that rise. For example, because of advances in medical technology, children who are born prematurely or who have severe disabilities that previously were fatal are now more likely to survive, but they may still have impairments that require some form of long-term care. In addition, the prevalence of certain potentially disabling diseases is increasing. Asthma is becoming more common, and respiratory disorders in general, including asthma, are a significant cause of disability among children. The prevalence of diabetes among the young is growing as well, perhaps because of an upswing in obesity. (If diabetes is untreated or poorly managed, it can eventually limit a person's mobility.)

2. That analysis of spending growth is based on Congressional Budget Office data and a personal communication from Brian K. Bruen, Research Associate, Urban Institute.

and out-of-pocket spending.[9] A number of factors underlie the limited rise that CBO projects for the use of private insurance. Some factors are related to the unique characteris-tics of long-term care—the interaction of private insurance and Medicaid and the inability to insure against certain kinds of risk. Other factors are common to most insurance markets but particularly to new ones—they include issues related to administrative costs, premium stability, and adverse selection.

9. Ibid.

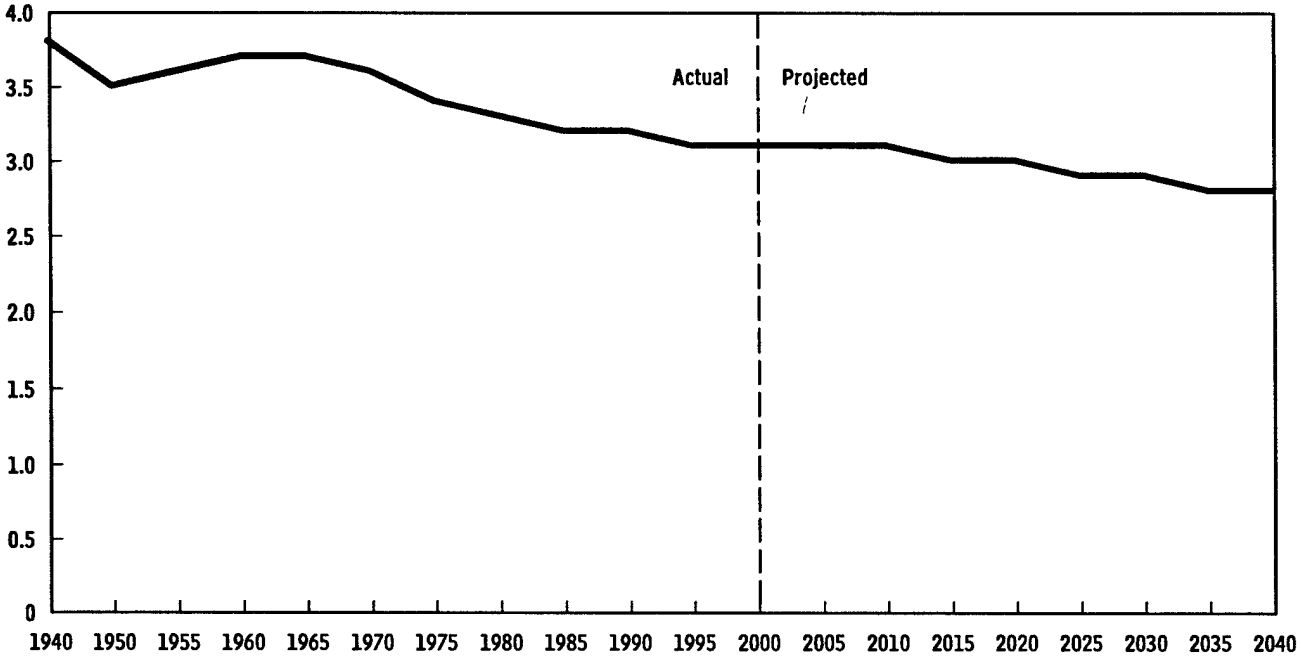
The Availability of Medicaid

Although Medicaid in general serves people with very low income and assets, it also provides assistance to impaired people who exhaust all other sources of financing for their long-term care. As discussed in Chapter 1, even people who have set aside significant savings may eventually become eligible for Medicaid assistance. In that way, Medicaid serves as an alternative form of insurance for people who do not have private coverage and who are impaired for a significant period. Indeed, Medicaid's impoverishment requirement may discourage people from saving because the less they have, the quicker they will qualify for coverage. It also creates an incentive for people

Figure 2-3.

Average Family Size, 1940 to 2040

(Number of people)



Sources: Congressional Budget Office (projections for 2015 to 2040) and Bureau of the Census (data for 1940 to 2010, which are available at www.census.gov/population/www/socdemo/hh-fam.html).

to hide their assets so that they can qualify for Medicaid and still preserve their personal wealth.

Medicaid is not a perfect substitute for private LTC insurance, however. As a means-tested program, it requires eligible applicants to rely on out-of-pocket spending until they use up all of their savings. In addition, because Medicaid generally pays lower fees for services than those paid by private payers, beneficiaries may not receive the same quality of care that private policyholders receive. In some states, moreover, Medicaid might not be as flexible in the types of services it covers as private insurance would be; an impaired person with private coverage would probably have a broader choice of providers and types of care than a Medicaid beneficiary would have.

Those drawbacks to Medicaid's coverage are balanced by features that some people might consider advantageous. Medicaid is free (except for the taxes that people pay regardless of whether they ever qualify for the program's coverage), and it pays for most kinds of LTC services. In addition, Medicaid has a defined-benefit structure—that is, it covers a particular set of services. As a result, it may be more attractive than private insurance to people planning for their long-term care needs, because private insurance ensures that a policyholder will have a specified monetary benefit to pay for care but does not guarantee that the money will be sufficient to pay for that care if prices rise faster than the value of the benefit.

The availability of coverage through Medicaid after people "spend down" (exhaust) their own resources has several effects on the LTC financing structure. Although Medicaid's coverage is not a perfect substitute for that of private insurance, it may nevertheless reduce the demand for private policies. Indeed, one recent study found that it constitutes a substantial deterrent to the purchase of private insurance for people at various income levels.[10]

10. Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market" (unpublished working paper, University of Illinois at Urbana-Champaign, April 2004).

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 long-term care. People who buy private insurance or set aside savings for long-term care substantially reduce the probability that they will ever qualify for Medicaid benefits. In that sense, as people prepare financially for long-term care needs, they forgo the value of the Medicaid benefits that they might otherwise have obtained—which raises the relative 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 may be more substantial for people of relatively modest means.

The Inability to Insure Against Certain Risks

Private LTC insurance may be unattractive to some consumers because it does not, in general, insure against the risk of significant price increases for long-term care. (Some types of so-called continuing-care retirement communities guarantee care for life, but that type of coverage is relatively uncommon.) Most policies guarantee to provide contractually specified cash benefits in the event that the policyholder becomes impaired. To protect themselves against inflation in the price of LTC services, 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.[11] Over a 20-year period, a nursing facility benefit of $100 per day in today's dollars would grow to $265 per day with an annual inflation protection rider of 5 percent. But the benefit would need to grow to $366 per day to keep up with a 6.7 percent annual growth rate—should costs continue to grow that fast in the future.

Another risk not covered by private LTC policies is the possibility that the insurer will go bankrupt and not be able to pay policyholders' claims. LTC insurance is a relatively new product, which makes it difficult for insurers to accurately predict the volume of claims that they will have to satisfy. Amplifying that difficulty is uncertainty about trends in, for example, impairment (see the earlier discussion). In some cases, LTC policyholders have seen their premiums increase substantially because an insurer underestimated its future claims costs.[12]

An additional risk is the possibility that the policy might become obsolete at some point in the future. LTC services, and the private insurance policies that cover such care, are steadily evolving as the LTC insurance market matures. That fluidity may give some consumers pause, and indeed, one prominent insurance rating agency recommended in 2000 that people purchase LTC coverage no earlier than age 60 to avoid the problem of obsolescent coverage.[13] Some consumers might also be reluctant to purchase LTC insurance if they believed that changes in public policy at some point could render their coverage obsolete.

At least one of those risks, that of insurer insolvency, is being addressed. The recently implemented LTC insurance program for federal employees and annuitants, for example, includes safeguards against the possibility that insurers will become insolvent.[14] (The government's Office of Personnel Management promises to continue an enrollee's coverage in the event that the group policy ceases to exist.)[15] Holders of policies not purchased through the federal program may have some protection as well. Each state has a life and health insurance guaranty association that provides coverage, up to certain statutory limits, for holders of policies issued by insolvent insurers.

11. CBO based its calculations of increases in Medicaid's reimbursement rates on data from James H. Swan and others, "Medicaid Nursing Facility Reimbursement Methods: 1979-1997," *Medical Care Research and Review,* vol. 57, no. 3 (2000), pp. 361-378, and on a personal communication to CBO from James Swan.

12. Ann Davis, "Shaky Policy: Unexpected Rate Rises Jolt Elders Insured for Long-Term Care," *Wall Street Journal,* June 22, 2000, p. A1.

13. See Weiss Ratings, Inc., *Long-Term Care Policies Vary Drastically in Cost to Consumers* (Palm Beach Gardens, Fla.: Weiss Ratings, Inc., April 5, 2000). Weiss Ratings evaluates the financial condition of insurers (including companies that sell life, health, property and casualty, and LTC insurance) and banks and savings and loan institutions.

