

RESPONDING TO THE CHALLENGES OF LONG-TERM CARE

The United States is experiencing record growth in its aging population. In fact, according to Census Bureau projections, the number of people ages 65 and older will increase an unprecedented 115 percent between 2010 and 2050. And for the first time that segment will represent more than 20 percent of the nation's total population. At the same time baby boomers get older and life expectancy increases, the U.S. is also seeing advancements in medical technology that allow individuals with chronic illnesses and disabilities to live longer than ever before. This increased longevity among the aging population is creating greater demand for long-term health care services and spurring states and communities to develop innovative new strategies to address the growing needs of seniors.

For states and communities dealing with the health care challenges of an aging population, Medicare, the federal government's primary program for senior health, does surprisingly little to address long-term care needs. Instead, costs are shouldered by the elderly themselves, their families, and when they have exhausted their financial resources, by state Medicaid programs. Medicaid accounts for 22 percent of total state budgets and is now the nation's primary long-term care program with roughly one-third of all Medicaid spending going to long-term care for seniors and people with disabilities, according to the Urban Institute. States are facing a growing demand to develop new alternatives and services to meet the needs of the growing aging population and reduce state spending.

Alternatives to Nursing Homes

National polls consistently show that 80 percent of Americans prefer to age at home, and doing so is cheaper than staying in a nursing home. Studies show that it is less costly for Medicaid—which accounts for nearly half of total long-term care spending in the U.S.—if care can be provided at home. On average, community-based long-term care is about one-third the cost of comparable nursing home care. Finding ways to care for the elderly and disabled in their homes is a win-win situation for families and state budgets, and states are taking note.

Medicaid is the single largest source of financing nursing home care for the elderly, totaling \$47.2 billion in 2005. Medicaid has historically provided strong financial incentives to provide long-term care in nursing homes, creating an institutional bias toward financing nursing home stays over in-home care. Generally, any eligible person cannot be denied service if a nursing home bed is available. No such entitlement exists for services delivered in the community; eligible people who want to receive care



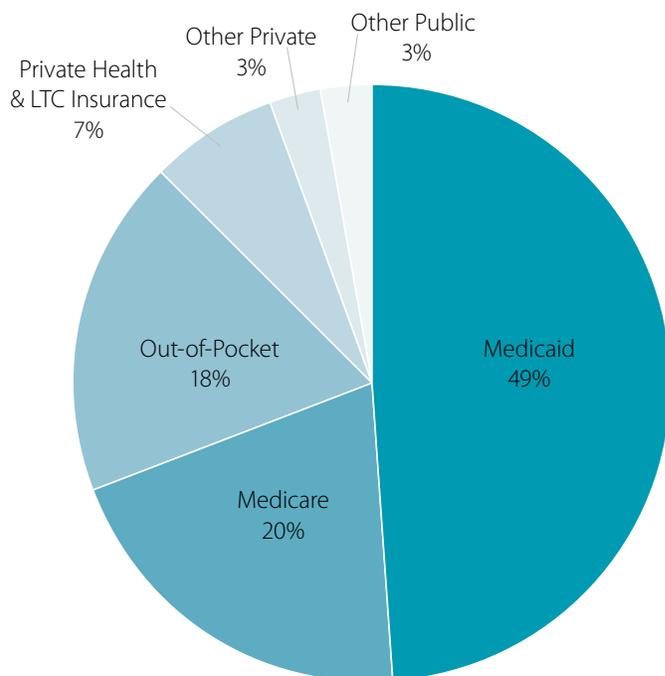
What is Long-Term Care?

Long-term care is a range of medical and social services designed to help people who have disabilities or chronic care needs. Services may be short- or long-term and may be provided in a person's home, in the community, or in residential facilities such as nursing homes or assisted living facilities.

at home must request funding and wait for services to become available. But now that Medicaid accounts for more than 20 percent of total state spending, solutions to these growing long-term care costs are becoming top priorities for states, and many are looking more and more to the community for such care.

Vermont is a national leader in balancing its Medicaid spending between nursing homes and community services. Vermont received a first-of-its-kind Medicaid waiver in 2005 that allowed the Department of Disabilities, Aging and Independent Living to pool funds for nursing home and community care. It is the first program in the nation to allow seniors, families and state caseworkers to determine where a patient will receive care. The program, Choices for Care, sends a team of nurses throughout the state to

National Spending for Long-Term Care by Payor, 2005



Source: Burwell, et.al. Medicaid LTC Expenditures:2005

Medicare and Medicaid: Critical Differences

Funding: Medicare is a federal program, funded through individual payroll contributions. Medicaid is a state-federal matching program with the states' share paid for with state and local public funds. State shares for Medicaid vary, with the poorest states getting a greater percent of federal funding. The federal government pays a minimum of 50 percent but not more than 83 percent of a state's Medicaid costs.

