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Long-Term Care Policy: Where Are We Going?

Gerontology Institute, University of Massachusetts Boston

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
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■ ***Long-Term Care Policy:
Where Are We Going?***

Gerontology Institute
University of Massachusetts at Boston



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**Gerontology Institute
University of Massachusetts at Boston**

**Prepared by OMB Watch, Washington, D.C.
April, 1990**

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THE NEED FOR LONG-TERM CARE

At A Glance

The Nursing Home Population

- In 1985, about 1.5 million people lived in 19,000 nursing homes nationwide. Of the total, 1.3 million were age 65 and over — 16% were age 65-74; 39% were age 75-84 and 45% were 85 and older.
- Seventy-five percent of nursing home residents in 1985 were women; nearly 84% had no spouse.
- The 1.3 million elderly in nursing homes represented only about 20% of dependent elderly. The other 80% were being cared for at home.

Increasing Numbers of Elderly

- In 1987, 29.8 million Americans were age 65 and older — about one in eight Americans or about 12%.
- The number of Americans age 65 and older in the year 2020 is estimated to be about 50 million — one in five Americans or approximately 20% of the population.
- Between 1960 and 1980, the percentage of elderly 85 and over rose from 5.6% to 8.8%. By the year 2000, these “old-old” are expected to comprise 14.7% of the total elderly population. The number of Americans age 85 and over was 2.7 million in 1985; that number is projected to increase to over 7 million by 2020.

Nursing Home Costs

- Nursing home care today costs from about \$25,000 to \$40,000 a year. The Brookings Institution estimates such care to cost about \$55,000 a year by 2020.
- The American Health Care Association estimates that about one-half of the elderly in nursing homes in 1988 had out-of-pocket expenses greater than \$5,000 for their stay that year, and over 10% incurred personal expenses of over \$50,000.

CHAPTER I.

INTRODUCTION

"There is something fundamentally wrong with a system in which people must impoverish themselves to find even minimally decent care in their final years."

Ford Foundation Project on Social Welfare and the American Future¹

Millions of Americans suffer from physical or mental conditions that make it difficult for them to live fully independent lives. These are the frail elderly, disabled and chronically ill persons of all ages, and many mentally ill or mentally retarded persons. They need help to manage daily activities, whether they live in their own homes or in nursing homes.

Such care can be extremely expensive, since it often must be provided for many years, even a lifetime. Today, those costs are met largely by the individuals themselves or by their families and by public programs for low-income persons.

For many years, persons in the U.S. in need of long-term care have struggled along with a patchwork system of private financing, insufficient state and federal funding, and limited private insurance. But today there is a new awareness and a new public focus on the difficulties that disabled and chronically ill Americans face in obtaining and paying for long-term care services.

Two factors are largely responsible for this heightened understanding. One is an increase in the number of elderly persons who are living into their 80s and 90s when disabilities become more prevalent. The other is advanced medical technology that is helping to save the lives of thousands of people who now survive a serious accident, injury, or birth defect, but still face a lifetime of crippling disabilities.

Although those who need long-term care include a child with cerebral palsy or an adult left paralyzed from an automobile accident, the major focus of the debate about the country's long-term care system tends to focus on the elderly. They are the biggest users of long-term care services today—and their numbers are growing dramatically. This means increasing numbers of nursing home residents and growing pressure on community services and families to help the elderly who want to remain in their homes.

The cost for such service for months and years is high. The wealthy generally can afford to pay for private care services, at home or in nursing homes. But the poor have to depend on

¹ "The Common Good: Social Welfare and the American Future," Policy Recommendations of the Executive Panel, Ford Foundation Project on Social Welfare and the American Future (May 1988).

Medicaid — a federal-state welfare program — or other scarce public services. For middle-income elderly, the need for long-term care often means exhausting all their own resources and then turning for financial help to Medicaid to pay for nursing home costs. That is putting a greater burden on a program intended to provide health care services for the poor.

When those public dollars are spent for long-term care services for middle-income people, there are fewer dollars available for non-elderly, low-income persons because of tight constraints on federal and state budgets.

But even Medicaid assistance is not available to many of those who remain in their homes or to those who are not poor enough to qualify for the program. Long-term care services must be paid for out-of-pocket or the families become the providers of care.

Despite these many problems, long-term care was an issue that remained in the shadows for many years. The two-year debate over the Medicare Catastrophic Coverage Act, culminating in passage of the law in June 1988, focused more attention on the issue. Although most lawmakers and policymakers supported the thrust of the catastrophic care legislation, many were concerned that there was no provision for long-term care coverage. The need for long-term care is easily the number one financial risk for the elderly, many experts say, and certainly a more likely catastrophic event than an extended stay in a hospital.

But, ironically, the passage of the catastrophic coverage legislation not only brought the long-term care problem to the forefront, it also may have contributed to pushing a solution to the problem further off into the future. The new law generated considerable controversy among the elderly because for the first time in the history of Medicare, the beneficiaries were expected to finance the new benefits. A surtax on higher-income elderly in particular drew complaints from thousands of the elderly. Many protested that they were being forced to pay for coverage they already had through private insurance or provided by former employers.

In the face of this forceful opposition, Congress has retreated on the legislation — and in the process has become much more cautious about considering new programs to deal with long-term care needs. Such programs are estimated to cost five to six times more than the catastrophic coverage program. If the elderly are unwilling to pay for catastrophic care benefits, lawmakers say, can they assume the much higher costs of long-term care benefits? And are there not other competing needs in American society such as the millions of Americans without any health insurance at all?

Still, the growing need for long-term care and the high costs of such care have forced federal policymakers to question whether the current haphazard and poorly coordinated system should continue. By common agreement, it is a system that forces thousands of Americans into poverty, exhausts the strength and resilience of their families, and diverts public funds from other social goals.

This report examines the background of the long-term care issue and the debate that has developed in Congress on how to address concerns about the financing and availability of long-term care.

CHAPTER II.

DEFINING THE PROBLEMS

Long-term care consists of services provided for people with chronic physical or mental conditions that reduce their ability to function independently. Their disabilities may last for many months or years – or perhaps a lifetime.

These conditions range from Alzheimer’s disease, strokes, osteoporosis, Acquired Immune Deficiency Syndrome (AIDS), dementia, chronic degenerative diseases, and many other disabling conditions that affect all age groups. Children with lung disease who might have died in the past now are able to live with the help of mechanical respirators, for example. There are an estimated 3 million people with Alzheimer’s disease, half a million with Parkinson’s disease and millions of others who suffer from heart ailments, strokes and other ailments.

Long-term care is not necessarily nursing home care; the setting in which the care is provided does not define the need or the issue. And long-term care is not solely a health issue since the services that are needed run the gamut: skilled nursing, physical therapy, social services, and maintenance services.

A. Chronic Care Needs

A person’s need for long-term care is determined in large part by the severity of a person’s disabilities (and thus dependency). This need is generally evaluated by determining how many “activities of daily living” (ADLs) a person can perform independently, such as eating, dressing, bathing, getting in or out of a bed or chair, using a toilet or maintaining bladder and bowel control. A person who needs help with five or six ADLs is considered severely disabled.

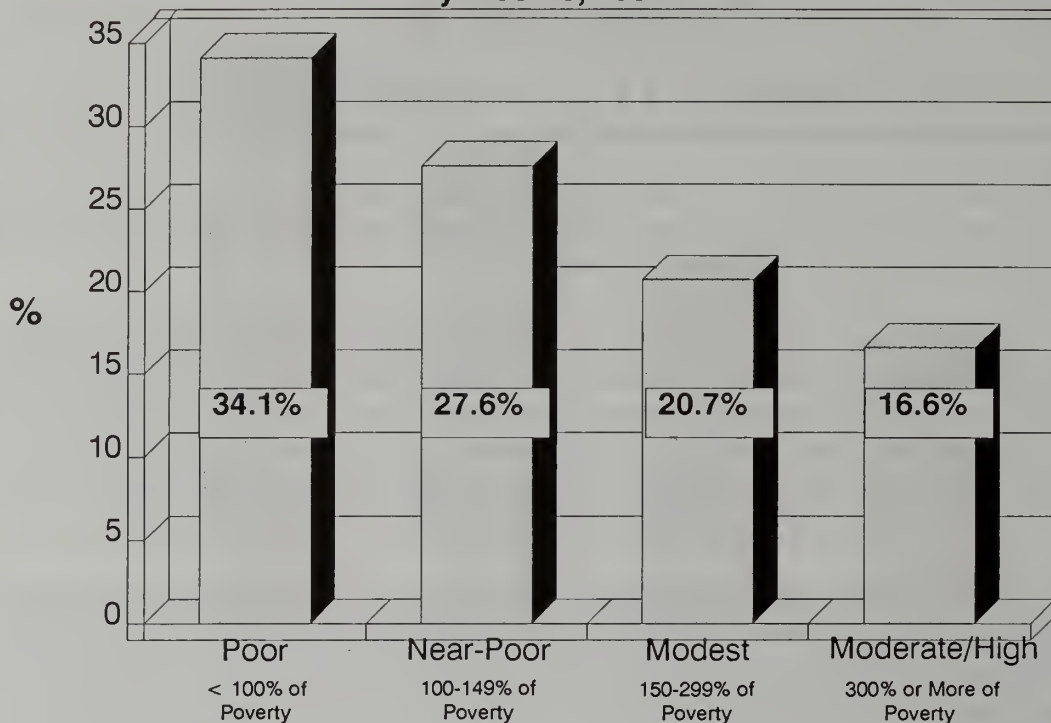
Less severely disabled persons may be able to handle most of these basic everyday activities, but still need help with housework or shopping or managing money. These types of activities are called “instrumental activities of daily living” or IADLs.

