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Interim Report of the Blue Ribbon Commission to Address the Financing of Long-term Care

November 6, 2002

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Executive Summary

A. Legislative history and commission process

The Blue Ribbon Commission to Address the Financing of Long-term Care was established by Resolve 1999, chapter 114. The commission is composed of 9 members appointed by the President of the Senate, 10 members appointed by the Speaker of the House of Representatives and the Commissioner of Human Services or the commissioner's designee and the Treasurer of State or the treasurer's designee.

The duties of the commission include analysis of the future costs of providing long-term care and recommendations for an integrated system of financing that preserves and promotes consumer choice. In performing these duties the commission was directed to consider whether the financial risk of long-term care should be shared in a public or private insurance system, whether individual savings for long-term care needs should be encouraged and whether each generation of working adults should pay for the long-term care costs of their parents and grandparents.

The commission met on September 19, October 1, October 15 and October 31, 2002. Four more meetings are authorized during 2003. The resolve contains authorization for one meeting in 2002 and one in 2003 to be public hearings scheduled during nonbusiness hours.

B. Commission recommendation

The commission supports the provisions of LD 2220, the supplemental budget bill that will be considered by the 120th Legislature in a Special Session on November 13, 2002, that impose a licensing fee on nursing facilities and intermediate care facilities and that increase reimbursement for long-term care services, provided the fees and reimbursement increases are tied together. The commission acknowledges that this is a short-term fix for a system that is in crisis due to perennial underfunding. The commission will continue to work through 2003 to identify funding and structural issues in long-term care and to propose new approaches to financing that will ensure a fiscally healthy long-term care system.

C. Continued work

The commission is authorized to meet 4 times during 2003. The commission is forming subcommittees to work on issues during the First Regular Session of the 121st Legislature. When the First Regular Session adjourns the commission will begin its second season of work with reports from the subcommittees. The subcommittees, for which there have been a large number of volunteers, will work on private and public responsibility in the long-term care system. The subcommittees will return to the full commission in 2003 with background information, options and any recommendations on which they are able to agree.

I. INTRODUCTION

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At the October 31st meeting commission members decided to form 2 subcommittees to continue the work of the commission in preparation for the 2003 meetings. The subcommittees will collect and analyze information on private and public responsibilities in long-term care and will report to the full commission in 2003 after the First Regular Session of the 121st Legislature on options and any recommendations of the subcommittees.

II. BACKGROUND INFORMATION

The commission sought and considered background information on the current long-term care system in Maine, the fiscal health of Maine's long-term care system, long-term care and financing in other jurisdictions within and outside the United States and long-term care insurance. This information provided a solid basis for commission discussion and the interim recommendation.

1. Overview of Maine's long-term care system

The commission has determined to study public responsibility, in which public long-term care programs provide reimbursement for long-term care, during the time period before the 2003 commission meetings and as a topic at those meetings. As documentation of what commission members have learned and to prepare for the 2003 meetings, the following information is noted.

Who pays for long-term care? The federal-state Medicaid program and the Federal Medicare program are the biggest purchasers of long-term care.[1] MaineCare pays for home and community care and nursing facility care for persons with disabling diagnoses who are of low income and

[1] The federal-state Medicaid program is known in Maine as the MaineCare program and will be referred to under that name in this report. Exceptions will be made when the reference is to federal requirements for the program or national statistics.

who have few assets. State and federal funding for MaineCare long-term care programs in state fiscal year 2001 was $307,005,738.[2] Medicare pays for skilled nursing and home health care for a limited period of time. Medicare is entirely federally funded so there are no costs for the state in this category. Medicare funding for long-term care in 2001 totaled $56,708,000. State-funded programs in Maine pay for services not available under the MaineCare program and for individuals whose income exceeds the MaineCare limits. State spending under these programs, the only funding, in state fiscal year 2001 totaled $21,575,926. Individuals and families and any private insurance that they may have pay for long-term care also. In 2001 they paid, through private pay and insurance, $78,778,000 for long-term care.[3]

The Department of Human Services, through Christine Gianopoulos, the Director of the Bureau of Elder and Adult Services, reported that in state fiscal year 00-01 Maine provided reimbursement through joint state-federal programs and through state-only funded programs to over 30,000 persons.[4] Maine served under the MaineCare program 24,130 clients in nursing and residential care facilities, adult day health services, private duty nursing, personal care services, services under waivers for consumer directed care and elders and adults with disabilities and home health care.[5] Ms. Gianopoulos reported that state-only funded programs serve another 6,738 clients in home-based care for elders and adults with disabilities, consumer-directed home-based care, adult day services, congregate housing services and programs, assisted living, Alzheimer's respite care and homemaker services. Additional services were provided in 2000 in Maine under the Medicare home health program for 19,120 persons, through 692,525 total visits, for a total value of $49,907,026.