14. The federal program was created with the passage of Public Law 106-265 in September 2000. Under that legislation, federal employees and their families have access to employer-sponsored LTC coverage, although like most employees of private firms that offer such coverage, they must pay the full premium.

15. Federal Long-Term Care Insurance Program, "Continuation of Coverage," available at http://www.ltcfeds.com/the_federal_program/Continuation_Of_Coverage.html, updated June 28, 2002.

Although the private LTC insurance market is too new to have encountered problems with such insurers, the insolvency protection of state guaranty associations is believed to extend to those policyholders.[16] In addition, most states require LTC insurance carriers to adhere to certain standards that are intended to prevent their future insolvency. For those reasons, and because insurers will gradually become more adept at predicting the claims costs of their policyholders, these concerns are likely to be less of an impediment to consumer demand in the future.

Administrative Costs

Administrative costs contribute a substantial amount to LTC insurance premiums because most policies are sold individually rather than as group (employer-sponsored) policies.[17] The costs of marketing to and enrolling individuals are much higher than—in fact, about double—those for groups, for which economies of scale may apply.

On average, administrative costs in the future are likely to fall as group policies make up a larger share of the private LTC insurance market. In 2001, group policies constituted about 25 percent of new LTC policy sales. (By comparison, nearly 90 percent of people with private health care insurance hold group coverage.) But group policies are accounting for an increasing share of the LTC insurance market, a trend that is likely to continue if more employers offer LTC coverage as an employee benefit. If employers offered such a benefit, the part of the premium for their employees' LTC coverage that they paid, like their contributions for regular health insurance, would not be included in employees' taxable income. As more people became interested in having LTC coverage as part of their compensation package, they might be willing to accept lower wages or slower growth in the taxable portion of their compensation in exchange.

16. Personal communication to the Congressional Budget Office from Joni Forsythe, National Organization of Life and Health Insurance Guaranty Associations, November 26, 2003.

17. Statistics in the remainder of this section are drawn from the following sources: personal communications to the Congressional Budget Office by Frank Dino of the Florida Department of Insurance and Jonathan Shreve of Milliman & Robertson (an actuarial consulting firm), May 23, 2000; Susan A. Coronel, *Long-Term Care Insurance in 2000-2001* (Washington, D.C.: Health Insurance Association of America, January 2003), p. 16; and Robert J. Mills, *Health Insurance Coverage: 2000*, Current Population Reports, Series P60-215 (Bureau of the Census, September 2001).

Premium Instability

Although LTC insurers typically offer premiums that do not automatically increase as the policyholder grows older or experiences deteriorating health, state insurance regulators allow them to increase premiums for all holders of a given type of policy in a state (known as a rating class) if they find that they have miscalculated the expected cost of their claims. Some insurers have boosted premiums several times for that reason, leading many policyholders to cancel their coverage and in all likelihood deterring some potential purchasers from acquiring LTC coverage. However, premiums may be stabilizing: a survey of top-selling LTC insurance carriers by the Health Insurance Association of America observed fairly steady premium levels from 1997 to 2001 after a sustained decline in average premiums from 1990 to 1996.[18]

Policyholders can obtain some protection against large jumps in premiums by purchasing nonforfeiture benefits with their policy. That feature enables policyholders who cancel their coverage to recoup from the insurer as much as all of the premiums they have paid. Nevertheless, although policyholders might get a proportion of their premiums back, they do not receive the associated returns on the investment of that money.

Adverse Selection

The relative newness of the market for LTC insurance and the still fairly small number of policies being sold suggest that the market may be affected by adverse selection. According to that theory, people who purchase LTC insurance have greater expectations than nonpurchasers of using services in the future, and those greater expectations are not captured in the information that insurers collect as they enroll purchasers of their policies. If insurers believed that adverse selection was occurring, it might lead them to set premiums higher than a policyholder's health status would suggest so as to incorporate the greater likelihood that that policyholder would use the insurance. In turn, the higher premiums might deter people who would purchase coverage if the premiums reflected their relatively lower expectations of using LTC services.

Recent research suggests, however, that although adverse selection does exist in LTC insurance markets, it may not

18. Coronel, *Long-Term Care Insurance in 2000-2001.*

be producing higher overall claims costs.[19] According to that study, the higher costs of policyholders with higher-than-average expectations of using services in the future are offset by the costs of people who purchase LTC insurance because they are averse to risk and whose probability of using services in the future is actually lower than the average for the population at large. Because of the market's youth, there are no clear data to resolve the question of adverse selection, but the phenomenon appears unlikely to be a problem over the long run.

19. Amy Finkelstein and Kathleen McGarry, *Private Information and its Effect on Market Equilibrium,* Working Paper no. 9957 (Cambridge, Mass.: National Bureau of Economic Research, September 2003).

CHAPTER

3

Policy Approaches to Long-Term Care Financing

Two sets of broad policy approaches might be used to alter the incentives described in Chapter 2 and shift the mix of sources of long-term care financing. The first set entails tightening eligibility for Medicaid and limiting Medicare's home health care benefit. The second set examines policies to alter the incentives that encourage people to substitute Medicaid for private LTC insurance (but without restricting eligibility) and to increase price competition among insurance carriers. Those approaches include standardizing private policies and allowing consumers to purchase private policies that supplement Medicaid's coverage.

A third set of alternatives would expand publicly financed LTC insurance programs. Although part of the total range of available options, that general approach would run counter to efforts to alleviate the federal fiscal pressures anticipated with the aging of the baby-boom generation and could further undermine the development of the private market for LTC insurance. Box 3-1 briefly summarizes some of those alternatives.

Restrict Growth in Long-Term Care Spending by Medicaid and Medicare

The fiscal strains that are expected to emerge with the baby boomers' aging could be somewhat constrained by limiting the rise in spending for long-term care by Medicaid and Medicare that is likely to occur under current law. Limits on the growth of public LTC spending could be phased in over an extended period to allow people who faced new restrictions on eligibility and benefits ample time to make other financial arrangements. Rather than rely on public programs, they could seek private solutions to their future LTC financing needs by setting aside savings or purchasing private long-term care insurance.

Reduce the Number of People Eligible for Medicaid Coverage

Medicaid's spending for long-term care could be constrained by making it more difficult for middle-income people to qualify for coverage by spending down their resources. One approach would tighten existing limits on income and assets, which would delay some applicants' entry into the Medicaid program and discourage others from applying at all. Another approach would eliminate some of the mechanisms that people currently use to spend down their income, which might significantly reduce the number of individuals who became eligible for coverage.

Place New Limits on Income and Assets. Medicaid's current rules already restrict applicants from keeping more than a nominal amount of assets. Yet despite such restrictions, many applicants manage to protect a significant portion of their assets and still qualify for Medicaid coverage by taking advantage of certain rules regarding the disposition of assets. That practice, which is referred to as Medicaid estate planning, comprises several methods, some of the more common of which are discussed below.

Asset Conversion. Medicaid applicants can convert so-called countable resources (assets), such as savings and investments, into uncountable—or protected—resources by using them to purchase, for example, home improvements, an automobile, or appliances. In addition, applicants may place their assets in certain types of trusts or purchase annuities to convert assets into income.[1]

1. Applicants can purchase annuities to convert jointly held assets into a stream of income for a spouse who remains in the community.

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Box 3-1.

Expanding Public Programs That Finance Long-Term Care

A policy to expand publicly financed long-term care (LTC) insurance could increase the number of people with LTC coverage, but the drawbacks of such a policy are likely to outweigh its benefits. Increasing spending by public programs—for example, by relaxing Medicaid's financial eligibility requirements, expanding Medicare's benefits for long-term care, or offering tax credits to people who become functionally impaired—would probably worsen the fiscal difficulties that future demographic changes are expected to bring if current law remains unchanged. Such a policy could shift spending for long-term care from private sources to the federal programs as well as diminish incentives for people to purchase private insurance.

Expand Medicaid Eligibility

The federal government and the states could broaden coverage under Medicaid by raising the current limits on income and assets so that more people met the program's criteria for financial eligibility. Such an option would, of course, bring a rise in costs—for states in particular, unless the federal government agreed to cover a larger fraction of Medicaid's expenditures than it does now. (That model is followed in the State Children's Health Insurance Program.) The costs that both the federal and state governments would incur by permitting beneficiaries to retain a larger amount of their assets could be somewhat constrained by establishing stricter standards for transferring assets to prevent people with significant resources from qualifying for Medicaid coverage.

Just as reducing the number of people eligible for Medicaid coverage is likely to stimulate additional sales of private LTC insurance (see the discussion in Chapter 2), increasing it is likely to further depress sales of private coverage by strengthening Medicaid's distortionary impact in that market. The effect might not be large, however, unless the new asset standards for Medicaid eligibility were significantly higher than they were before. Another issue is that many of the individuals who qualified under the new criteria would otherwise have had to spend down more of their assets. Consequently, much of the increase in Medicaid's expenditures would probably represent a shift from out-of-pocket spending.