A nursing home may be the only alternative for the severely disabled person who can’t manage many of the ADLs and has no family to help provide care. But difficulty with one or more IADLs often can be addressed by community services, such as “Meals on Wheels” for meals and “representative payees” to handle writing checks and paying bills.

Elderly with One or More Limitations in

Activities of Daily Living (ADLs)

By Income, 1984



Source: National Health Interview Survey and Supplement on Aging, 1984

B. Providers of Long-Term Care

Services in the home

Despite the association in many people's minds of the term "long-term care" with nursing homes, more long-term care services are provided in the home than at any other location. At-home care includes "formal" paid services from health care providers and home health care aides and "informal" services from family members.

Family members are "caregivers" for about three-fourths of the disabled persons who remain in their homes. A national survey of caregivers by the American Association of Retired Persons (AARP) and the Travelers Companies found that 7 million U.S. households contained caregivers in 1987 and that 55 percent of these caregivers also had jobs outside the home.²

Living in a nursing or rest home

For those without family caregivers, nursing homes or rest homes (called "board and care" homes in many parts of the county) become the only answer.

² "Working Caregivers Report: A National Survey of Caregivers," American Association of Retired Persons, March 1989.

Nursing homes provide either “skilled,” “intermediate” or chronic care. In a skilled facility, nursing or rehabilitation services are provided by registered and licensed practical nurses and therapists under the supervision of an attending physician. The intermediate care facility provides less intensive nursing care than the skilled facility, with the stress on rehabilitation therapy to help a patient handle as many basic daily activities as possible. Nursing homes for the chronically ill provide the basic care that those with functional disabilities need.

For many low-income dependent persons of all ages, the answer is not a nursing home, either because they can’t afford one or, more likely, because they can still live somewhat independently but have little money and no family help. So they often live in rest homes of one kind or another, because that’s all they can afford. These homes often provide little more than a room and meals, but there is generally at least minimal supervision. In 1987 there were a total of about 41,000 licensed homes with about 563,000 beds.

Long-term care services are also available at life-care or continuing-care communities or in institutions other than nursing homes, such as mental institutions or hospice facilities.

Long-term care workers and families

Paid long-term care workers include people with various levels of skills ranging from registered nurses, therapists and social workers to home health aides, nursing assistants, and housekeepers. In nursing homes, nursing assistants are estimated to provide 80 to 90 percent of the “hands-on” care received by residents.

C. Who Needs the Services?

The Young and the Old

While it is true that the elderly are more likely to need long-term care than other age groups, there are hundreds of thousands of children and adults under 65 who have the same needs. The dearth of studies or surveys on the under-65 long-term care population makes it difficult to determine how large the numbers may be. Also, many younger dependent persons are cared for at home and their numbers not tracked. However, it is known that in 1985 between 175,000 and 200,000 people under age 65 were living in nursing homes.

The National Governors’ Association Center for Policy Research and Analysis suggests that in the year 2000, 40 percent of functionally dependent Americans will be under 65 years of age.³

Children and adults below the age of 65 face different problems financing long-term care than do the elderly. They are not eligible by reason of age for even the limited assistance available under Medicare. And many are in families whose incomes are not low enough to qualify them for Medicaid. The family of a child with a rare disease or a birth defect can face a lifetime of costs that they must meet themselves. Private insurance is seldom available.

3 Aiken, Linda H., “The Aging of America: Implications for State Policy,” *Building Affordable Long Term Care Alternatives: Integrating State Policy*, National Governors’ Association Center for Policy Research and Analysis, Washington, D. C. (April 1987), p. 11.

And there are often difficult tradeoffs for states between the old and the young when it comes to spending public dollars for their care. In 1988 testimony before a congressional committee, Charles Atkins, Commissioner of the Massachusetts Department of Public Welfare, talked about the problems facing states in allocating Medicaid dollars for long-term care for the elderly in nursing homes or in providing health care services for poor children and their families.

Atkins said that many states have not been able to adjust their eligibility limits or cash payments under Medicaid to meet increases in the cost of living. As a result, he said, states must either reduce their budgets “intended for poor children and families, or place an intolerable financial burden on the elderly who require long-term care services.”

“Poor women and children should not be put in the position,” he said, “of having to compete with the elderly for vital services that they depend upon for their health and well-being.”⁴

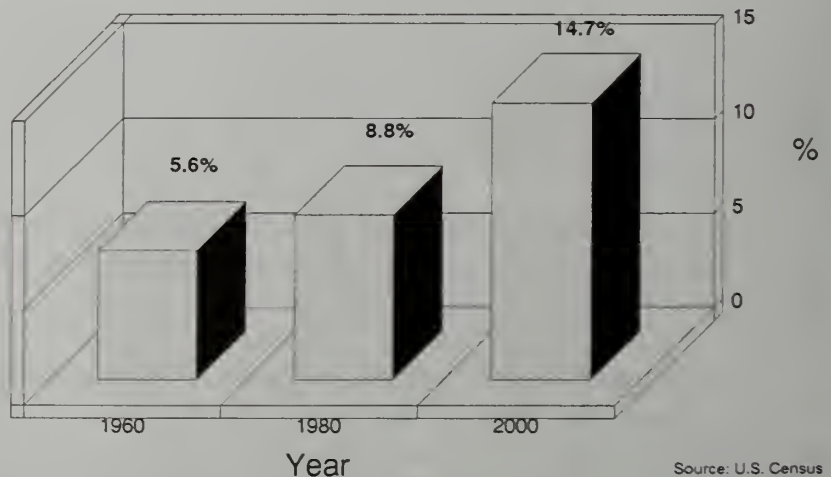
The Old-Old

Still, it is the elderly who are the largest consumers of long-term care services today, particularly in terms of nursing home care, and they are the population whose needs are growing the fastest.

“Nursing home residents are disproportionately very old, female, and white,” reports the U.S. Senate Special Committee on Aging. Seventy-five percent of residents in 1985 were women; about 45 percent were age 85 and over. Nearly 84 percent of the residents were without a spouse.

The fact that such a large proportion of the nursing home population are age 85 and over—the so-called “old-old”—is significant to forecasting how serious a problem the country faces in the near

The Old Are Becoming Older
Percentage of Elderly Age 85 and Older



⁴ Atkins, Charles M., Commissioner of the Massachusetts Department of Public Welfare, testimony before the U.S. Senate Committee on Finance Subcommittee on Health, June 17, 1988.

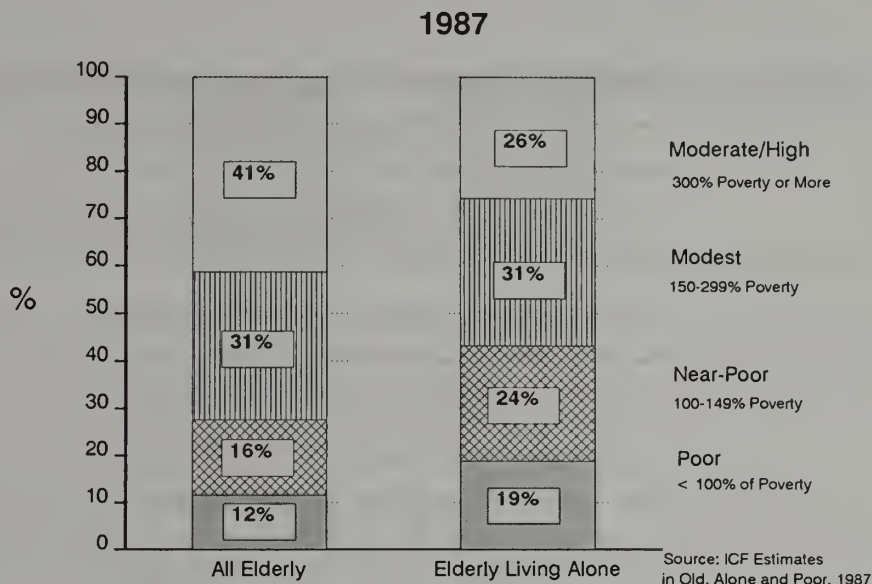
future. For this age group is the fastest growing in the population. There were 2.7 million persons age 85 and above in 1985; that number is projected to increase to over 7 million by 2020.

Living Alone and Poor

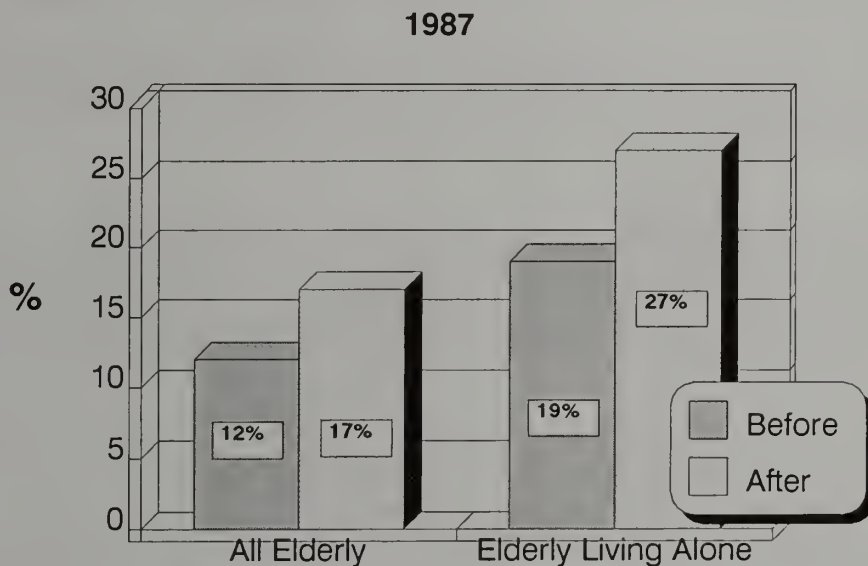
Another statistic about the elderly affects the debate about long-term care: the number of elderly living alone. This group of the elderly have higher poverty rates than elderly couples and most tend to be older and frailer than other elderly people. Thus they are more likely to be vulnerable and dependent.⁵

And poverty is particularly prevalent among the oldest of the elderly. In 1986, the poverty rate for persons 85 and over was 17.6 percent, compared to a poverty rate of 10.3 for persons age 65 to 74 and 13.7 percent for all persons under age 65.⁶

Income Distribution of the Elderly



Poverty Before & After Medical Expenses



⁵ Rowland, Diane and Barbara Lyons, *Medicare's Poor: Filling the Gaps in Medical Coverage for Low-Income Elderly Americans*, The Commonwealth Fund Commission on Elderly People Living Alone, Baltimore, Md. (November 1987), p. 15.