Program Administration: Medicare is run by the federal government and is the same in all states. Medicaid programs are administered by states that must comply with federal rules. State Medicaid programs vary widely in services covered and eligibility.

Populations Served: Medicare is almost exclusively a health care program for the elderly. There are no income rules for coverage, except for prescription drug coverage. Medicaid provides health care for adults, children, people with disabilities and pregnant women who meet state-established income levels.

Long-Term Care: Medicare does not cover the costs of long-term care that exceed a rehabilitation period after an illness, accident or hospitalization. All state Medicaid programs cover long-term care for elderly who do not have the resources to pay themselves; however different rules apply. Often seniors exhaust their own funds and must turn to Medicaid to cover nursing home and other long-term care costs. State Medicaid programs are developing home based services as alternatives to nursing home care.

work with individuals in need of long-term care services. When patients become too frail to live on their own or are admitted to a hospital, nurses determine what level of care is needed and what the patient wants. Once a decision is made, patients either go to a nursing home or work with state case-workers to arrange needed home services, which are sometimes as basic as wheelchair-accessible home upgrades or funds for hiring caregivers.

In Massachusetts, an innovative program is undergoing a major transformation to allow more individuals to remain in their homes. The MassHealth Adult Family Care Program matches individuals who need assistance with families who provide those services in a home setting. The new Enhanced Adult Family Care Program can meet the needs of individuals who need a higher level of care, in addition to broadening the definition of acceptable caregivers to include family members. The program is structured so individuals who need care can choose to either move into the caregiver's home or allow the caregiver to move into his or her home. The Enhanced Adult Family Care service is provided if an individual is eligible for MassHealth (Massachusetts' combined Medicaid and SCHIP program) and meets specified functional requirements. Under the program, caregivers receive a \$1,500 monthly stipend to provide 24-hour care for patients at home.

In addition to state-funded programs, 12 states have been awarded federal grants for nursing home diversion. Nursing home costs often exhaust the financial resources of an individual, which then makes them Medicaid-eligible. The federal grants are aimed at assisting Medicaid programs in Arkansas, Connecticut, Georgia, Illinois, Kentucky, Maryland, Michigan, Minnesota, New Hampshire, New Jersey, Vermont and West Virginia to cut costs by reaching older adults before they enter the nursing home through a number of innovative programs.

Consumer Directed Care

Another innovative approach is cash and counseling, a program in which some states provide cash allowances along with infor-

mation services directly to consumers. This allows people who need long-term care services to hire health care workers and purchase the health care services or medical goods they believe best meet their needs. The cash and counseling program, funded by the Robert Wood Johnson Foundation and the U.S. Department of Health and Human Services, began as a research demonstration for Medicaid recipients with disabilities. Arkansas, Florida and New Jersey were the first to try the cash and counseling approach in the 1990s. Because of the programs' successes in cutting Medicaid costs, 11 more states instituted cash and counseling programs: Alabama, Iowa, Kentucky, Michigan, Minnesota, New Mexico, Pennsylvania, Rhode Island, Vermont, Washington and West Virginia. Illinois also instituted a cash and counseling program with funding provided by a Chicago philanthropic organization, making it the 15th state to provide this type of care.

A review of all states' programs found that allowing consumers to select their own caregivers was either cheaper or no more costly than Medicaid's traditional in-home services. A study of the Arkansas program found that participants were more satisfied with home care services, had increased access to paid care, had fewer unmet needs and experienced a better quality of life. In addition, allowing patients to hire family members expanded the pool of health care workers—significant especially since many areas in the U.S. are experiencing critical shortages in the health care work force.

Single Point of Entry

A similar effort involves providing a one-stop shop for services. Since the early 1990s, some states have been implementing or considering single points of entry for long-term health care services. The single point of entry is generally one agency or organization where patients can access information about long-term care, receive referrals for services and also apply for the services they need—a one-stop shop.