Expand Benefits Under Medicare

Medicare could provide more-comprehensive LTC coverage than it currently does by expanding its benefits for skilled nursing facility and home health care or by covering other types of LTC-related services. Policymakers could enhance skilled nursing care coverage by dropping the requirement of a three-day prior hospitalization, by increasing the 100-day limit on coverage (making it more of a true "long-term" benefit), or by reducing the cost sharing that the benefit requires. They could also broaden the eligibility criteria for home health care services so that a greater number of impaired beneficiaries qualified for coverage.

A more modest expansion might entail covering respite care, under which an impaired beneficiary living in the community is entitled to one to two

Timing of Illegal Asset Transfers. Because of the way Medicaid applies penalties for illegal asset transfers, applicants may be able to protect as much as half of all their assets and still become eligible for Medicaid. For the purpose of simplicity, the following discussion uses an asset transfer amount of one-half, but depending on an individual's situation, it could be less.

An applicant who is applying this strategy transfers about half of his or her assets to another party. (The transfer can be made as late as the day that the applicant enters the nursing home.) The applicant then spends the remaining portion of the assets on long-term care—typically, nursing home services. Once those remaining assets have been used, the person applies for Medicaid benefits.

Box 3-1.

Continued

weeks' stay in a nursing home each year. The benefit is intended not so much for the impaired senior as for caregivers providing informal care. A break from what may be a heavy burden of care might help those caregivers sustain their efforts over a longer period—thus preventing the elderly person from entering a nursing home permanently and possibly becoming dependent on Medicaid.

An expansion of Medicare might not affect consumers' buying decisions in quite the same way that an expansion of Medicaid would, for two reasons. First, unlike Medicaid, Medicare is not means-tested—it has no income or asset limits that must be met before people are eligible for benefits. As a result, it does not discourage people from saving money (so they can purchase LTC services when they need them) or from buying private LTC insurance coverage. Second, private LTC insurance generally does not cover services that are covered by Medicare—in that sense, it supplements Medicare. If Medicare's benefits were expanded, consumers might not desire as much private coverage as they otherwise would buy because some of their LTC needs would be covered by Medicare.

Establish Tax Credits for Impaired People

An alternative to direct public funding of long-term care would be to offer tax credits to taxpayers who are functionally impaired or who have a functionally impaired dependent. (The Bush Administration has proposed that an additional personal exemption be allowed for people who care for impaired relatives living in their homes. An exemption operates as a deduction from taxable income, whereas a credit directly reduces tax liability.) A tax credit program would depart significantly from traditional public LTC financing in the sense that it would provide a defined contribution—a cash subsidy of a specified amount—rather than a defined benefit. Beneficiaries would be able to exercise a greater degree of choice about the type of care they purchased and the providers from whom they purchased it. In fact, if they preferred, they could spend the money on goods and services not directly related to long-term care.

A tax credit might be more attractive to potential beneficiaries than a traditional program would be—because of the unrestricted nature of a cash benefit—but it could also have some substantial drawbacks, including its cost to the federal budget. Because cash has value to people whether or not they are impaired, a tax credit might offer a greater incentive relative to a more standard LTC benefit for people to exaggerate their impairments to qualify for the credit. In addition, the substantial discounts that public programs can often obtain from providers would probably not be available to recipients of cash assistance.

Asset transfers are illegal if they take place within 36 months of a person's application for benefits, and thus the Medicaid program's rules require caseworkers to "look back" 36 months to see if the person transferred assets during that time. (Caseworkers are required to check back 60 months for transfers from certain types of trusts.) The applicant is penalized for having made an illegal asset transfer during the look-back period—the penalty is that his or her eligibility is delayed by the amount of services that could have been purchased with the transferred assets. However, the penalty begins on the date that the assets were transferred. Since half of them were transferred, the penalty ends on the date that the person uses up the other half of the assets and is otherwise eligible for Med-

icaid. Thus, the applicant has effectively protected half of his or her assets—the half that was originally transferred to another party.[2]

Refusal of Support. In cases in which the spouse of a nursing home resident lives in the community, assets may be protected if the community spouse is willing to refuse to support the institutionalized spouse. Under that approach, the resident transfers all assets to the community spouse, who then refuses to make them available to pay for LTC services. (Box 1-2 on page 6 explains the rights of community-dwelling spouses under Medicaid's rules.) This strategy takes advantage of a Medicaid policy that supports nursing home residents who have been abandoned by relatives.

The use of Medicaid estate planning inflates the program's spending for long-term care by allowing people to qualify for Medicaid more quickly than they otherwise would have and without having to expend all of their own savings and other assets first. Little evidence exists regarding the extent of Medicaid estate planning, however. Anecdotal evidence suggests that it may be prevalent in only a few states—in particular, New York, New Jersey, and Massachusetts, whose Medicaid programs offer relatively generous benefits. Yet some analysts believe that it is becoming more common.[3] Strengthening the rules to reduce the use of such strategies would delay the point at which some people became eligible for benefits and would prevent others from qualifying. It could also discourage some people from going through the application process.

Eliminate Mechanisms for Spending Down Assets and Income. Under current law, states allow people with moderate income and assets to exhaust those funds and become eligible for Medicaid benefits under the medically needy option or the special income rule combined with the use of Miller Trusts (see Box 1-2 on page 6 for details). The number of people covered under Medicaid could be reduced by:

- Eliminating the medically needy option for spending down income and assets;
- Requiring all states to adopt the special income rule, whereby people must have income below a specified ceiling to qualify for Medicaid coverage; and
- Eliminating Miller Trusts as a method for reducing countable income below the ceiling.

Together, those actions could significantly reduce the number of people who became eligible for Medicaid. In effect, people with income above a specified level—even if that level was less than the cost of living in a nursing home and they had no other assets—would be unable to meet the financial requirements to qualify for Medicaid coverage.

Tightening eligibility for Medicaid would shift the sources of financing of long-term care and might modestly improve efficiency. As people came to understand that their likelihood of being eligible for Medicaid was significantly lower than under current law, they would be more likely to make their own preparations for impairment in old age—by setting aside savings (if they chose to self-insure) or by purchasing private insurance. And if they did become impaired and were unable to obtain assistance from Medicaid, they would be more likely to shop for lower-cost providers and to use fewer services in order to conserve their resources.

Another potential effect from a tightening of Medicaid eligibility is that people who did not make their own preparations might find it more difficult to obtain care. One alternative would be to seek help from friends and family in the form of informal care or cash assistance (to purchase services). Limits on Medicaid eligibility might also affect providers of LTC services, especially nursing homes, who would probably see their expenditures for charity care and bad-debt expense rise as public financing declined. Some local governments might also increase spending.

2. The Congress included a provision in the Balanced Budget Act of 1997 that made it a crime to accept fees for advising Medicaid applicants about making illegal asset transfers. The provision's constitutionality came into question, however, and the Attorney General notified the Congress on March 11, 1998, that the Department of Justice would not enforce that part of the law.

3. See Joshua M. Wiener, David G. Stevenson, and Jessica Kasten, *State Cost Containment Initiatives for Long-Term Care Services for Older People*, CRS Report for Congress RL30752 (Congressional Research Service, May 8, 2000).

Limit Services under Medicare's Home Health Benefit

Medicare's spending for long-term care could be constrained by altering coverage under the program's home health care benefit. Compared with the skilled nursing facility benefit, which provides only modest coverage after the first 20 days of care and must be preceded by a hospitalization, the home health care benefit is relatively generous. Once a person meets the physical qualifications for coverage, there are no copayments or other coinsurance requirements. A modest cost-sharing requirement for beneficiaries could decrease the program's LTC expenditures because beneficiaries would probably reduce the amount of care they used in response to that kind of financial incentive. Its overall impact on LTC spending, however, would likely be a modest one.

Improve the Functioning of the Market for Private Long-Term Care Insurance

Approaches that might improve the market for private long-term care insurance include standardizing private policies and allowing consumers to supplement Medicaid benefits with private coverage. Each of those approaches could provide a more attractive set of choices for people who wished to protect themselves against the financial costs of impairment, and each approach would improve the functioning of the private LTC insurance market. Nevertheless, each approach also has drawbacks. For example, although the standardization of policies could increase competition among insurers based on prices and lead to lower average premiums, it might also limit insurers' ability to respond to changes in the long-term care marketplace and could restrict the variety of insurance options available to consumers.

Standardize Long-Term Care Insurance Policies

A policy to standardize the variety of LTC insurance policies now being sold would make it easier for consumers to compare premiums, might lead to more competition among insurers, and could make policies generally more understandable. Furthermore, benefit packages that conformed to governmental standards might not only boost consumers' confidence in LTC insurance but also reduce the potential for favorable selection by preventing insurers from tailoring their products to appeal only to healthier purchasers.

The Health Insurance Portability and Accountability Act of 1996 already provides some standards that LTC policies must meet to qualify for tax-exempt status, such as benefit "triggers"—in the form of levels of impairment—and provisions for consumer protections. In addition, most states have adopted at least some aspects of the model legislation on LTC policies recommended by the National Association of Insurance Commissioners. But the model legislation is primarily concerned with protecting consumers and not with standardizing policies. Moreover, states' acceptance of any portion of the legislation is voluntary, and thus adoption has been piecemeal in nature. To limit the current variation in benefits and strengthen consumer protections might require federal intervention.