⁶ *Aging America: Trends and Projections, 1987-1988*, prepared by the U.S. Senate Special Committee on Aging, pp.42-44.

CHAPTER III.

WHAT ARE THE ISSUES?

Although the long-term care issue has drawn national attention in the last few years, few politicians or policymakers seem sure of how the country should address the issue. Should it be tackled as part of a more comprehensive reform of the country's entire health care system – one component of a universal health care system, for example? Should an attempt be made to shift the focus from institutionalization and nursing homes to development and encouragement for community and home-based programs? Should efforts be directed toward a social insurance model for long-term care or is a public-private mix of financing a more appropriate mechanism in an age of fiscal constraints?

To answer these questions, policymakers look at issues of financing and access.

A. How to Share the Financing

Undoubtedly, the most controversial question revolves around the financing of long-term care services and what should be the appropriate roles of government, the private sector and individuals.

Nursing home care today costs from about \$25,000 to \$40,000 a year. The Brookings Institution estimates that such care by the years 2016 – 2020 will cost \$55,000 a year.⁷ Home care services from a private agency range from about \$50 to \$200 a day – or \$18,250 to \$73,000 a year if used every day. In 1988, the average home health care visit reimbursed by Medicare cost \$63.

With billions of dollars already being spent on long-term care services, the question is whether individuals and their families should continue to shoulder as much of the cost burden as they do today or whether government programs should pick up a greater share. Since state governments through the Medicaid program already share costs almost equally with individuals today, questions about changes in the financing of long-term care also focus on the degree to which the federal government, possibly through Medicare, should increase its share and whether individuals should be expected to contribute to their own long-term needs through insurance or savings.

If federal and state governments pick up a greater share of the costs of long-term care,

⁷ Rivlin, Alice M. and Joshua M. Wiener, *Caring for the Disabled Elderly. Who Will Pay?* The Brookings Institution, Washington, D.C., 1988, p. 42.

some researchers worry that it will stimulate a “woodwork effect.” Families who had been taking care of their relatives would turn to the government for help, asking for paid workers to substitute for the families’ unpaid labor. Thus, people would “come out of the woodwork” to claim federal dollars – and the costs to the federal and state governments would explode. Other analysts are less certain that would be the result of greater federal financing of long-term care. They believe families would continue their support for their relatives, but would only tap into federal resources to help give them some respite from their difficult burden.

B. Where Will Care be Provided?

Access to long-term care services depends on many factors: one’s ability to pay for care in an institution or for formal services at home supplied by private providers, the availability of space in a nursing home or a life-care community, or the availability of paid service providers such as therapists or home health aides.

Shortages of nursing home beds exist in many parts of the country. Another problem is shortages of trained aides and assistants who provide the bulk of the hands-on care for nursing home residents and people in their homes.

Ability to Pay

Even though nursing homes are not supposed to discriminate against Medicaid applicants in favor of private-pay applicants, few doubt that many nursing homes find private-pay applicants more desirable than Medicaid applicants. The reasons are simple: nursing homes say that many states fail to reimburse them adequately for the care of Medicaid residents. So a nursing home may try to find ways to attract private-pay residents and to discourage Medicaid applicants.

Problems exist also for low-income dependent persons who seek out affordable housing in rest homes. Many rest home residents rely on the federal-state Supplemental Security Income (SSI) program which is available to low-income persons who are blind, disabled or elderly. The federal monthly payment to SSI recipients in 1990 is \$386; most states supplement that amount. But many operators of these homes complain that the total monthly payment often fails to meet their expenses for housing SSI residents.

Space Shortages

The number of nursing-home beds available for dependent elderly varies considerably from one state to another. In 1985, the supply ranged from approximately 202 beds per 1,000 elderly in Minnesota to about 60 beds per 1,000 in Florida.⁸ Nationwide, the nursing home occupancy rate is about 93 percent.

Crowded nursing homes are not only caused by an increasing number of elderly needing institutionalization, but also may result from state actions to control the rate of increase in

⁸ U.S. General Accounting Office, *Long-Term Care for the Elderly: Issues of Need, Access, and Cost, Report to the House of Representatives Select Committee on Aging*, Washington, D.C. (November 1988), p. 21.

Medicaid costs by limiting the number of nursing home beds. One way states can limit growth in nursing home beds is by tightening Medicaid reimbursement. Medicaid law requires that the rates states pay to nursing homes for services to Medicaid residents be “reasonable and adequate” to meet the costs incurred by nursing homes that are operated “efficiently and economically” and which are meeting federal and state standards for quality and safety. But nursing homes say that the per-day expense for which they are being reimbursed does not match their actual costs.

Shortages of Workers

Shortages of home health care workers also limit how much assistance a disabled person can obtain at home. These workers are seldom well-trained and often underpaid. Consequently, turnover is high in these occupations. Some nursing homes are seeing an 80 percent annual turnover rate for nursing assistants, and RNs or LPNs are also in short supply. Nursing home residents on the average receive only 7 to 12 minutes of professional care daily, according to one researcher.⁹

At the same time, the role played by family members – which is such a key component of long-term care today – is expected to diminish. The factors that are responsible include more women working at paid jobs outside the home, a continuing high divorce rate, the geographic separation of family members, and fewer children to care for aging parents as the “baby boom” generation is replaced by the “baby bust” generation.

⁹ Fulmer, Terry, “Beyond Financing: Who Will Provide Long-Term Care?” Paper presented at Congressional Breakfast Seminar of the Gerontological Society of America, Washington, D.C., December 6, 1988.

CHAPTER IV.

WHO PAYS THE BILLS?

National spending for long-term care is high — \$45 billion in 1985. Of that total, \$36 billion went for nursing homes and \$9 billion for home care.

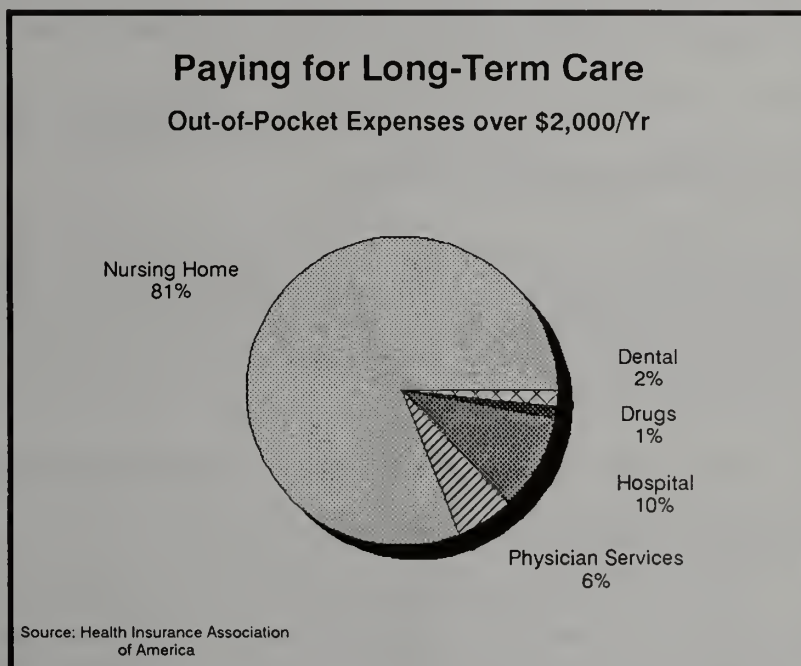
By 1987, the total for nursing homes had risen to \$41.6 billion, a 15% jump from 1985. Residents and their families paid about \$21 billion (51 percent) and Medicaid covered \$17.3 billion (41.6 percent). Medicare's share was only \$592 million (1.4 percent) and private health insurance paid \$400 million.

A. Out-of-Pocket Payments

Nursing homes cost from \$25,000 to \$40,000 a year, depending on location. Paid home care services can cost between \$50 to \$200 a day, depending on the services needed, the length of time the services are needed, and the degree of skill required of a home care worker.