The Department of Human Services performed assessments of need for long-term care services through a medical eligibility determination process that utilized nurses making home, nursing facility and hospital visits for 16,359 persons between July 1, 2000 and June 30, 2001. Sixty-nine percent of the persons assessed were women and 17% were under 65 years of age. Of the persons assessed 94% needed assistance or were totally dependent on others in the activity of daily living labeled bathing, 86% needed assistance or were totally dependent on others in dressing and 69% needed assistance or were totally dependent on others in toilet use. Of the persons assessed 57% reported receiving assistance from children, 25% from a spouse, 15% from another relative and 21% from a sibling, parent or non-relative.[6]

The medical eligibility determination process results in a calculation of the amount of assistance a person needs with: daily nursing care; therapies; activities of daily living, which include bathing, dressing, toilet use, transferring, moving between locations, moving in bed and eating. The assessment also considers eligibility based on cognitive impairment and behavioral problems and the amount of assistance needed with instrumental activities of daily living, which include

[2] State of Maine, State and Medicaid Long-term Care Expenditures, Department of Human Services, prepared 2002. Numbers of consumers served is not unduplicated. See Appendix C.
[3] Summary of Historical Nursing Facility Utilization, Maine Health Care Association, Fall 2002. See Appendix D.
[4] Ibid.
[5] Ibid.
[6] MeCare, Maine's Long-term Care Preadmission Screening Program, Summary, July, 2000 to June 2001, Maine Department of Human Services, Bureau of Elder and Adult Services.

preparing meals, shopping, managing money, using the telephone, doing housework and taking medication.

In 2001 25,455 persons who were elderly or disabled adults received financial assistance in obtaining long-term care. Of these persons, 49% received home-based care, 33% received care in a nursing facility and 18% received care in an assisted living facility. By type of expenditure in each setting, 20% of the state's spending for long-term care was spent on home-based care, 61% was spent on nursing facility care and 19% was spent on assisted living care.

Nursing facility care is the most intensive and most costly component of the long-term care system. In 2001 nursing facilities provided care for 1,764,000 patient days under reimbursement through the MaineCare program, while reimbursement through Medicare, private pay and other insurance together totaled 767,000 patient days. MaineCare accounts for 70% of the patient days while paying a total of 64% of the total revenue for nursing facilities. Medicare, private pay and other insurance together account for 30% of the patient days and pay 36% of the total revenue.

2. Fiscal health of Maine's long-term care system

Commission members heard testimony from Christine Gianopoulos, of the Department of Human Services, and from Michael McNeil, of the Maine Health Care Association, both of whom are commission members, establishing that there is estimated to be a gap between allowable costs under the MaineCare program for nursing facility reimbursement and actual reimbursement of $18,000,000 in 2001. Based on 2000 cost report data for non-hospital based nursing facilities, the average actual cost of operations for nursing facilities was $166.81 per day, the average allowable MaineCare cost was $128.80 per day and the average MaineCare reimbursement was $117 per day. Mr. McNeil and Ms. Gianopoulos told the commission that the gap between actual costs and MaineCare reimbursement will continue annually and may grow annually until funding is provided to enable the Department of Human Services to increase reimbursement rates. The commission also heard of a gap in MaineCare reimbursement for residential care facilities of $10,000,000 in 2001, continuing annually in the same manner as the nursing facility funding gap.

Short-term relief for the long-term care system may be in sight. LD 2220 in the 120th Legislature proposes a 6% licensing fee for nursing facilities and intermediate care facilities for mental retardation (ICF-MR'S). These fees are estimated to generate income for the General Fund and funding for the long-term care system. From the nursing facility and ICF-MR licensing fees, the bill proposes to direct $10,400,000 to the General Fund to assist in meeting the budget shortfall, $10,438,777 to increased reimbursement for nursing facilities, $1,614,000 for increased reimbursement for home health agencies and community services and $457,261 for increased reimbursement for intermediate care facilities. Commission members acknowledge that these fee increases are short-term fixes for a system with challenges caused by traditional and continued underfunding in the MaineCare program. The consensus of the commission was to endorse the licensing fees provided the fees are accompanied by a commitment to fund the reimbursement increases. The commission will continue to study long-term care financing and to search for permanent solutions to provide a strong fiscal foundation for the system.