A major downside of standardization is that such an approach might dampen the demand for LTC coverage and thus block the objective it was meant to achieve. A required minimum set of benefits and consumer protections might be so comprehensive that insurers would have to charge higher average premiums, which would inevitably deter some potential purchasers. In addition, standardization might constrain insurers' innovations in response to changes in LTC services or in the market for those services. A further disadvantage of standardization is that it could prevent insurers from offering a variety of products to meet consumers' diverse needs.

Allow Consumers to Supplement Medicaid Coverage with Private Policies

Permitting consumers to purchase private policies that supplemented Medicaid coverage could remove a significant impediment to the efficient functioning of the market for private LTC insurance. In general, Medicaid's rules for financial eligibility do not allow enrollees to hold supplemental private insurance. Applicants for Medicaid must exhaust all other sources of LTC financing—including benefits offered by any private insurance they might carry. Being able to supplement Medicaid with private insurance coverage would make such policies a more realistic option for people who have a modest amount of income and assets that they would like to protect—that is, people with enough resources to desire some form of insurance coverage but not enough to justify the premiums they would have to pay for the several years of benefits they would need to effectively protect those resources under current law.

Box 3-2.

Comparing the Financial Impacts of a Partnership Policy and Other Insurance Options

The Partnership for Long-Term Care offers people with modest income and savings a potential advantage by allowing them to protect more of those funds than they could under a conventional long-term care policy. The following example considers a man who purchases a policy at age 55 and becomes impaired at age 75, and whose income is less than the income ceiling for Medicaid eligibility.[1] The example compares the financial effects under a policy that provides one year of payments and a policy that provides two years' worth. In the case of the one-year policy, the man is assumed to have $100,000 in savings at the time he becomes impaired; for the two-year policy, the assumption is that he has savings of $200,000. A third option is also examined—that the man has no insurance. In that case, the assumption is that he saves the money that he would have spent on premiums, investing it at an annual rate of return of 8 percent.

In this example, the premium for a policy purchased at age 55 and covering approximately one year of care at a maximum of $100 per day (total benefit of $36,500) would be $47 per month. For two years of care (total benefit of $73,000), the premium would be $65 per month.[2] The policies would both be adjusted for inflation of 5 percent per year. Thus, at age 75, the one-year policy would pay a total of about $97,000 ($265 per day), and the two-year policy would pay about $199,000 ($265 per day in the first year and $278 per day in the second year). The example assumes that the policy's benefit amount covers all necessary expenses.

The table to the right compares the financial impact that the man would experience with a three-year and five-year period of impairment under a partnership policy, a conventional policy, or no insurance. If the man had a one-year policy, his coverage would run out at age 76. At that point, the man would have to pay out of pocket for his care until he became eligible for Medicaid coverage. If he had a partnership policy, about $97,000 (the value of his policy's benefit, as noted above) of the $100,000 in savings he had accumulated by age 75 would not be included in determining his eligibility for Medicaid.

1. Based on average 2001 premiums for partnership policies in California. Such policies specify coverage limits by expenditures, not time. But the policies' dollar value generally conforms to the yearly increments found in the policies offered in other states. For example, a policy that provides a daily maximum benefit of $100 is packaged as a total payout of $36,500 for one year of coverage, $73,000 for two years, and $109,500 for three years.

2. Premiums for partnership policies and conventional coverage are the same because the coverage itself does not differ between the two policy types. What differs is that the partnership policy allows some of the policyholder's savings to be designated as uncountable assets for purposes of determining eligibility for Medicaid.

Box 3-2.

Continued

The Financial Impact of Three Insurance Options

(Thousands of dollars)

	Partnership	Conventional Private Insurance	No Insurance
One-Year Policy			
Savings at age 75	100	100	130
Savings at age 78	97	0	0
Savings at age 80	97	0	0
Age at which insurance expires	76 years	76 years	n.a.
Age at which savings are used up	Never	77 years, 2 months	76 years, 4 months
Two-Year Policy			
Savings at age 75	200	200	240
Savings at age 78	199	13	0
Savings at age 80	199	0	0
Age at which insurance expires	77 years	77 years	n.a.
Age at which savings are used up	Never	79 years, 3 months	77 years, 8 months

Source: Congressional Budget Office.

Note: n.a. = not applicable.

Under a conventional policy, the man's savings would be depleted when he reached 77 years and two months of age. If he was uninsured, he would have about $30,000 more in savings at age 75 than if he had carried insurance (because he would have paid no premiums), but he would have to use the money to pay for his long-term care before he could qualify for Medicaid. Those savings would last until he was aged 76 years and four months; at age 78, he would have no savings left other than the minimal amount of assets allowed under California's rules for Medicaid eligibility.

The outcome for the two-year policy would be similar. The partnership policy would leave the policyholder with nearly $200,000 in savings (the value of the policy benefit) at age 78 (and at age 80 as well). Conventional coverage would enable the policyholder to preserve some of his savings if the period of impairment lasted three years. But if it lasted five years, all of those savings would be exhausted. If the person was uninsured, he would run out of funds at 77 years and eight months of age.

One example of how to structure supplemental LTC insurance is provided by the Partnership for Long-Term Care, which currently operates in California, Connecticut, Indiana, and New York.[4] Originally sponsored by the Robert Wood Johnson Foundation, the program joins with state Medicaid programs to provide long-term care for beneficiaries who purchase partnership coverage. In essence, partnership policies are intended to allow middle-income people to purchase less-expensive, shorter-term LTC coverage and protect some or all of their assets.

Partnership policies resemble typical private LTC insurance policies in every respect except that they offer additional protection of assets. Policyholders who become impaired for an extended period and exhaust all of their LTC insurance benefits can apply for Medicaid coverage; the value of their assets up to the amount of their exhausted LTC benefits is not included in determining their eligibility. (New York and Indiana offer policies that protect all of a policyholder's assets.) A substantial number of one- and two-year policies have been sold in California, Connecticut, and Indiana; New York requires three-year coverage. (See Box 3-2 on page 28 for an example of how a partnership policy works.)

Despite the potential advantages that the partnership program offers to its policyholders, the program is relatively small. One reason is probably that the average partnership policy has historically been somewhat more expensive—about 15 percent higher in 1995 and 1996—than the average conventional policy because the partnership coverage had to include consumer provisions, such as inflation protection, that until HIPAA had not been required of conventional LTC insurance policies. Perhaps because of the price differential, partnership policyholders in 1996 actually had higher income and more assets than holders of conventional LTC insurance policies, rather than the lower income and fewer assets that the program's originators envisaged would be the case.[5]

Table 3-1.

Average Annual Premiums for Policies of the Partnership for Long-Term Care, 2004

(Dollars)

If Policy Is Purchased at Age	Premium for a Policy with a Term of		
	One Year	Two Years	Three Years
55	1,487	2,026	2,505
60	1,775	2,433	3,098
65	2,358	3,264	4,083
70	3,355	4,662	5,872
75	5,098	7,097	8,954

Source: Congressional Budget Office using data from Connecticut's Office of Policy and Management, February 2004.

Note: The table reflects policies offering a benefit of $200 per day for both nursing home and home care, a 90- to 100-day elimination period, and automatically compounded inflation protection of 5 percent.

Another likely reason that the partnership program remained small in the late 1990s was that many insurers were reluctant to sell such policies because of the time and effort required to develop them and get them approved by the participating states. (Also dampening insurers' enthusiasm were the data-reporting and other requirements established by the states.) The fact that the policies were not portable—a partnership policyholder in Indiana could only expect that state's Medicaid program to honor the enhanced eligibility advantages of a partnership policy—was another feature that diminished sales. Indiana and Connecticut have since passed legislation that would allow for portability of the Medicaid asset-protection benefit that their policies include.

Today, the prices of partnership and conventional policies are similar, and many more policies are being sold to the more modest-income segments of the market that the partnership program was originally intended to target. HIPAA's requirements for qualifying as a tax-advantaged policy have narrowed the gap in prices since 1996. In

4. In 1993, the Congress effectively limited the partnership program to the original states by stipulating that policyholders in other states wanting to participate in the program would be subject to estate recovery. In other words, the states would be required to recover at least some of the assets of policyholders after they died, up to the value of Medicaid's expenditures on their behalf. Thus, the value of a partnership policy was limited to preserving policyholders' assets while they were alive. The President's proposed budget for 2005 would eliminate the estate recovery requirement and so allow other states to establish programs under the same provisions that apply to the original four.