Nursing home costs quickly exhaust the assets of many elderly. A 1987 study by the U.S. House Select Committee on Aging found that after only 13 weeks in a nursing home, 7 in 10 elderly living alone spent down their income to the federal poverty level. Even when both income *and assets* were considered, nearly one-half of this group became impoverished within 13 weeks. Within one year, two-thirds of elderly living alone had depleted their savings and were at risk of impoverishment.¹⁰

Less widely reported are



¹⁰ Select Committee on Aging, U.S. House of Representatives, "Long Term Care and Personal Impoverishment: Seven in Ten Elderly Living Alone Are At Risk," U.S. Government Printing Office, Washington, D.C. (October 1987), pp.6-7.

the costs that families incur in caring for a dependent relative at home, without paid help. The AARP and Travelers survey of caregivers showed that two-fifths of all caregivers reported that they had incurred at least some additional expense as a result of caregiving.¹¹

Another economic cost for caregivers is time lost from jobs in order to handle the problems of a relative or to cope with emergencies. A survey of employees nationwide, conducted by *Fortune Magazine* and John Hancock Financial Services, found that 38 percent of those with elder care responsibilities had to take unscheduled days off, 37 percent had late arrivals or early departures, and 30 percent reported being absent periodically.¹²

B. Medicare and Medicaid

Medicare currently pays only a very limited role in long-term care today. Medicaid is carrying a much more considerable share of the financial burden.

Medicare is a social-insurance program which covers all elderly over the age of 65 and the permanently disabled of any age. To be eligible, beneficiaries must have earned Social Security credits. Medicaid is, on the other hand, a means-tested program intended for low-income persons of any age and the blind and disabled. The program is financed jointly by the federal and state governments, but the states determine eligibility by setting limits on income and assets.

At least until recently, many older Americans mistakenly believed that Medicare covered long-term care in a nursing home. The long debate over the Catastrophic Coverage Act may have helped to dispel that idea in the minds of many by making it clear that the new benefits did not include long-term care coverage – and neither did the existing Medicare program.

I. Medicare

a. Limited nursing home coverage

Medicare has contributed only about 1 to 2 percent of the financing of long-term nursing home care in recent years. That is because the program pays only for “skilled” nursing care or physical therapy for up to 100 days in a “skilled” nursing home. The benefit is further limited by the requirement that a person must have been hospitalized for at least three days before entering the nursing home.

Thus, the program does not cover custodial care in a nursing home.

b. Home health care services

Medicare also provides some limited coverage for home health care services, but the benefit is very restricted. Skilled nursing or physical therapy can be covered only when such care is on a part-time or intermittent basis. Medicare assistance is not available for the

11 Working Caregivers Report: A National Survey of Caregivers, *op. cit.*

12 Sing, Bill, “Elder Care: New Benefit for Workers,” *Los Angeles Times*, June 1, 1989.

Parkinson's patient, for example, who needs help getting in and out of bed and eating a meal.

II. Medicaid

The federal government provides matching funds to the states for the Medicaid program based on a state's per capita income. Wealthier states receive matching funds for at least 50 percent of Medicaid expenditures and poorer states receive as much as 78 percent. The states set eligibility criteria and coverage within federal guidelines.

a. Payer of nursing home bills

Although Medicaid was created to provide primary and acute medical care for the poor, it has become the primary government payer of nursing home bills. In 1987, Medicaid paid \$17.3 billion (about 42 percent) of the national nursing home bill that year of \$41.6 billion.¹³

The 1985 National Nursing Home Survey showed that at the time of admission, Medicaid was the primary source of payment for 40.1 percent of elderly nursing home residents.¹⁴

To qualify for Medicaid, a person's income and assets must be low enough that the person qualifies for welfare assistance under the Aid to Families with Dependent Children (AFDC) program or the Supplemental Security Income (SSI) program. Income guidelines for AFDC and SSI vary from state to state. The federal government sets a floor of \$338/month income (including Social Security) for persons over 65 years of age. Individual states can supplement this amount. In Massachusetts an elderly person must have an income below \$535/month to be eligible for SSI and have no more than \$2,000 in assets (\$3,000 for a couple).

Many states also have a spend-down program. In these states, Medicaid will pay for the difference between the individual's income and the cost of the nursing home.

b. Spousal impoverishment

The Medicare Catastrophic Coverage Act included a "spousal impoverishment" provision, which allows the spouse of a Medicaid-eligible nursing home resident to retain at least \$12,000 in assets plus income that is at least 122 percent of the federal poverty level for a couple (\$815 a month in 1989). This provision was not repealed. The states may increase these limits to allow a spouse to retain up to \$60,000 in assets and \$1,500 in monthly income.

c. Home and community-based waiver program

Congress passed legislation in 1981 that included a Home and Community-Based Waiver Program (Section 2176 waivers) as an attempt to cut home Medicaid nursing home costs by

13 Committee on Ways and Means, U.S. House of Representatives, *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means, 1989 Edition*, U.S. Government Printing Office, Washington, D.C. (March 15, 1989), pp. 242-252.

14 Esther Iling, "Use of Nursing Homes by the Elderly: Preliminary Data From the 1985 National Nursing Home Survey." National Center for Health Statistics, *Advance Data*, No. 135 (May 14, 1987).

encouraging greater use of home and community-based services. Under the waiver program, the state must target services to individuals at risk of institutionalization and can extend Medicaid income limits up to 300 percent of the basic SSI payment level. That payment level was \$368 a month in 1989, which meant that a state could provide reimbursement under Medicaid for individuals with monthly income up to \$1,104. (What is being “waived” is the state’s general obligation to make services available under Medicaid to all persons who meet the state’s usual eligibility criteria.)

Under the waiver program, states can use Medicaid dollars for expanded home health care, homemaker services, respite care and other nonmedical services. Forty-two states had been approved for the waiver program by the end of 1988.

Even with the higher income levels, however, many elderly will still be excluded from the waiver program either because their incomes exceed the limits or because they don’t face an immediate threat of having to enter a nursing home.

CHAPTER V.

CONGRESSIONAL PROPOSALS

A. Political Considerations for the Future

In 1988, long-term care was an issue addressed by all major presidential candidates. That same year, a spate of proposals were introduced in Congress, offering a range of different approaches to the issue.

Yet despite this sudden interest and flurry of political activity, there were also a number of reasons why by the end of 1989, no long-term care legislation had even moved through a congressional committee.

- **The federal budget deficit.** Cost estimates for the major proposals introduced in 1988 ranged from \$20 billion to \$70 billion a year. At the same time, Congress was grappling with a budget deficit of about \$160 billion — and was finding it more and more difficult to meet the deficit reductions goals it had set for itself. In this climate, a new long-term care package would have to raise revenue to pay for itself.
- **Spreading the cost.** It is generally recognized that the cost of even a modest long-term care package would be too great for middle- and low-income elders if it is spread over only that population. Lawmakers have indicated that they are reluctant to increase payroll taxes, which would burden the working population, to pay for another program mainly for the elderly. There was no consensus in 1989 on how broadly these costs should be spread or what mechanism should be used.
- **The Medicare Catastrophic Coverage Act.** The legislation provided that for the first time in the history of Medicare, beneficiaries would be expected to bear the full cost of expanded benefits, rather than having the costs spread over the entire population. Also, a part of the cost was to be covered by a surtax based on income. After thousands of Medicare beneficiaries indicated their displeasure with this financing scheme and forced Congress to abandon it, lawmakers began wondering to what extent the elderly would be able or willing to share in the costs of a long-term care program.
- **The death of Claude Pepper.** The undisputed champion of the elderly, Rep. Pepper died May 30, 1989. His death removed from the scene probably the most powerful and forceful advocate of a long-term care program. In 1988, Pepper sponsored a bill to provide comprehensive long-term home care for people of all ages, which made it to

the House floor for a vote without any hearings. But it was defeated by lawmakers unwilling to rush a vote on such a costly program.

- **The Bipartisan Commission on Comprehensive Health Care.** Created by the Medicare Catastrophic Coverage Act, the commission's mandate is to issue recommendations both on the health care needs of uninsured Americans and the long-term care needs of the elderly and disabled. The members of the commission include all the lawmakers who have introduced major long-term care bills and whose committees will play key roles in formulating long-term care legislation. Many in Congress were prepared to wait for the commission's report — which was released in March 1990 — before taking any action.

B. Congressional Developments in 1989

When the 101st Congress convened, the climate for long-term care legislation had changed dramatically. Many said the uproar among the elderly over the catastrophic care legislation was the reason.

Medicare beneficiaries were required to pay an additional \$4 a month (in 1989) to the Part B premium, rising in stages each year until 1993 when the monthly premium was expected to be \$10.20. Those with higher incomes also were expected to pay an annual surtax, which for 1989 was to be 15 percent on each \$150 of tax liability, up to a maximum of \$800 for an individual and \$1,600 for a couple. The surtax was to reach 28 percent of tax liability in 1993, or a maximum of \$1,050 for a single person and \$2,100 for a couple.

It was the surtax in particular that drew the ire of many elderly. Members of Congress reporting receiving more angry mail on the subject of the financing of the catastrophic care legislation than on any other issue in recent memory.

After months of largely unsuccessful debate on whether it was possible get rid of the controversial surtax but still retain some of the program's benefits, the lawmakers finally voted to scrap the program. The only provisions that Congress retained were the spousal impoverishment benefit and Medicaid buy-in of Medicare premiums and copayments for certain low-income persons.

But in the end, the elderly may have lost more than they realized. Not only did they lose benefits which some of them, particularly the poorest, may well need one day, but they may have jeopardized their chances for the one benefit they were said to have really wanted — long-term care coverage. Lawmakers who had been sponsoring long-term care legislation grew more cautious in 1989 about proposing another program, which would either add to the federal budget deficit or cost Medicare beneficiaries additional expenses at a time when they seemed unwilling to pay for catastrophic care coverage.