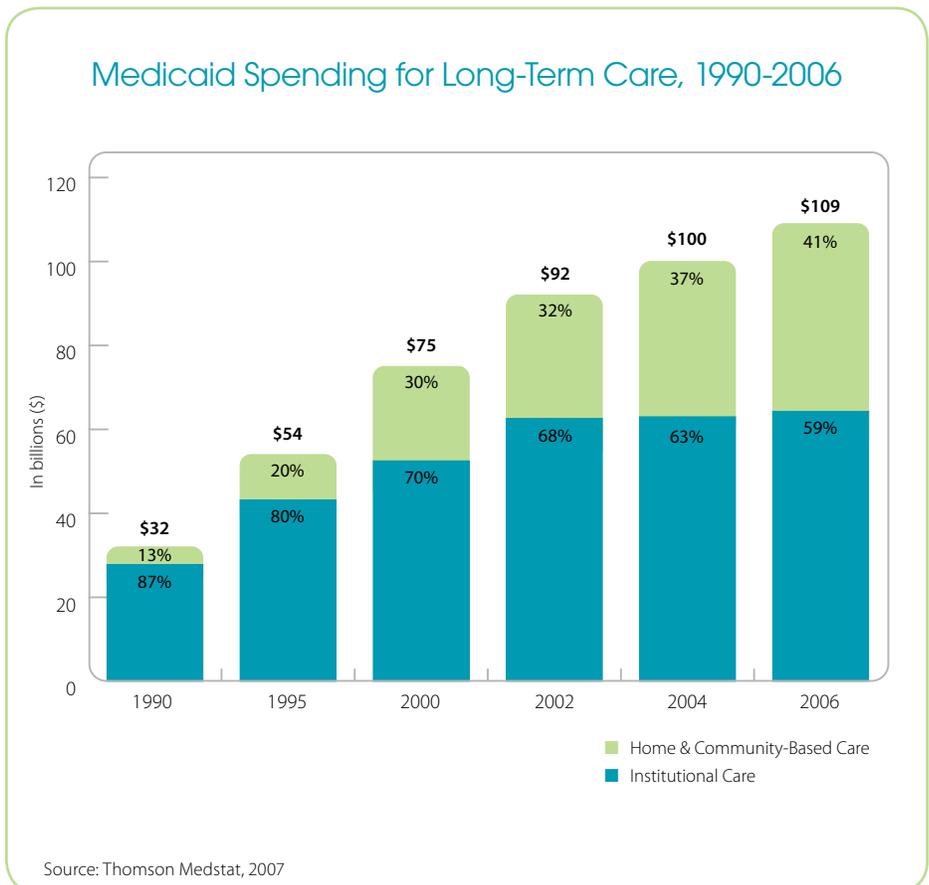
One of the best known programs is Oregon's single point of entry system that merges responsibility for all institutional and community-based care in one state agency. The state's Senior and Disabled Services Division is responsible for assessment, eligibility determination and care coordination. This approach enabled Oregon to develop coordinated state policies that promote common goals across all service settings. Despite a 30 percent population growth in Oregon from 1981 to 2002, the number of people receiving Medicaid-financed nursing home services declined by 33 percent during that time period. Meanwhile, the percentage of people receiving support in the community reached 83 percent in 2002.

At least 24 states have a single point of entry system for long-term care and several others are in development stages with plans for future implementation. In 2007, Michigan enacted House Bill 5389 that establishes up to four single points of entry sites statewide. Similar legislation is pending in Connecticut (House Bill 5791).