5. See Marc Cohen, "The Partnership for Long-Term Care: The Road Ahead," in Nelda McCall, ed., *Who Will Pay for Long Term Care?* (Chicago: Health Administration Press, 2001).

fact, from 1996, when HIPAA was enacted, until the end of 2000, the total number of applications for partnership policies grew from 28,000 to 120,000. Over the same period, total sales of all LTC insurance policies grew from about 5 million to 7.5 million. If the acceptance rate of applications remained relatively constant over that period, then partnership sales grew at a much faster rate than did sales of all types of LTC policies. One of the major factors stimulating significant increases in sales of partnership policies was the changes in the program that were made to keep pace with innovations in conventional policies. According to one study, sales grew from 300 percent to 500 percent over the one-year periods following the policy redesigns.[6]

Another problem that has contributed to the relatively low rate of participation in partnership programs is that short-term partnership policies have not been proportionally less expensive than policies with longer terms. For example, in Connecticut, the average premium for a partnership policy providing benefits for one year is about 72 percent of the average premium for a policy offering two years of benefits and about 58 percent of the average premium for a three-year policy (see Table 3-1). The policies with the most extensive coverage—those offering inexhaustible lifetime benefits—cost about 60 percent more than policies that pay benefits for four years, according to Weiss Ratings.[7] Nevertheless, short-term policies are at least somewhat less expensive than conventional policies, and thus their sales offer less incentive to insurance agents, whose sales commissions are tied to the size of a policy's premium.

An additional potential drawback to partnership policies is that they might increase Medicaid's spending for long-term care. Without question, partnership policyholders would generate more Medicaid LTC expenditures than would holders of conventional policies because partnership coverage would allow policyholders to qualify for Medicaid without first exhausting all of their assets. And Medicaid expenditures would increase for those people purchasing partnership coverage who would have purchased conventional coverage if partnership coverage had not been available.

What is not as clear is how Medicaid expenditures might be affected by people who would otherwise not have purchased insurance at all. On the one hand, partnership policyholders might qualify for Medicaid more quickly than if they had never purchased LTC insurance. People with insurance do not pay the full price of long-term care; most of it is paid by their insurance coverage. As a result, they use more care—and qualify for Medicaid—more quickly than if they had had to pay for all of their care out of pocket. On the other hand, people without insurance might qualify for Medicaid faster than they would if they had held a partnership policy. People without insurance have a diminished incentive to preserve their finances because by exhausting their resources quickly, they qualify for Medicaid that much faster. They also have a strong incentive to try to protect some of their assets using Medicaid estate planning. One reason that New York originally chose to require partnership policyholders to purchase 36 months of coverage was that that period exceeded the average time (30 months) during which a New York resident was penalized by having to pay for long-term care if he or she had previously transferred assets to become eligible for Medicaid.

6. Mark R. Meiners, Hunter L. McKay, and Kevin J. Mahoney, "Partnership Insurance: An Innovation to Meet Long-Term Care Financing Needs in an Era of Federal Minimalism," in Francis G. Caro and Robert Morris, eds., *Devolution and Aging Policy* (Binghamton, N.Y.: Haworth Press, Inc., 2002).

7. Congressional Budget Office calculations using data from Table 1-3.

APPENDIX

A

An Overview of Long-Term Care Services

Long-term care services are generally categorized as either institutional or based in the home and community. Institutional care is provided primarily in nursing facilities, or nursing homes. Home and community-based services (HCBS) may be provided in people's homes or in various facilities in the community, such as assisted living facilities (ALFs), board-and-care homes, and congregate housing. Some common types of home and community-based services are home health care, personal care services, and adult day care.[1]

Nursing Facilities

Nursing facilities typically provide skilled nursing care for people who are recovering from acute episodes of illness involving a recent stay in the hospital; they also offer custodial care for people who are functionally impaired and unable to live independently. People who require skilled nursing care tend to remain in a facility for a relatively brief period, and their stays are likely to be covered by their health insurance—the same insurance that covers their hospital stays and office visits to physicians. (Medicare covers much of that type of care.) In contrast, functionally impaired residents of nursing facilities may remain there for extended periods—depending on their longevity, in some cases for many years. Their costs may be paid by Medicaid, or they may rely on their own resources if they do not qualify for public coverage.

The number of people in nursing homes has declined in recent years as a result of several factors, including the increasing use of home-based care and assisted living facilities and a decline in the prevalence of functional disability. From 1973 to 1985, about 50 of every 1,000 persons over age 65 resided in nursing homes.[2] In 1997, that number had fallen to 43 per 1,000.[3] About 56 percent of those residents were covered by Medicaid. (See Tables A-1, A-2, and A-3 for additional data.)

Assisted Living Facilities

These facilities can be an attractive residential alternative for people who require some assistance but do not need the intensity of care provided at a nursing facility. And they may have special appeal for middle-income seniors because they tend to be less expensive than nursing homes and in many cases offer more attractive physical surroundings. ALFs range in size from very small operations to large-scale developments with 600 to 800 residents. Although they are not licensed as medical facilities (and most states do not license them to provide care to residents who are bedridden), ALFs may offer a wide

1. For more information on types of long-term care services, see the Web site of the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services (http://aspe.hhs.gov/daltcp/diction.shtml).

2. Based on an analysis by Genevieve W. Strahan, *An Overview of Nursing Homes and Their Current Residents: Data from the 1995 National Nursing Home Survey*, Advance Data no. 280 (Centers for Disease Control and Prevention, National Center for Health Statistics, April 25, 2000); and on population data from the Bureau of the Census, available at http://eire.census.gov/popest/archives/national/nation2/intfile2-1.txt.

3. Calculated from data in Celia S. Gabrel, *Characteristics of Elderly Nursing Home Current Residents and Discharges: Data from the 1997 National Nursing Home Survey*, Advance Data no. 312 (Centers for Disease Control and Prevention, National Center for Health Statistics, April 25, 2000); and population data from the Bureau of the Census, available at http://eire.census.gov/popest/archives/national/nation2/intfile2-1.txt.

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Table A-1.

Elderly Nursing Home Residents, by Age and Sex, 1997

Age Group	Both Sexes		Males		Females	
	Number (Thousands)	Percent	Number (Thousands)	Percent	Number (Thousands)	Percent
65 to 74 Years	198.4	13.5	80.8	21.7	117.7	10.8
75 to 84 Years	528.3	36.1	159.3	42.8	368.9	33.8
85 Years and Older	738.3	50.4	132.0	35.5	606.3	55.5
Total	**1,465.0**	**100.0**	**372.1**	**100.0**	**1,092.9**	**100.0**

Source: Congressional Budget Office based on Celia S. Gabrel, *Characteristics of Elderly Nursing Home Current Residents and Discharges: Data from the 1997 National Nursing Home Survey,* Advance Data no. 312 (Centers for Disease Control and Prevention, National Center for Health Statistics, April 25, 2000).

range of personal care and health-related services that appeal to people with functional impairments. In addition to room and board, ALFs provide 24-hour emergency monitoring, supervision and dispensing of medications, opportunities for socializing, and assistance with one or more activities of daily living. Home and community-based services provided in ALFs may be covered under Medicaid HCBS waiver programs, but room-and-board costs cannot be covered.[4] As a result, some states, such as Oregon, use ALFs extensively in their Medicaid programs because they are less expensive than nursing facilities yet offer many of the same services.

Board-and-Care Homes

Also called an adult care home or group home, a board-and-care home offers housing and personal care services to between three and 16 residents. Services such as meals, supervision, and transportation are usually provided by the home's owner or manager. A board-and-care home may be a single-family dwelling; it is licensed as either an adult family or adult group home.

Congregate Housing

Congregate housing describes facilities with individual apartments plus shared dining and other common areas in which residents may receive some services, such as a daily meal, with other tenants. (Additional options may include housekeeping, transportation, and individual meal preparation but not personal care and protective supervision.) Typically, residents pay for congregate housing with their personal resources, but some people may obtain federal housing grants to pay for these living arrangements.

Adult Day Care

Adult day care is a community-based program for functionally impaired adults that provides a variety of health, social, and related support services in a protective setting.

Table A-2.

Average Length of Stay of Current Elderly Nursing Home Residents, by Age and Sex, 1997

(Days)

Age Group	Both Sexes	Males	Females
65 to 74 Years	857	823	881
75 to 84 Years	789	759	801
85 Years and Older	932	725	977
Average, All Groups	**870**	**761**	**907**

Source: Congressional Budget Office based on Celia S. Gabrel, *Characteristics of Elderly Nursing Home Current Residents and Discharges: Data from the 1997 National Nursing Home Survey,* Advance Data no. 312 (Centers for Disease Control and Prevention, National Center for Health Statistics, April 25, 2000).

4. Under the waiver programs (which are discussed in more detail in Appendix B), states have the option of providing impaired people with enhanced community support services that are not otherwise authorized by the federal statutes governing Medicaid.

Table A-3.

Average Length of Stay of Discharged Elderly Nursing Home Residents, October 1996 to September 1997

Reason for Discharge	Length of Stay (Days)	Percentage of All Discharged Residents
Recovered	60	10.2
Stabilized	55	19.0
Deceased	729	27.1
Admitted to Hospital	392	28.3
Admitted to Another Nursing Home	126	7.5
Other	78	7.6
Average, All Discharged Residents	**341**	**100.0**

Source: Congressional Budget Office based on Celia S. Gabrel, *Characteristics of Elderly Nursing Home Current Residents and Discharges: Data from the 1997 National Nursing Home Survey,* Advance Data no. 312 (Centers for Disease Control and Prevention, National Center for Health Statistics, April 25, 2000).

Adult day care centers are often the locus of treatment for programs such as PACE (Program of All-Inclusive Care for the Elderly), which serves impaired seniors who wish to remain in the community. Typically, the functionally impaired person spends the day at the center and the night at home. Some state Medicaid programs cover that form of care; the Medicare fee-for-service program does not, although some alternative Medicare financing programs may. (Appendix B discusses PACE in more detail.)