“If we can't finance [the catastrophic care law], an \$8 billion or \$10 billion program,” asked

Rep. Willis Gradison (R-OH), "how are we going to finance a \$25 billion to \$50 billion program for long-term care?"¹⁵

C. Key Congressional Proposals

The major bills introduced in the 100th Congress are summarized below. Although these bills are changing in reaction to recently released studies, their main outlines show the range of options that have been considered in the past. Their sponsors are Sens. Edward M. Kennedy (D-MA) and George Mitchell (D-ME) and Reps. Henry A. Waxman (D-CA) and Fortney (Pete) Stark (D-CA). Also discussed is the Pepper bill and an insurance proposal by Sen. David Durenberger (R-MN).

These proposals offer different approaches to how benefits will be financed, when coverage will begin, the amount of cost-sharing, who will be covered and what services will be provided.

The issues to consider

- How benefits are financed. All the major proposals recommend that benefits be financed at least partially through raising the current \$45,000 cap on the 1.45 percent Hospital Insurance (HI) payroll tax. Other proposed sources of financing include raising the limit on earnings subject to the FICA tax, levying additional estate and gift taxes, and requiring state and local government employees to pay the hospital insurance payroll tax.
- When coverage begins. The proposals differ most significantly on "first-dollar" coverage versus waiting periods of two months to two years for nursing home care. A long waiting period ensures that long-term care coverage is catastrophic coverage, that is, targeted at those with the highest costs. On the other hand, first-dollar coverage ensures that the majority of nursing home residents will not be wiped out by a relatively short nursing home stay.
- The amount of cost-sharing. The federal government and beneficiaries would share the costs of all the proposed programs. For the beneficiaries, the costs would consist of deductibles, coinsurance and/or premiums. Large premiums place the burden onto the beneficiaries of the program regardless of their need for services. Large deductibles and coinsurance fall on those who need long-term care.
- Who would be covered. Kennedy proposes covering children up to age 19 and Medicare beneficiaries; Pepper's proposal includes chronically ill children, as well as the elderly and disabled; the others cover only Medicare beneficiaries. The proposals also differ in terms of how severely disabled a person must be to qualify for home care assistance, such as whether they are unable to perform two or more ADLs.

15 Dentzer, Susan, "The Calamity of Catastrophic Coverage," *U.S. News & World Report* (May 8, 1989), p. 36.

Long-Term Care: Key Congressional Proposals

Sponsor	Eligibility	Waiting Period for Nursing Home	Cost Sharing	Home Care Services	Financing	Cost
KENNEDY	65 or older, disabled, or under 19; completely dependent in 1 or 2 ADLs	No waiting period covers 1st six months	<i>nursing home:</i> 35% coinsurance after 1st 6 months; <i>home care:</i> lesser of 10% coinsurance or 5% of monthly Social Security	Current home health services plus homemaker and heavy chore services; adult day care; no payment limit	Increase FICA wage cap from \$45,000 to \$75,000; premium at 45% of cost of stay in nursing home	\$20.5 billion
MITCHELL	65 or older, disabled, 2 ADLs	Two years	<i>nursing home:</i> 30% coinsurance after 1st 2 yrs; <i>home care:</i> \$500 deductible/yr., 20% coinsurance; <i>respite care:</i> 50% coinsurance on \$2,000 annual benefit	Current home health services plus homemaker and chore aide; payment limit: 65% of average annual Medicare nursing home services	Remove HI wage cap; increase Medicare monthly premium by \$2; 5% surtax on gross estates in excess of \$100,000	\$21.2 billion
WAXMAN	65 or older, disabled, 2 ADLs	Two months	<i>nursing home:</i> 33% coinsurance for months 3-24; 10% for months over 24; <i>home care:</i> 20% copay for home health, adult day care	Current home health services and homemaker-personal care; payment limit dependent on severity of impairment: severe, 65% of annual state nursing home services cost; moderate, 50%; mild, 35%	Remove cap on entire FICA tax; \$3.50 per \$100 surtax on income tax liability of all taxpayers; 10% surtax on taxable estates or gifts over \$100,000	\$50-55 billion
STARK	65 or older, disabled, 3 ADLs for nursing home benefit; 2 ADLs for home care	Three months	<i>nursing home:</i> 20% coinsurance after 1st three months; <i>home care:</i> 20% coinsurance	Current home health services; adult day care; payment limit dependent on needs: skilled nursing and rehabilitation — 100% of Medicare nursing home limit on routine services; home health and adult day care, 75%; home health care only, 65%	State and local employees to pay HI tax; raise HI cap to \$100,000; raise HI tax 0.7% for employer and employee; increase Part B premium \$5 a month; reduce estate and gift tax exemption to \$300,000; other estate and gift tax changes	\$46 billion
PEPPER	Chronically ill children, elderly and disabled who are dependent in at least 2 ADLs	No nursing home benefit	No cost-sharing for home care benefits, unless HHS Secretary determines financing shortfall	Current home health services, 18-month day care demonstration; payment limited to 62% of monthly state average of Medicare nursing home services	Eliminate HI wage cap	\$8.9 billion

- What services would be provided. In addition to nursing home care, the proposals would pay for range of home care services that include the assistance of home health aides and homemakers, chore services, and adult day care. The payment for services in any plan adopted is likely to encourage the offering and use of those services to the exclusion of services not paid for.

Other proposed legislation described briefly in this report looks at ways to encourage private-sector approaches to long-term care, such as establishing minimum federal standards for private long-term care insurance.

Lifecare

(Sen. Edward M. Kennedy, D-MA)

Sen. Kennedy's bill covers disabled and chronically ill children under 19 years of age as well as persons age 65 and older who are completely dependent in one or two ADLs. The program consists of a Part A that provides coverage for home and community-based care and the first six months in a nursing home, and a Part B optional program available at age 45 and at age 65 that would cover nursing home stays of longer than six months. The federal government would cover 65 percent of the Part B costs, with beneficiaries responsible for the other 35 percent. In addition to the coinsurance, beneficiaries would pay monthly premiums, which Kennedy says would average \$25 a month at age 65.

Home care under the Kennedy bill would include homemaker, home health aide, heavy chore services, and adult day health care. These services would require 10 percent coinsurance or 5 percent of a beneficiary's monthly Social Security benefit, whichever is less.

The Congressional Budget Office (CBO) estimates the costs of Kennedy's program at \$20.5 billion a year – about \$9 billion for home care services and \$10 billion for the Part A nursing home benefit and \$1.5 billion for the government's share of Part B. (The beneficiary share through the copayments is estimated to bring in \$3.0 billion).

Kennedy proposes financing the program by raising the ceiling on the FICA payroll tax from \$45,000 to \$75,000 a year for employers and employees, which he says would raise \$17.7 billion (or by uncapping the FICA tax entirely to raise \$36 billion). Alternate sources of funding that Kennedy has suggested include raising taxes on alcohol and tobacco (from \$6.7 billion to \$12.4 billion).

Long-Term Care Assistance Act of 1988

(Sen. George Mitchell, D-ME)

Sen. Mitchell's bill provides expanded Medicare coverage for both nursing home and home care for Medicare beneficiaries who need assistance with two ADLs.

The key feature of Mitchell's bill that distinguishes it from other major proposals is its two-year waiting period before Medicare will begin covering 70 percent of nursing home costs with the Medicare beneficiary responsible for the other 30 percent. Medicaid spend-down requirements would be waived for beneficiaries who pay the two-year deductible.

This “back-end” protection means that only those residents who have long stays in a nursing home will be eligible for benefits. But over 40 percent of all admissions to nursing homes are for 90 days or less; 72 percent are for under two years. Mitchell’s approach calls for individuals to purchase private insurance policies to cover the first two years of nursing home care. Since the insurer’s risk would be limited to those two years, Mitchell reasons that the insurance industry could market much less expensive policies.

Mitchell’s bill also expands Medicare’s current home health care benefits to include homemaker and chore aide services. Home care benefits would kick in after a \$500 deductible has been met, after which Medicare would pay for 80 percent of covered services and the beneficiary would pay for the other 20 percent. Payments for home health and adult day services would be limited to 65 percent of the annual national average of Medicare skilled nursing facility services. A respite benefit also is included that is limited to \$2,000 a year, with a 50 percent copayment.

The Congressional Budget Office estimates the cost of the Mitchell program at \$21.2 billion in 1993 – \$13.2 billion for the nursing home component and \$8 billion for home care. Mitchell proposes raising the money to cover the cost by uncapping the \$45,000 ceiling on the hospital insurance (HI) portion of the FICA payroll tax (estimated to raise \$8.5 billion) and by levying a 5 percent surtax on gross estates over \$200,000 (\$3-4 billion). Another \$2.5 billion would be raised through an additional \$2 a month on the Part B premium and an income-based supplemental.

The philosophy behind the two-year waiting period in the bill is to encourage the development of private, long-term care insurance. Many persons would buy policies to protect them against the costs of the two-year period, Mitchell reasons. But since few elderly spend more than two years in a nursing home, it would mean the major costs – possibly as high as \$50,000 to \$60,000 – would still be met by individuals and would still result in most people having to deplete all their assets.

A Consumers Union analysis of the waiting period issue shows that nearly four times as many people would get benefits from a six-month “first dollar” approach versus a two-year waiting period (817,548 compared to 212,417).¹⁶

The Elder-Care Long-Term Care Assistance Act **(Rep. Henry A. Waxman, D-CA)**

Waxman’s bill provides coverage for nursing home, in-home, and community-based services to all Medicare beneficiaries with two or more ADLs. Nursing home care would be covered after a two-month waiting period, after which the beneficiary would be required to pay 33 percent of the cost of the care until the 24th month when the coinsurance becomes 10 percent. For home and adult day care, a beneficiary would be responsible for 20 percent coinsurance.