3. Projections of need

Robert Mollica, of the National Academy for State Health Policy and a commission member researched future long-term care needs and presented information to the commission. Based on 2002 figures and using a model developed by the Lewin Group, Mr. Mollica estimated moderate growth in the numbers of persons requiring assistance with activities of daily living in the year 2010: increasing in state and MaineCare funded programs from 14,108 to 15,212 for persons needing assistance with one ADL, from 7,910 to 8,552 for persons requiring assistance with 2 ADL's and from 5,319 to 5,761 for persons requiring assistance with 3 ADL's. Commission members questioned the calculations since the starting total for 2002 amounts to 27,337 while figures from the Department of Human Services show 30,868 persons on state funded and MaineCare programs in 2001. This issue was partly resolved by knowing that the Lewin method was based on 1990 census figures and that the Department of Human Services numbers do include some duplication of consumers. The disparity, which brought into question the accuracy of the Lewin method of estimating growth and thus the projections themselves, was not resolved.

Projections of future need and future costs are intertwined. The Congressional Budget Office estimates that nationally long-term care expenditures will grow by 2.6% annually from 2000 to 2040 while the prevalence of disability will decline by 1.1% annually.[7] National research reported in "A Profile of Older Americans: 2001", from the U.S. Department of Health and Human Services, Administration on Aging, indicates that over the next 30 years, as the "baby boomers" advance to old age, the number of people age 65 and older will increase from 12.4% of the population in 2000 to 20% of the population in 2030. The percentage of Maine's population in 2000 who were age 65 and older was 14.4%. As the population ages concerns grow about the number of persons who need assistance with activities of daily living and instrumental activities of daily living. The percentages of persons with disabilities rise with age. A third of persons age 65 and older report having one severe disability. Of the population age 80 and older, almost three-quarters report at least one disability and 34.9% report needing assistance as a result of a disability. Persons reporting a disability were more likely than others to report poor or fair health. In addition many older persons report chronic conditions and diseases. In addition, as predictions are made for the needs of the elderly, the needs of children and adults with disabilities must be taken into consideration.[8]

Predicting a "perfect storm" of demographic, technological and societal trends, authors Brian Raftery and Carolyn Kates, point out that the "age wave" of "baby boomers" will result in 2050 in 40 Social Security beneficiaries per one taxpayer, as contrasted with one Social Security beneficiary per 40 taxpayers when the program began.[9] They point out that technological advances and healthy lifestyles have led to longer life expectancies and that living longer means collecting benefits for longer. The third factor in the perfect storm is societal changes, the altered American family. They point out the there are more families headed by single adults and adults

[7] "Projections of Expenditures for Long-term Care Services for the Elderly," Congressional Budget Office Memorandum, March 1999.
[8] "A Profile of Older Americans: 2001," U.S. Department of Health and Human Services, Administration on Aging.
[9] "The Perfect Storm," by Brian Raftery and Carolyn Kates, 2001.

working who in previous generations may have been available to provide care for older family members.

"Alzheimer's Disease: The Costs to U.S. Businesses in 2002" reports that 4,000,000 persons in the United States are estimated to suffer from Alzheimer's disease now and that the costs to business totals over $61,000,000,000 per year. The cost is based on estimates that 64% of persons with Alzheimer's disease have a caregiver in the workforce full or part time and that businesses pay direct and indirect health care costs and health care research costs. This report estimates that when the baby boomers age the number of persons suffering from Alzheimer's disease will mushroom to 14,000,000 and the costs to families, business and government will be unsustainable.

4. Long-term care services and financing in other jurisdictions

Commission members studied long-term care systems and financing in other states and countries. They were very interested in the newly enacted Hawaii Long-term Care Financing Act that establishes a long-term care financing program.[10] The program, which will take effect on July 1, 2003, will establish a state long-term care benefits fund overseen by a board of trustees overseen by the Governor. The program will require all Hawaii residents ages 25 and older to pay $10 per month to the fund for a period of at least 10 years in order to receive full benefits. Residents will qualify for benefits from the program through an individual assessment, with a threshold of needing assistance with 2 ADL's or a diagnosis of Alzheimer's disease or dementia. Program materials describe the benefits as partially meeting the cost of long-term care, and as being designed for use in conjunction with private long-term care insurance and other payment sources. Additional information about the Hawaii program will be obtained for consideration during the 2003 commission meetings.