Table A-4.

Average Duration of Care of Elderly Home Health Care Patients, 1996

(Days)

	Both Sexes	Males	Females
Discharged Patients	107	104	109
Current Patients	336	331	338

Source: Congressional Budget Office based on Martha Little Munson, *Characteristics of Elderly Home Health Care Users: Data from the 1996 National Home and Hospice Care Survey,* Advance Data no. 309 (Centers for Disease Control and Prevention, National Center for Health Statistics, April 25, 2000).

Home Health Care

Home health care provides medically oriented services for acute or chronic illness in the patient's home; it often follows a hospital stay for an acute medical condition or a discharge from another type of medical facility. Most insurers, including Medicaid, Medicare, and private insurance, provide at least limited coverage for home health care. (Tables A-4 and A-5 provide demographic information on elderly home health care patients.)

Personal Care

For people who need assistance in performing activities of daily living, Medicare covers some personal care services—known as home health aide visits—under its home health care benefit. Beneficiaries must be receiving home health care services to qualify for such visits. State Medicaid programs have the option of offering personal care but vary in their coverage of such services. Many of them cover personal care as part of a Medicaid HCBS waiver program. However, the most common source of personal care is the donated care of family members and friends.

Table A-5.

Elderly Home Health Care Patients, by Age and Sex, 1996

Age Group	Both Sexes		Males		Females	
	Number (Thousands)	Percent	Number (Thousands)	Percent	Number (Thousands)	Percent
65 to 74 Years	527.9	30.1	180.4	34.2	347.5	28.4
75 to 84 Years	820.5	46.8	253.5	48.0	566.8	46.3
85 Years and Older	404.9	23.1	94.4	17.9	310.6	25.4
Total	**1,753.4**	**100.0**	**528.3**	**100.0**	**1,224.8**	**100.0**

Source: Congressional Budget Office based on Martha Little Munson, *Characteristics of Elderly Home Health Care Users: Data from the 1996 National Home and Hospice Care Survey,* Advance Data no. 309 (Centers for Disease Control and Prevention, National Center for Health Statistics, April 25, 2000).

APPENDIX

B

Recent Policy Initiatives Affecting Long-Term Care Financing

The federal government has undertaken several initiatives to control how much publicly financed programs spend on long-term care (LTC) and to increase the efficiency of LTC services. Additional objectives of those initiatives include improving the quality of care provided to people who are impaired and better coordinating Medicare and Medicaid benefits for people who are eligible for both programs. The initiatives have reduced costs modestly and improved efficiency to some degree, but evaluations of the programs have generally concluded that those outcomes were largely achieved through so-called favorable selection of participants (participants were healthier than average) or by the shifting of costs to other programs. Indeed, some new programs' expenditures have actually been higher than costs for the fee-for-service programs that they were designed to replace.

The rest of this appendix reviews some of the government's major initiatives regarding publicly financed LTC programs. The first two sections, those dealing with home and community-based services (HCBS) programs and the so-called Cash and Counseling Demonstration fall under the "consumer-directed" rubric (which implies greater participation of the beneficiaries in planning their care) and are two of the most prominent such programs. The remaining discussion describes some representative attetmps to integrate state and federal financing for long-term care.

Home and Community-Based Services Programs

In 1981, the Omnibus Budget Reconciliation Act gave states the option of setting up HCBS waiver programs under Medicaid to serve impaired people—both seniors and individuals under age 65—in the community rather than solely in nursing homes. Established under section 1915(c) of the Social Security Act, the waiver programs allowed states to provide enhanced community support services (such as respite care, home modifications, and nonmedical transportation) that are not otherwise authorized by the federal Medicaid statutes. The programs held out the promise of reducing states' Medicaid spending by caring for qualified HCBS patients in the community rather than in nursing homes—not only to save money but also to help patients retain some sense of independence. As of 2001, 49 states and the District of Columbia had established some type of HCBS waiver program. (Arizona provides home and community-based services under a separate demonstration program, as discussed later.)[1]

In general, Medicaid's spending per patient for HCBS programs is much lower than its spending for nursing home care: Medicaid's average costs per HCBS recipient were $3,135 in 2000, compared with about $20,220 for the average nursing home resident.[2] But those savings may be illusory because of the so-called woodwork effect and because of cost shifting.

1. Demonstrations are programs in which one or more regulations are relaxed to test different ways of managing a particular program.

2. The average cost of $20,220 includes nursing home patients who were institutionalized for the entire year as well as patients who had much shorter nursing home stays.

As evaluators of HCBS programs discovered, the increased availability of home-based care brought new patients "out of the woodwork"—patients who were eligible for care in a nursing home but who would not have entered one in the absence of the HCBS program.[3] Of course, the increased spending implied by such an effect is not necessarily inappropriate or unwelcome, since the people who benefit are eligible for the new program and presumably were meant to receive its services. But the woodwork effect boosts the number of recipients beyond what it would have been if only nursing home care had been available. As a result, it increases Medicaid's costs for providing long-term care, even though home and community-based services cost less per patient than institutional care does. To encourage states to more aggressively move institutionalized Medicaid beneficiaries back into the community, the President, in his 2005 budget, has proposed that the federal government pay all HCBS costs for those beneficiaries for the first year after they leave the facility.

Some programs may have succeeded in saving money, however. Evaluations of a few state programs concluded that they might have reduced spending below what it would have been without the HCBS waiver—by aggressively screening applicants, exploiting other sources of financing, and carefully controlling spending for home-based services, among other approaches. The authors caution, however, that the results' validity is limited by the lack of an appropriate control group.[4]

Another reason that the savings attributed to home-based care may be exaggerated is that a portion of them represents not actual economies but a shift in costs to payers other than Medicaid. When a Medicaid enrollee who is eligible for nursing home care lives at home rather than in a nursing facility, room and board are his or her responsibility.[5] (However, enrollees living at home are also allowed to keep more of their income than they could if they were institutionalized at Medicaid's expense.) In addition, some spending on home-based services shifts from Medicaid to the Medicare program under its home health care benefit. Thus, substituting HCBS for institutional care might be desirable to the impaired person and could reduce both Medicaid and overall LTC expenses. However, it would not necessarily reflect a more efficient use of resources.

The Cash and Counseling Demonstration

Three states—Arkansas, Florida, and New Jersey—are participating in this program, which allows impaired Medicaid beneficiaries who reside in the community to use the program's funds to purchase services on their own rather than rely on Medicaid-provided care. The program is intended to give beneficiaries more choices among types and sources of services and a stronger incentive to search for lower prices to get the most care for their money.[6] (Typical Medicaid coverage provides less of a financial incentive to use services efficiently because beneficiaries experience no direct benefit from doing so.) The President has proposed to further strengthen that incentive by allowing beneficiaries enrolled in the demonstrations to accumulate savings and still maintain their eligibility for Medicaid and Supplemental Security Income coverage.

Preliminary evaluation results from Arkansas, the first state to implement the demonstration, showed that participants in the cash and counseling program were more satisfied with the quality of the care they received, had more access to paid care, and had fewer unmet needs for services relative to participants in the traditional Medic-

3. See Steven Lutzky and others, *Review of the Medicaid 1915(c) Home and Community Based Services Waiver Program Literature and Program Data* (prepared by the Lewin Group for the Department of Health and Human Services, Health Care Financing Administration, June 2000).

4. See Lisa Maria B. Alecxih and others, *Estimated Cost Savings from the Use of Home and Community-Based Alternatives to Nursing Facility Care in Three States,* Pub. no. 9618 (Washington, D.C.: AARP Public Policy Institute, November 1996); and General Accounting Office, *Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs,* GAO/HEHS-94-167 (August 1994).

5. States that use assisted living facilities (ALFs) in their Medicaid programs save money because residents pay the room-and-board charges. (ALFs offer a wide range of personal care and health-related services but not the intense care provided in a nursing facility.)

6. More information is available at www.cashandcounseling.org. See also Kevin J. Mahoney and Lori Simon-Rusinowitz, "Cash and Counseling Demonstration and Evaluation: Start-Up Activities," *Journal of Case Management,* vol. 6, no. 1 (Spring 1997), pp. 25-30.

aid program.[7] The evaluators noted, however, that the results also suggested that the program could lead to paid care's replacing unpaid care and a rise in total Medicaid spending.

Moreover, the program could have an even larger woodwork effect than that observed in the Medicaid-sponsored HCBS programs. Impaired people who met Medicaid's eligibility criteria but had not previously accepted government coverage might choose to claim benefits under the new program if they had greater flexibility in using Medicaid assistance. In turn, their participation could push up spending, although that might not be an undesirable outcome if those expenditures served impaired people who otherwise might have gone without care or obtained it only through hardship imposed on family and friends. In addition to spending prompted by a woodwork effect, the program might see some inappropriate expenditures if some people exaggerated their physical infirmities to qualify for benefits.