16 Shearer, Gail, *Long-Term Care: Analysis of Public Policy Options*, Consumers Union, Washington, D.C. (January 1989), pp. 65-66.

A beneficiary would be determined to be eligible for home and community-based services after being evaluated by a long-term care assessment team of a Community Assessment Review and Evaluation (CARE) agency, which could be either units of state or local governments or nonprofit organizations. For those eligible for assistance, the CARE organization would develop a plan of care, make arrangements for the care and monitor the provision of the services.

Those who are eligible for the home health services would receive financing based on their degree of impairment. Those with the most severe limitations would receive coverage for services valued at up to 65 percent of the cost of a year of nursing home care — over \$20,000 in 1991. The moderately impaired would receive care valued up to 50 percent and the mildly impaired up to 35 percent of the annual cost of nursing home care.

The Waxman program is estimated to cost \$50 billion to \$55 billion in 1991. Waxman proposes financing the benefits through three sources: 1) removing the cap on wages covered by the entire FICA payroll tax (not just the hospital insurance portion), 2) a surcharge of \$3.50 per \$100 of income tax liability for all taxpayers, and 3) a 10 percent surcharge on taxable estates or gifts over \$100,000.

Chronic Care Medicare Long-Term Care Coverage Act of 1988 **(Rep. Fortney (Pete) Stark, D-CA)**

Rep. Stark's bill covers Medicare aged and disabled beneficiaries. The program has two parts: Part A consisting of extended nursing home care for beneficiaries impaired in at least three ADLs and Part B covering homemaker/personal care and adult day care for persons impaired in at least two ADLs. The nursing home benefit becomes available after a three-month waiting period and then requires 20 percent coinsurance.

Home care services require 20 percent coinsurance from the beneficiary. If a beneficiary needs skilled nursing and rehabilitation care, the program would cover up to the limit that is allowed a Medicare-certified nursing facility for routine services, but if the beneficiary is already receiving home health and adult day care, the payment rate would be 75 percent. For those already receiving home health care, the payment rate is 65 percent.

The price tag for the Stark program is \$46 billion, according to the CBO. He proposes financing the Part A coverage by requiring all state and local employees to pay the hospital insurance portion of the FICA tax (\$2 billion), by raising the limit on earnings subject to that tax to \$100,000 (\$7 billion) and by increasing the HI portion of the FICA tax 0.7 percent on each employer and employee (\$28 billion). For Part B, he proposes increasing the Part B premium by \$5 a month (\$2 billion) and making several changes in estate and gift taxes that would raise another \$8 billion.

Rep. Stark also introduced a bill in the spring of 1989 to establish standards for private long-term care insurance. In addition to incorporating most of the provisions of the National Association of Insurance Commissioners Model Act, the bill prohibits the conditioning of

benefits on prior hospitalization and requires policies to permit full refunds of premiums if a policyholder chooses to cancel within 30 days of receiving the policy.

The Stark bill also requires a uniform disclosure statement by insurers that is to include: levels and length of coverage, qualifying events for coverage, daily or per visit payment rates, maximum amounts payable, lifetime limits, inflation adjustments, and conditions under which a policy can be canceled. The bill also provides criminal sanctions against insurers or agents who misrepresent the benefits in policies.

Medicare Long-Term Home Care Catastrophic Protection Act
(Rep. Claude Pepper, D-FL and Edward Roybal, D-CA)

With the death of Rep. Pepper, the future of this legislation became clouded. Although cosponsor Rep. Roybal reintroduced the measure shortly before Pepper's death, the bill's chances without its outspoken and prominent champion may have been considerably diminished. However, since Pepper was the only lawmaker to propose covering people of all ages, his bill merits attention.

The bill proposes providing home care benefits under Medicare to any person unable to perform two or more ADLs. Technology-dependent children would be eligible. The benefits to be covered range from nursing care to homemaker/home health aide services to rehabilitation therapies and patient and family education.

Independent professional case management teams would determine the condition of each eligible beneficiary and the services that would be required. Monthly payments would be limited to two-thirds of the monthly Medicare rate for skilled nursing home services. The benefits could be covered, Pepper said, by eliminating the cap on the hospital insurance payroll tax.

When the bill was debated on the House floor, opponents argued that the costs of the program could be much higher than estimated because families might substitute paid care for the informal family support that had been provided previously. But Pepper argued that there were numerous cost control measures in the legislation, including a cap limiting expenditures to 62 percent of the Medicare nursing home rate. The Secretary of Health and Human Services and the Director of the Congressional Budget Office were directed to estimate each year the total costs of the program as compared to expected revenues. If costs appeared to be exceeding revenues, the Secretary would be required to impose a copayment of up to 5 percent for services and to reduce the 62 percent payment cap.

Long-Term Care Insurance Consumer Protection Act of 1988
Sen. David Durenberger, (R-MN)

Durenberger's bill would create a voluntary certification program for policies that meet NAIC Model Act standards and that also include a free-look period, guaranteed renewable feature, and information about long-term care benefits available under Medicare.

As another approach toward private saving for long-term care, Durenberger has also proposed a plan for the establishment of long-term care savings accounts, which would receive favorable tax treatment. Under the program, individuals would receive a 10 percent tax credit on contributions of up to \$2,000 a year. The money accumulated in the savings account could be used to purchase long-term care insurance or to pay for long-term care services directly. Covered services could be provided in a nursing home, a hospital, a retirement home, or in a person's own home if a state licensed medical practitioner certified that without home care the individual would have to enter a nursing home.

In addition to specific proposed legislation, there are three federal groups looking at methods of financing long-term care.

The U.S. Bipartisan Commission on Comprehensive Health Care

The less formal name of the Bipartisan Commission is the "Pepper Commission" in honor of Claude Pepper, who was its first chairman. The present chairman is Sen. Jay Rockefeller (D-WV). The other commission members are: Reps. Henry Waxman (D-CA), Mary Rose Oakar (D-OH), Fortney (Pete) Stark (D-CA), Willis Gradison (R-OH), and Tom Tauke (R-IA), and Sens. Edward Kennedy (D-MA), David Pryor (D-AR), Max Baucus (D-MT), David Durenberger (R-MN), and John Heinz (R-PA). The presidential appointees are John Cogan, a senior fellow at the Hoover Institution at Stanford University and former OMB official; Dr. James Davis, president of the American Medical Association; and James Balog, chairman of the board of the Lambert Brussels Capital Corporation and former chairman of the Private/Public Sector Advisory Committee on Catastrophic Illness for the Secretary of Health and Human Services.

The Pepper Commission was established by the Medicare Catastrophic Coverage Act of 1988 to examine the current health care delivery and financing mechanisms that limit access for all individuals to comprehensive health care. Its report included recommendations for financing long-term care services for the elderly and disabled and for health care services for all individuals.

The Advisory Council on Social Security

A 13-member Advisory Council on Social Security was appointed in June 1989 by Health and Human Services Secretary Louis W. Sullivan to review the adequacy of the Medicare health care financing system and major Social Security financing issues. The chair of the group, Deborah Steelman, has said that the council will develop recommendations "for a sound, sustainable health care financing system, one that delivers the benefits people need, at a price we can all afford."

A report by the council on the health care financing issues, which will include long-term care, is expected by July 1990.

The HHS Departmental Working Group

A working group within the Department of Health and Human Services has also been established to consider options for improving coverage of the uninsured and long-term care. Under Secretary Constance Homer chairs this group. Their report is expected in the summer of 1990.

CHAPTER VI.

PRIVATE-SECTOR DEVELOPMENTS

A. Private Insurance Market

In 1987, private insurance covered only about 1 percent of total nursing home expenditures. There has been a limited market for long-term care insurance in past years, and a reluctance on the part of insurance companies to cover this kind of risk.

One major reason why few older people purchased such insurance was that many believed until recently that they were covered for nursing home and home care costs through Medicare. This misunderstanding may have been largely erased as a result of the debate on the catastrophic care legislation, which helped publicize the shortcomings of Medicare in regard to long-term care coverage.

Another factor that discourages purchase of insurance, however, is that private policies are expensive and increase in cost with advancing age. According to the Health Insurance Association of America (HIAA), the average annual premium on policies sold by its member companies was \$312 for a person age 50, \$792 for a 65-year-old, and \$2,772 for someone at age 79.¹⁷ There are many policies on the market that cost even more – and cost is determined not only by age but also by the extent of the coverage. The better the coverage, the higher the premium.

Then, too, the “denial” factor has played a part: a tendency on the part of people to ignore an unpleasant possibility – in this case, the possibility of needing to enter a nursing home.

For its part, the insurance industry has been hesitant to expand its coverage because of the difficulties of measuring the risk. With few people buying the policies that have been on the market, there was little experience on which to build and the possibility of very long periods of time elapsing between the purchase of a policy and its use. Insurers believe they must be cautious if they are not to see profitability wiped out by inflation or changes in mortality and disability over those years.