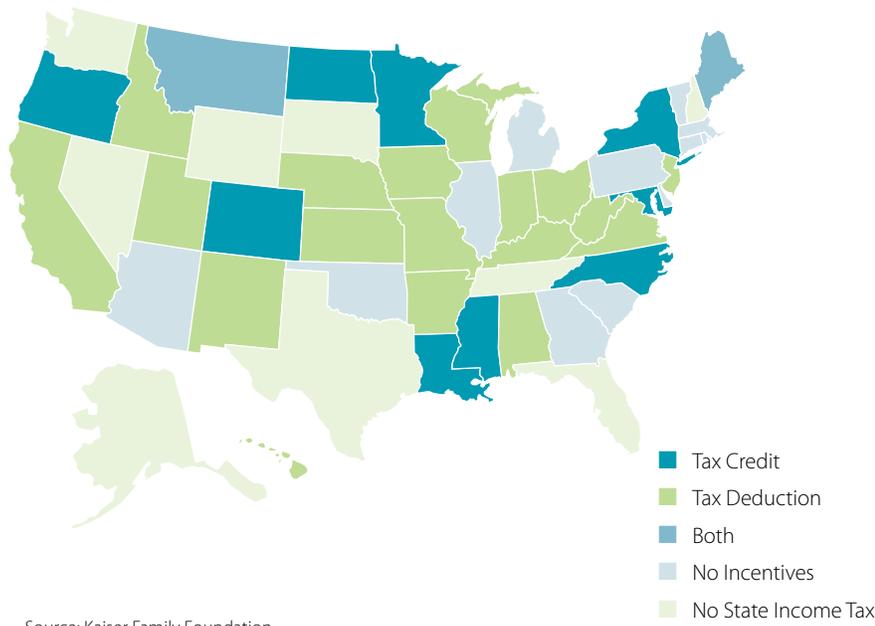
Long-Term Care Insurance

In an effort to cut the rising Medicaid costs, some states are working to persuade aging baby boomers to purchase long-term care insurance. The two main tools of persuasion are tax incentives and the Long-Term Care Partnership Program, but their impacts thus far are less than promising.

Two states—Maine and Maryland—provide a tax deduction or credit for employers offering group long-term care insurance policies, and 30 states now provide tax deductions or credits for the purchase of individual long-term care insurance policies. Tax deductions reduce the cost of long-term care insurance policies in direct proportion to the purchaser's tax bracket, whereas tax credits reduce the cost of a long-term care policy dollar-for-dollar, regardless of an individual's tax bracket. Such tax credits are generally regarded as more powerful incentives for individual policies, especially for middle- and low-income buyers.



State Tax Incentives for Purchase of LTC Insurance, 2008



The Long-Term Care Partnership Program offers special long-term care policies that allow buyers to protect assets and qualify for Medicaid when the long-term care policy runs out. The program, previously restricted to a handful of states, is now available for all states under the Deficit Reduction Act of 2005. The program aims to reduce Medicaid spending on long-term care by deferring the use of Medicaid for those who would otherwise exhaust their financial resources to qualify for Medicaid benefits.

California, Connecticut, Indiana and New York offer partnership programs, and at least 22 states have enacted legislation to authorize partnership programs under the Deficit Reduction Act, including Arkansas, Colorado, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, Virginia and Washington.

But a 2006 report from the University of Hawaii's Public Policy Center concluded that both strategies are failing. The tax incentive programs have not increased the sale of long-term care insurance policies because the state subsidies are insufficient to prompt people to buy such insurance, according to the report. The study further determined that the partnership program

in the four states studied—California, Connecticut, Indiana and New York—failed to induce additional sales of private insurance for long-term care beyond what could have been predicted from demographic factors. The report concludes that “unless states enact substantially more generous subsidies and focus the subsidies on more price-conscious potential buyers of insurance, the programs are counterproductive. They draw resources away from state coffers that could be better spend preparing for the approaching long-term care crisis.”

Individual Planning for Long-Term Care

Approximately 13 million Americans needed long-term care in 2000, and that number is expected to grow substantially in the next 30 years as the population ages and longevity increases. These demographic changes will increase the demand for long-term care services and highlight the importance of individual planning for future long-term care needs. A recent study commissioned by the GE Center for Financial Learning found that most boomers are unprepared for their long-term care needs. The study found only 7 percent had an adequate plan in place.

In an effort to reverse this trend, 18 states joined in a federal program created to in-

crease the public's awareness about the importance of long-term care planning. The Own Your Future initiative is a collaboration of three federal agencies providing services to seniors supported by the National Governors Association, and is designed to help Americans take an active role in planning ahead for their future long-term care needs.

The Own Your Future effort includes information on various ways senior citizens can finance long-term care. Governors from participating states send letters to constituents between the ages of 45 and 65 addressing the importance of long-term care planning and encouraging them to order a free Long-Term Care Planning Kit developed by the U.S. Department of Health and Human Services. States are also promoting the campaign and developing and disseminating state-based information and resources, such as long-term care Web sites.

In Ohio, for example, the state is offering free community forums that will give residents a chance to talk with professionals about long-term care. Pennsylvania will establish statewide public education and outreach unit coordinated by the Pennsylvania Department of Aging to provide information about the importance of long-term care planning. Other participating states—Arkansas, Georgia, Idaho, Kansas, Maryland, Michigan, Missouri, Nebraska, Nevada, New Jersey, Rhode Island, South Dakota, Tennessee, Texas, Virginia and Washington—offer similar programs.

Conclusion

As the U.S. population ages, the challenges in long-term care will continue to grow. There are no easy solutions and no single entity can assume total responsibility for solving the long-term care needs of the nation. However, because states bear the brunt of the financial responsibility for the long-term care needs of seniors and persons with disabilities through Medicaid, they will continue to be at the forefront in developing innovative strategies to address these pressing needs.

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