Demonstrations That Integrate Acute and Long-Term Care

Health maintenance organizations and some other providers of acute care accept some financial risk in serving their patients because they receive a fixed payment for each enrollee regardless of the amount of care he or she may use. That system encourages providers to reduce costs by eliminating unnecessary treatment—which can increase efficiency—but it gives them no incentive to provide services that might eliminate or lessen the need for long-term care and no encouragement to coordinate acute and long-term care to both save money and benefit the patient.[8] Assigning financial responsibility for both kinds of care to a single organizational entity could create that incentive and make service delivery more efficient. For example, directing more resources toward rehabilitating a patient after a stroke might increase spending on acute care, but it could also lead to overall savings and a better outcome for the patient if rehabilitation restored functions lost through the stroke and thereby prevented or delayed years of long-term care.

Since the early 1980s, the Centers for Medicare and Medicaid Services, or CMS (formerly the Health Care Financing Administration), has authorized several demonstrations in which providers receive capitation payments that cover the entire spectrum of care—from acute to long term.[9] The demonstrations described in this section include social health maintenance organizations, or S/HMOs; the Program of All-Inclusive Care for the Elderly (PACE); and related variants initiated by the states.[10]

Social HMOs

These entities are similar to Medicare Advantage (formerly, Medicare+Choice) health plans:[11] they receive a monthly capitation payment from Medicare and accept full financial risk for the cost of all medical benefits to which their enrollees are entitled. But the payments that S/HMOs receive are somewhat higher than the payments made to Medicare Advantage plans to allow S/HMOs to provide a modest array of LTC benefits in addition to the services typically covered by the Medicare plans. Social HMOs enroll both healthy and impaired seniors, although the majority of enrollees are not impaired. The programs are funded almost exclusively by Medicare and by enrollees' premiums. (S/HMOs may receive Medicaid funding for their enrollees who are eligible for that program, but most S/HMO enrollees are not so eligible.)

Four S/HMO sites were established in the project's first phase, in 1984. Three are still operating and as of January 2004 enrolled just over 70,000 Medicare beneficiaries.[12] The Congress authorized a second round of sites in 1990;

7. Stacy Dale and others, "The Effects of Cash and Counseling on Personal Care Services and Medicaid Costs in Arkansas," *Health Affairs* Web Exclusive, November 19, 2003, available at www.healthaffairs.org.

8. Acute health care comprises such services as hospital care and physicians' visits.

9. Capitation is a payment method whereby a contracting provider of care receives a flat monthly fee to provide services to an enrollee over that period. Typically, the payment does not vary, regardless of how many services are provided.

10. For more details, see Edward Alan Miller, *Federal and State Initiatives to Integrate Acute and Long-Term Care: Issues and Profiles*, CRS Report for Congress RL30813 (Congressional Research Service, January 22, 2001).

11. The change in name will take effect in 2006, but the Congressional Budget Office, like many organizations, has begun to use the plans' new name.

12. The operating sites are Elderplan, Inc., in Brooklyn, New York; SCAN Health Plan in Long Beach, California; and Senior Advantage II, part of Kaiser Permanente of the Northwest, in Portland, Oregon.

one phase II S/HMO is now operating in Las Vegas, with roughly 50,000 members.[13] Compared with the sites set up in the first phase of the project, the Las Vegas plan is designed to provide more specialized geriatric care. It also features expanded case management to better coordinate care and thus address some of the problems with coordination that had been identified among the phase I sites.

The LTC benefits offered by S/HMOs typically include community-based services—such as help with homemaking activities and household chores, personal care, transportation to medical appointments, adult day care, respite care, and case management—as well as limited nursing home services.[14] Spending for LTC services offered by S/HMOs is subject to ceilings that differ by the type of benefit (home and community-based care or nursing home care) and period (monthly, annual, or lifetime). The annual maximum benefit ranges from $7,800 to $9,600 per enrollee. In general, the S/HMO may provide LTC services only to enrollees who are impaired enough to qualify for admission to a nursing home.

For each enrollee of plans established during the project's first phase, the S/HMO base payment is 105.3 percent of the county rate for Medicare Advantage plans. That payment is adjusted on the basis of the enrollee's age and sex as well as several other factors, including whether the enrollee is a nursing home resident, is enrolled in Medicaid, is working, or has end-stage renal disease. In addition to the slightly higher base payment, phase I S/HMO payments differ from those of Medicare Advantage plans in that they are higher for community-dwelling enrollees who meet the state's eligibility criteria for admission to a nursing home.[15] Payments to Medicare Advantage plans are not adjusted in that fashion. As a result of those payment differences, phase I S/HMO plans receive payments that average about 15 percent to 30 percent more than those of their Medicare Advantage counterparts.

The payment method for phase II sites is completely different from the phase I approach. The payment for each enrollee is based on an analysis of data from the Medicare Current Beneficiary Survey and depends on the enrollee's sex, the presence or absence of certain chronic diseases, the ability to perform the activities of daily living, self-reported health, and the ability to walk a quarter mile. Each year, the payments are updated, in part through surveys that gather new data on each enrollee's health status. Under this new method, payments for the phase II S/HMO plan and for Medicare Advantage plans in the same county differ by only about 5 percent.

Like Medicare Advantage plans, S/HMO plans are in the midst of a transition to a new risk adjustment mechanism called the CMS-Hierarchical Conditions Category (CMS-HCC) model. Under that new method, the base payment is adjusted according to the enrollee's frailty as measured by the CMS-HCC model. The shift to the new payment methodology began this year and will continue for several years. In 2005, Medicare Advantage plans will be paid half on the basis of the CMS-HCC model and half on the basis of the system in place in 2003. S/HMO plans will be paid 30 percent on the basis of the CMS-HCC model and 70 percent on the basis of the 2003 system.

Research on the S/HMO demonstrations suggests that they may not provide better health outcomes than those provided by typical Medicare (and Medicaid) fee-for-service coverage of post-acute care. Indeed, analyses show that impaired S/HMO enrollees have had somewhat higher mortality rates than fee-for-service beneficiaries have had.[16] Enrollees' satisfaction with the program appears to vary by their functional status. Assessments of the phase I demonstrations indicated that in general, S/HMO enrollees who were not impaired were more satisfied with the care they received than were Medicare fee-for-service beneficiaries, whereas impaired S/HMO enrollees were less satisfied. The data on customer satis-

13. Personal communication to the Congressional Budget Office by Thomas Theis, Project Officer, Centers for Medicare and Medicaid Services, February 17, 2004.

14. See Appendix A for a description of adult day care. Nursing home services are not intended to cover long stays. For example, the SCAN Health Plan in southern California offers a "short-term institutional stay" benefit for respite care or to help frail patients rest for up to two weeks after a hospital stay. The benefit has a maximum lifetime cap of $15,000 on expenditures.

15. That so-called frailty adjustment is intended to reflect the historically higher amount that the Medicare fee-for-service program spends on health care for institutionalized beneficiaries.

16. That finding is documented in Miller, *Federal and State Initiatives to Integrate Acute and Long-Term Care;* and Kenneth Manton and others, "Social/Health Maintenance Organization and Fee-for-Service Health Outcomes Over Time," *Health Care Financing Review,* vol. 15, no. 2 (1993), pp. 173-202.

faction, however, are from the late 1980s and may not be representative of the experience of today's enrollees.[17]

A study that compared enrollees in the S/HMO demonstrations with Medicare Advantage enrollees in the same counties showed many of the same results as in the fee-for-service comparison and found no justification for the higher payments that S/HMOs receive. For example, evaluators found no evidence that enrollees in the phase II S/HMO obtained better health outcomes than their Medicare Advantage counterparts, and enrollees in phase I S/HMOs were no more satisfied with the quality of their care or their health insurance coverage. Moreover, except for the Kaiser S/HMO, there was no measurable difference in health status or functioning between Medicare Advantage and phase I S/HMO enrollees, although the S/HMO enrollees were older. Evaluators also discovered that despite significantly higher payments for their enrollees, phase I S/HMOs—with the exception of the Kaiser site—did not spend all of the extra revenue on long-term care benefits.[18]

PACE (Program of All-Inclusive Care for the Elderly)

PACE began as a demonstration authorized under the Omnibus Budget Reconciliation Act of 1986, but the Balanced Budget Act of 1997 established the PACE model as a permanently recognized provider type under both the Medicare and Medicaid programs. Today, 32 PACE organizations provide preventive, acute, and LTC services to approximately 9,000 enrollees.[19]

PACE enrolls Medicare beneficiaries who are frail enough to be eligible for nursing home care but who want to continue living at home. Although not a requirement, nearly all PACE enrollees are also eligible for Medicaid. People who are not eligible for Medicaid may enroll in PACE, but they are required to pay a monthly premium similar to the state's payment for people who are eligible. The premiums have deterred many people who are not eligible for Medicaid from enrolling in PACE.

In PACE's model of service delivery, the main locus of care is the adult day care center, where enrollees receive the bulk of their care from multidisciplinary teams of providers that include physicians, nurses, and case managers. Typically, the providers are PACE employees, drawing a salary rather than charging fees for each service they provide.