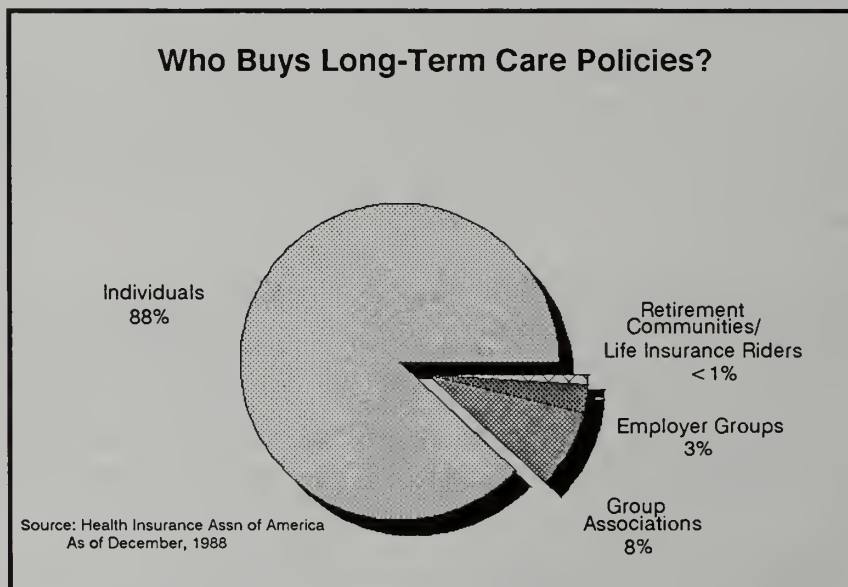
The industry has also been concerned about “adverse selection” – those who might need the coverage the most are the ones most likely to purchase it, thus preventing the insurer from spreading the risk among a larger group which would include many who would not tap into the

17 Letter to the *New York Times*, Health Insurance Association of America, May 28, 1989.

coverage. Insurers are not willing to cover certain risks. Policies are seldom available, for example, that cover pre-existing conditions or mental illness.

Another issue that worries insurers is whether there will be an increased use of services by people when they have insurance – whether people who are now being cared for by family members would switch to paid services if they were covered by insurance.

Despite these misgivings, HIAA says that the number of companies issuing policies is growing. According to an HIAA survey released in October 1989, the number of companies selling long-term care insurance had increased from 16 companies in 1984 to 109 by mid-1989. HIAA estimated that a total of 1.3 million individual and group long-term care policies had been sold as of June 1989, a 60 percent increase over 1987 when 815,000 policies were in force. The breakdown of those purchasing the policies were as follows: 88 percent to individuals, 8 percent through group associations, 3 percent to employer groups and less than 1 percent each as riders to life insurance policies or through continuing care retirement communities.¹⁸



TERMS OF COVERAGE

Premiums vary, depending on a person's age when purchasing the policy and on the benefit options chosen by the purchaser. Policies are not generally available to persons age 80 and above.

Policies generally pay a flat benefit per day for care in a nursing home, with the benefit ranging from \$25 to \$120 a day, a waiting period of up to 120 days, and a benefit period of up to six years. HIAA says a typical long-term care policy pays \$60 a day for nursing home care and \$30 a day for home health care.¹⁹

¹⁸ Long-Term Care Fact Sheet, Health Insurance Association of America, Washington, D.C., October 1989.

¹⁹ *Ibid.*

Some policies also provide limited benefits for home and community-based health services. Payments might be for a fixed amount per day or a percentage of the cost of services, such as 80 percent with the remaining 20 percent to be paid by the beneficiary. Or a plan might provide a percentage of the cost with a cap on the total.

CRITICISM OF EXISTING COVERAGE

Critics of the coverage provided by present-day long-term care policies cite the following problems:

- **Cost.** Unless a policy is purchased when a person is relatively young, the monthly cost can be high. At age 55, a policy might cost between \$20 and \$50 a month but at age 65 the monthly expense could be as high as \$100 and at age 75, over \$200 a month.
- **Lack of Protection Against Inflation.** Most policies offer *indemnity benefits*, a fixed amount such as \$50 a day for a specified period of time. A flat benefit will quickly become inadequate because of inflation. A very few policies adjust the benefits for inflation (at an increased premium rate). Some provide for flat benefit increases for a limited period, but even these might not be sufficient to keep up with inflation. For example, a policy might provide a 5 percent a year increase for 10 years. Even if the inflation rate is no higher than 5 percent for those 10 years, the policyholder will suffer a loss of value if the coverage is needed for 20 years.
- **Prior Hospitalization.** Many policies require a person to have been hospitalized for at least three days before entering a nursing home. Insurers also in many cases require the beneficiary to enter the nursing home within a stated period of time after leaving the hospital, such as within 14 or 30 days. Many people who need nursing home care, say the critics, have chronic conditions such as Alzheimer's disease that seldom require hospitalization.
- **Requirement for Prior Skilled Nursing Home Care.** Another requirement that limits collecting on a policy is that the policyholder must have received skilled nursing home care before he or she qualifies for benefits covering intermediate or custodial care.
- **Waiting Periods.** Insurers may require a six-month waiting period before coverage becomes effective. In the case of pre-existing conditions, the waiting period could be as long as two years.

In July 1988, the United Seniors Health Cooperative of Washington, D.C. surveyed 77 private long-term care insurance plans and options offered by 21 companies to consumers in Virginia, Maryland, and the District of Columbia. The cooperative concluded that 82 percent of the plans it had surveyed had restrictions in coverage so severe as to make it "very difficult for policyholders to collect any benefits."

The average probability of **not** collecting benefits from the plans studied was 61 percent,

the report said. Only 18 percent of the policies provided the policyholder with at least a 50/50 chance of receiving any benefits if he or she entered a nursing home, the cooperative said.²⁰

Another 1988 survey of 53 policies—this one by Consumers Union—found that some companies reject as many as 30 percent of applicants, generally those with higher than average health risks.²¹

MODEL STANDARDS

The National Association of Insurance Commissioners (NAIC) has drafted a Long-Term Care Insurance Model Act. By July 1989, 37 states had adopted NAIC-based rules regulating long-term care.

The Model Act has the following major provisions:

- A benefit period must be at least one year in duration.
- Insurers cannot cancel a person's policy because of advancing age of the insured; policies must be guaranteed renewable.
- Insurers cannot require a waiting period of longer than six months because of pre-existing conditions nor may policies exclude coverage for Alzheimer's disease.
- Policies cannot cover only skilled nursing care or provide significantly more coverage for skilled care than for lower levels of care.
- The minimum loss ratio of a policy should be 60 percent. (A "loss ratio" refers to the return in benefits coverage for the payment of premium; a loss ratio of 60 percent means that a policy is returning 60 cents worth of benefits for every \$1 in premium paid.)

LIFE INSURANCE POLICIES

Some insurers have been combining a long-term care benefit with traditional life insurance. An individual with such a policy could withdraw a portion of death benefits to help cover the costs of long-term care. One unresolved tax question, however, is whether a benefit paid to the policyholder before death is subject to income tax.

One development that some analysts believe may help lower the cost of private long-term care insurance policies is the action by the Internal Revenue Service in April 1989 to allow insurers to take a tax deduction for the reserves they must create when they issue long-term care policies. This would be similar to the deductibility of reserves for life and health insurance.

Insurance firms also argue that long-term care insurance premiums should be tax deduct-

20 Firman, James P., "Private Long Term Care Insurance: How Well Is It Meeting Consumer Needs and Public Policy Concerns?" United Seniors Health Cooperative, Washington, D.C. (September 1988), pp.4-5.

21 Shearer, *Long-Term Care: Analysis of Public Policy Options*, op.cit., p.25.

ible to the policyholder and benefits excludable from individual incomes to the same extent as medical benefits are under current law.

B. Employer Coverage

The range of benefits offered by employers to their employees has grown extensively over the last few decades. Originally, an employer-provided benefit program generally consisted of coverage for health care costs and perhaps life insurance. Today (90%) of all medium and large-sized firms offer such coverage.

Since those early plans, some employers have expanded their benefits package to include disability coverage, child-care allowances, and group legal aid. But many companies have grown wary about further benefit expansion in the face of skyrocketing costs for employee benefits, particularly for health care coverage.

This caution has developed among employers at a time when interest has also grown in the possibility of companies offering employees yet another benefit: coverage for long-term care costs, either for the employees or for their parents. Since individual long-term care insurance policies can be costly, group policies through an employer would have the advantage of being more comprehensive at a lower cost.

There are now 35 employers either offering or about to offer long-term care insurance, according to the HIAA. The states of Alaska, Maryland, and Ohio have such plans for their employees as do companies like American Express Co. and Procter & Gamble Co. Three insurance firms have such policies for their own employees: Aetna Life Insurance Co., Travelers Corp. (a subsidiary of American Express), and John Hancock.

The American Express plan offers employees and their spouses a choice of two plans: one that pays \$100 a day for nursing home care and \$50 a day for home care, or one that pays half those amounts. A person age 40 to 44 would pay about \$18 a month for the first plan and about \$9 a month for the second. The premiums are fixed at the amount paid by the employee when entering the plan. After an employee begins long-term care, there is a three-month waiting period before the coverage kicks in. The maximum payment for nursing home care is \$150,000 and for home care, \$75,000.²²

The company reported that from January to June 1988, about 7 percent of eligible employees, or 1,500 people, enrolled in the program. John Hancock says about 8 percent of its employees have signed up for their program and at Procter & Gamble, 9 percent enrolled.²³

Benefits consultants say their surveys show that the number of employer-provided plans will increase substantially in the next decade. A 1988 survey by the Washington Business Group on Health found that 75 percent of Fortune 500 companies were considering offering their employees long-term care insurance.

²² Ruffenach, Glenn, "Nursing Home Care as a Work Benefit," *Wall Street Journal*, June 30, 1988.

²³ *Ibid.*

The way the companies plan to hold down costs will be to require employees to pick up the entire cost of the premiums or at least a considerable share of the expense. Employers probably will not be interested in funding the benefit themselves since there is no tax incentive for doing so, as there is for funding pension plans.

Even if an employee is expected to pay the entire premium, the cost would be lower than buying a policy individually. But one drawback could be that the coverage might not keep pace with inflation – a drawback that would be particularly serious for young workers.

The automobile industry is taking the idea one step further by experimenting with paying the direct costs of nonmedical custodial care at home and in nursing homes for workers and dependents. The program had been requested by the United Automobile Workers.

In April 1989, Ford Motor Company began a two-year experiment of the program at two factories in Louisville, Ky. About 6,600 active and retired workers and their dependents are eligible for the program. Similar pilot programs are being planned at the General Motors Corporation and the Chrysler Corporation under terms of contracts signed in October 1987.

Other employers like International Business Machines (IBM) are developing long-term care counseling and referral services, instead of offering their employees long-term care insurance or paying for the costs directly of such care. The services help employees in finding care for elderly parents or other relatives, particularly when the employee lives many miles from the family member. American Telephone & Telegraph (AT&T) agreed in recent labor negotiations to offer its workers an “eldercare” package that includes leaves of absence, counseling and referral services and “flexible spending accounts” that allow employees to set aside pretax earnings for eldercare.

C. Home Equity Conversions

Since almost three-quarters of all the elderly own their own homes, some analysts suggest that one way to finance long-term care might be to allow these homeowners to tap into the equity in their homes – home equity conversions. One such model that is beginning to be employed is the reverse mortgage.

Under a reverse mortgage, a bank makes a loan to the homeowner, usually in the form of monthly payments, which are usually for a term of 7 to 10 years. At the end of that term, the homeowner may be given the option of obtaining another reverse mortgage or could repay the debt by selling the house. In some cases, the term of the loan may be for the lifetime of the owner, after which the debt is settled out of the sale of the house.

The theory behind reverse mortgages is that they give the elderly extra money that can be used to pay for long-term care services directly or to purchase long-term care insurance. But the banking industry has been moving cautiously on the concept and it is not clear how many of the elderly themselves will be interested in the idea. They may fear having to sell their house and move or being unable to leave the property to their children.

D. Social/Health Maintenance Organizations (S/HMOs)

The concept of social/health maintenance organizations is built on the health maintenance organization (HMO) model for medical care services. HMOs offer a broad range of health services for a fixed, prepaid fee. The services are provided by physicians, nurses, and other health professionals and hospitals affiliated with the HMO. Since fees are fixed in advance, the HMO has an incentive to manage medical care in as efficient a manner as possible to realize a profit. Generally, that means finding less costly alternatives to hospitalization, whenever that is appropriate.

The U.S. Department of Health and Human Services and private foundations are funding four demonstration projects around the country to test the idea of expanding the concept to long-term care services for the elderly. The demonstrations began in 1985 and are to continue to 1992.

The four sites are providing a range of services that include nursing home and home health services, homemaker/home health aide services, personal care, adult day care, respite, and home-delivered meals. Each site determines which benefits it will offer and sets an annual maximum dollar amount for its coverage, with the limits ranging from \$6,500 to \$12,000 a year.

E. Individual Medical Accounts (IMAs)

Individual Medical Accounts have been proposed as a way to encourage private savings for future long-term care costs.

Modeled after Individual Retirement Accounts (IRAs), the Individual Medical Accounts would encourage individuals to set up their own long-term health care savings accounts by according favorable tax treatment to such savings. Contributions in the account could be used to pay either for long-term care insurance or for long-term care services directly.

Legislation has not yet been passed to allow an individual to set up such an account.

CHAPTER VII.

STATE ACTIONS

Medicaid pays about 42 percent of all nursing home costs nationwide. But in a number of states, the percentage is even higher. The Medicaid program in Massachusetts, for example, pays 65 to 70 percent of nursing home costs and in Connecticut, 51 percent. Connecticut's spending for nursing home care increased 174 percent between 1977 and 1987, attributable in part to a 25 percent increase in the state's age-65-and-over population and a subsequent increase in the cost per nursing home resident.²⁴

Since the states pay approximately half of the Medicaid bill, these costs have led some of them to adopt new programs to reduce their financial obligations and to try to reverse the upward spiral of costs while maintaining quality.

One project on which several states have embarked aims at encouraging the development of more affordable and comprehensive private long-term care insurance. Seven states (California, Connecticut, Indiana, Massachusetts, New Jersey, New York, and Wisconsin) are involved in the project, which is being sponsored by the Robert Wood Johnson Foundation.

The heart of the project is a guarantee to individuals that they will not have to spend down their resources to qualify for Medicaid coverage of their nursing home bills if they will buy a private insurance policy that would cover at least the first year or two of a nursing home stay. The states theorize that if the risk to insurance companies is limited to a defined period of time (and thus, dollar amount), the companies will be encouraged to offer more comprehensive coverage at lower prices.

The first stage of the project was planning. To move into the demonstration phase, federal legislation will be necessary to waive certain Medicaid rules.

Some states have also encouraged and/or provided community based services as an alternative to expensive (and often unwanted) institutional care. Massachusetts has a state-funded Homecare program, in addition to the Medicaid home and community-based waiver program, which provides homemaker assistance to the frail elderly who don't have other supports. The more infirm a person is, the higher priority that person has for assistance. The services that can be provided include cleaning, cooking, shopping, and other chore services. Individuals whose incomes are less than \$8,606 (\$12,084 for couples) will have the services

24 Shearer, *Long-Term Care: Analysis of Public Policy Options*, op. cit., pp. 12-13.

provided at no charge; individuals with incomes between \$8,606 to \$13,580 (for couples, between \$12,084 and \$19,238) pay fees based on a sliding scale.

The state spent \$87 million on the program in fiscal year 1989 to serve 44,000 elderly.

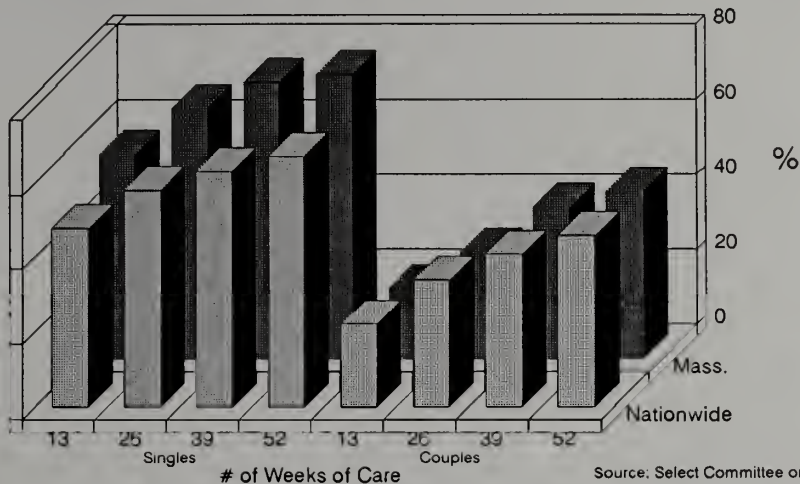
Several states have also attempted to coordinate long-term care home-based services as a means of keeping elders at home. Massachusetts has developed a program called "Elder Choices," which uses case management to coordinate a wide range of services provided in home or community settings, such as home health care, private duty nursing, and preventive health care services. Other states have consolidated the services in a single state agency. In Oregon responsibility for all funds supporting long-term care services for the elderly is placed with the

Senior Services Division, and in Texas the Office of Services to the Aged and Disabled administers Medicaid long-term services and the Social Services Block Grant funds for homemakers, and chore and home management services.

For individuals who are extremely disabled and need nursing home care, some states are designing case-mix reimbursement systems designed to increase the likelihood that these individuals will be accepted by a nursing home. New York State's resource utilization group system pays nursing homes according to the amount of resources necessary to care for residents. The greater the resident's care needs, the higher the level of reimbursement. Oregon

People (65+) at Risk of Impoverishment By Weeks of NURSING HOME CARE

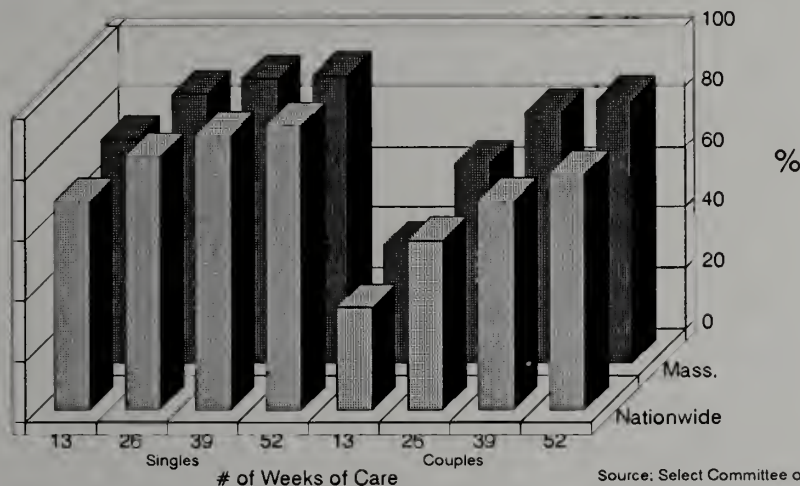
Based on Income & Financial Assets



Source: Select Committee on Aging

People (65+) at Risk of Impoverishment By Weeks of NURSING HOME CARE

Based on Income Only



Source: Select Committee on Aging

relates payment levels to resident outcomes by rewarding nursing homes that provide care that improves or maintains a resident's functioning. (The system does not, however, call for penalizing a nursing home if a resident's condition deteriorates because of a debilitating disease).

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