PACE plans receive monthly capitation payments from both Medicare and Medicaid to cover their enrollees' costs for acute and long-term care. Before January 1, 2004, Medicare calculated its PACE payment in the same way that it calculated a Medicare Advantage payment but then multiplied the payment by a frailty adjustment of 2.39. Beginning on January 1, 2004, the Medicare payment for PACE began a transition to a risk-adjustment approach using the CMS-HCC model (the approach also being used to adjust payments for Medicare Advantage and S/HMO plans). Under that method, the base payment will be adjusted by each enrollee's frailty score as measured by the CMS-HCC model as well as by a frailty score for the particular PACE organization to which the enrollee belongs.

Medicaid's payment for PACE enrollees is a rate negotiated between the state and the PACE organization that, in theory, is less than would otherwise have been paid for a comparable population. The state must establish an upper payment limit based on a comparable population, a limit that includes weighted costs from both the home and community-based population and the nursing home population. Typically, rates are set at a percentage of that upper payment limit, which varies by state.

Evaluations of PACE have shown less nursing home use, lower mortality rates, lower rates of inpatient utilization (hospital days), and higher satisfaction for enrollees than for their Medicare fee-for-service counterparts. However, PACE's ability to delay or prevent the need for nursing home care may result in part from favorable selection: although PACE enrollees are significantly impaired when they enter the program, they appear to be less impaired than nursing home residents. That finding suggests that if they had not joined PACE, they would still not have required care in a nursing home and their associated Medi-

17. See Office of Research and Demonstrations, Health Care Financing Administration, *Status Report on the Implementation and Evaluation of the Social Health Maintenance Organization Demonstration* (1996).

18. See Judith Wooldridge and others, *Social Health Maintenance Organizations: Transition into Medicare+Choice* (report submitted by Mathematica Policy Research, Inc., to the Health Care Financing Administration, January 5, 2001).

19. Personal communication to the Congressional Budget Office by Tonya Moore, Project Officer, Centers for Medicare and Medicaid Services, March 2004.

care costs might have been much lower than Medicare's capitation payment to PACE sites.

An evaluation published in 2000 found that care delivered through PACE costs a little more than care from the Medicare and Medicaid fee-for-service programs.[20] The analysis compared PACE's capitation payments with what Medicare and Medicaid would have spent, on a fee-for-service basis, for PACE enrollees during their first year in the program. Overall, the two programs' payments to the PACE plans exceeded what they would have spent if the PACE enrollees had remained under fee-for-service arrangements. Yet those results should be interpreted with caution because the study looked only at the first year of enrollment in PACE and the authors did not have a good comparison group. Currently, the potential impact of PACE on national LTC spending is limited by the small number of people who actually join the program. However, an expansion of the program's enrollment would probably increase rather than decrease Medicare's and Medicaid's LTC spending.

The Arizona Long-Term Care System

The Arizona Long-Term Care System (ALTCS) is the first capitated LTC Medicaid program in the nation to operate statewide. ALTCS provides both acute and long-term care for its enrollees and is their sole source of Medicaid-funded LTC services. The program serves severely impaired people both older and younger than age 65; clients must be so impaired that their condition qualifies them for a stay of at least 90 days in a nursing home (although they need not actually be institutionalized to qualify for coverage under ALTCS). Patients who require stays of less than 90 days may receive such care in Arizona's regular acute care Medicaid program if they otherwise meet the state's eligibility requirements for enrollment.

ALTCS controls costs by aggressively screening potential beneficiaries, which helps constrain possible woodwork effects. One study estimated that 97 percent of ALTCS enrollees needed help with toileting and eating compared with 65 percent of nursing home residents nationwide.[21] ALTCS also helps restrain spending by designing financial incentives to encourage the utilization of lower-cost care.

Health plans that participate in the Arizona program may be privately owned or operated by a county. The state pays the plans a capitation amount, which does not vary according to an enrollee's institutional status, to encourage them to provide services economically. To develop the payment for each plan, the state estimates the proportion of people who could be served through home and community-based services rather than in nursing homes in the coming year. It then sets the capitation rate to cover what the plan would have to spend on the basis of that assumption. If the actual proportion of enrollees served by home and community-based services is larger than had been estimated, the plan retains 70 percent to 100 percent of the savings depending on their magnitude; if the proportion is smaller, the state reimburses the plan for only zero to 30 percent of its resulting losses (again, depending on the extent of the savings).[22] Participating plans thus have a powerful incentive to use home and community-based services rather than nursing homes.

According to a CMS-funded evaluation of the ALTCS demonstration, the capitated system saved 16 percent of the costs that would have been incurred for nursing home care if Arizona's program had been a more traditional Medicaid program.[23] Another study, which compared ALTCS data with Medicaid data from other states, estimated that ALTCS produced savings equal to about 35 percent of the nursing home costs that would have been incurred without it.[24] The reasons for the Arizona program's success—which were identified in both studies—were the careful screening process (in one analysis,

20. Abt Associates, Inc., *Evaluation of the Program of All-Inclusive Care for the Elderly Demonstration: A Comparison of the PACE Capitation Rates to Projected Costs in the First Year of Enrollment* (report prepared for the Health Care Financing Administration, October 27, 2000).

21. See William G. Weissert and others, "Cost Savings from Home and Community-Based Services: Arizona's Capitated Medicaid Long-Term Care Program," *Journal of Health Politics, Policy, and Law,* vol. 22, no. 6 (1997), pp. 1329-1357.

22. See Michael S. Sparer, "Health Policy for Low-Income People in Arizona," in *Assessing the New Federalism,* Occasional Paper no. 32 (Washington, D.C.: Urban Institute, 1999).

23. See Nelda C. McCall and others, *Evaluation of Arizona's Health Care Cost Containment System Demonstration: Final Report* (prepared for the Health Care Financing Administration by Laguna Research Associates, San Francisco, February 1996).

24. Weissert and others, "Cost Savings from Home and Community-Based Services."

nearly 75 percent of the ALTCS clients were deemed to be at high risk of nursing home placement) and the aggressive use of home and community-based services rather than institutionalization. But the savings that ALTCS produced may be exaggerated if some of the clients who were at high risk of institutionalization would not, in fact, have chosen to enter a nursing home if home and community-based services had not been available.

Another consideration in weighing the value of the demonstration is that the stricter eligibility criteria employed by ALTCS may mean that many of the people who failed to qualify are still significantly impaired and must either purchase long-term care or obtain it informally from a family member or friend. (In another state, those people might have qualified for LTC services under a more traditionally run Medicaid program.) Such individuals may also use greater amounts of acute care than they would have if they had been accepted into the ALTCS program.

Other Long-Term Care Programs for Elderly People

A number of states participate in the Medicare/Medicaid Integration Program, an effort sponsored by the Robert Wood Johnson Foundation that seeks to better coordinate financing, case management, and the delivery of services for people who are eligible for coverage under both of those public programs. The current roster of states receiving funding comprises Colorado, Connecticut, Florida, Maine, Massachusetts, Minnesota, New Hampshire, New York, Oregon, Rhode Island, Texas, Vermont, Washington, and Wisconsin. For the purposes of illustration, the following discussion highlights three of those programs.

Minnesota Senior Health Options, the Wisconsin Partnership Program, and Massachusetts Senior Care Options are demonstrations that are working to delay institutionalization (by expanding home and community-based services), control costs, and reduce administrative complexity. Wisconsin's program enrolls only people whose impairments are severe enough to qualify them for nursing home care; the Minnesota and Massachusetts programs enroll both healthy and impaired seniors.

In general, these demonstration programs receive monthly capitation payments from Medicare and from their respective state Medicaid programs. For each impaired enrollee (a Medicare beneficiary), the demonstration programs, like PACE plans, receive funding from Medicare that is 2.39 times the county payment rate for Medicare Advantage plans. (The programs' payments for healthy enrollees are essentially the same as those to the Medicaid Advantage plans.) And, like the S/HMOs and PACE plans, these state demonstration programs are shifting to the CMS-HCC risk-adjustment approach. The transition began this year: programs were paid 90 percent on the basis of the old method and 10 percent on the basis of the CMS-HCC model. In 2005, the plans will be paid 30 percent on the basis of the CMS-HCC method and 70 percent on the basis of the system in place in 2003.

The states' Medicaid payments are also capitated and adjusted to cover the costs of an impaired population. In the Minnesota program, for example, the Medicaid payment for impaired seniors equals the average monthly payment for home and community-based services less 5 percent. For enrollees who are admitted to nursing homes, the demonstration programs pay all costs for the first six months. After that, the state is responsible for paying the nursing home's basic per diem rate, and the programs must pay all remaining expenses.

Conclusion

In general, demonstrations integrating acute and long-term care do not by themselves offer much promise of substantially lowering future LTC spending, although the model they represent may be beneficial for their enrollees. Programs that rely on voluntary enrollment—even though they may provide cost-effective, high-quality care—have not attracted large numbers of people. In addition, because most of the programs are available only to people who are eligible for Medicaid, the pool of potential participants includes just a fraction of the people who need LTC services. Indeed, for many of the programs, an important objective has been to better coordinate funding from Medicare and Medicaid because elderly impaired people and their caregivers are often overwhelmed by the administrative complexity involved in receiving benefits from both programs.

Enrollees in S/HMOs need not be eligible for Medicaid, and therefore those programs could have a larger enrollment than is possible for some of the other integrated programs. The distinction is moot, though, since few managed care plans have been willing to participate, and the LTC benefits may be inadequate for people with significant long-term care needs.