The Canadian long-term care system varies by province. It is financed through a mixture of federal grants and provincial taxes. Administration is done on a provincial level but may be contracted out to regional or district agencies. Financial eligibility varies from province to province. Benefits for facility-based care require payment of room and board costs.[11]

Commission members looked at long-term care in Germany, Japan, New Zealand, Sweden and England.[12] All countries provided long-term care in the full range of settings, from home care to nursing facility care. The German system includes mandatory contributions from employer and employee, or retiree and pension fund, and includes benefit payment through vouchers or cash. Out-of-pocket contributions are required in addition to payments for room and board. Japan has a newly enacted system funded half through general taxes and half through employer/employee or retiree/pension fund. Co-payments of 10% are required and benefits are capped depending on the service setting. The New Zealand program is integrated with the national health program and relies on general tax financing at the national level. Maximum benefit levels and co-payments

[10] The Hawaii Long-term Care Financing Act, HB 2638, Act 245, 2002.
[11] "Long-term Care: Other Countries Tighten Budgets While Seeking Better Access," Government Accounting Office, 1994.
[12] Preliminary Comparison of Long-term Care System Financing. See Appendix E.

depend on the level and location of service. In Sweden the long-term care program is locally run and 90% locally financed, 10% nationally financed. Facility-based care does not include the cost of room and board. The last country studied, England, incorporates local administration and national funding. Facility-based care requires room and board payments while other services require income-based co-payments.

5. Long-term care insurance

The commission has determined to study private responsibility, in which private long-term care insurance plays a large role, during the time period before the 2003 commission meetings and as a topic at those meetings. As documentation of what commission members have learned and to prepare for the 2003 meetings, the following information is noted.

Long-term care insurance provides payment for long-term care in a variety of settings and under the terms and conditions specified when the purchaser and the insurance company execute a contract for benefits. Purchasing long-term care insurance can be confusing as there are a whole set of terms to learn and factors to weigh. The Bureau of Insurance, within the Department of Professional and Financial Regulation, puts out a consumer guide to long-term care, nursing home care and home health care insurance. The publication is also available on line, as are guides to tax qualified policies.

What are all the variables? Long-term care insurance in Maine offers coverage for skilled, intermediate and custodial care in a skilled nursing or intermediate care facility, custodial care benefits and home health coverage. Benefits for the covered person begin through a diagnosis of a clinical deficiency in activities of daily living or cognitive impairment and upon the expiration of any contractually agreed upon elimination period. Coverage continues as long as the beneficiary continues to qualify, for a maximum of the contractually agreed upon benefit period. Policies are purchased annually, with renewal guaranteed upon payment of the next year's premium. Inflation protection, which may be purchased as part of the contract, protects against premium increases in excess of a stated amount each year.

The choices to be made in purchasing a long-term care insurance policy include the elimination period after which benefits are payable, benefit level, duration of benefits, the types of benefits desired and inflation protection. This is best illustrated by example: 3 years of benefits, paying $125 per day for nursing facility or home care, with a 90 day elimination period, for a person 30 years old could cost $604 per year. Five years of benefits, under the same terms could cost $767 per year and unlimited lifetime benefits could cost $1,184 per year. Raising the purchaser's age to 70 increases premiums for the same policies to $2,401, $2,997 and $4,117 per year. It is a balance of anticipated needs, preferences and personal resources and assets. Purchasing more coverage and purchasing later in life costs more. Purchasing less coverage and purchasing earlier in life costs less.

Are there tax consequences from purchasing long-term care insurance? Yes. Premiums paid for tax qualified long-term care insurance are deductible up to a certain amount from federal income

tax provided the taxpayer itemizes deductions on Schedule A.[13] In Maine, under Title 36, Maine Revised Statutes Annotated, sections 2525-A, subsection 2, paragraph C, employers are allowed tax credits for premiums paid on behalf of their employees. Under section 5122, subsection 2, paragraph P, individual resident taxpayers are entitled to a tax deduction for long-term care insurance premiums for policies certified by the Maine Superintendent of Insurance. Benefits for federally tax qualified long-term care insurance are, with a few exceptions, not taxable as income. For non-tax qualified policies, the Internal Revenue Service has not provided guidance. Prior to the enactment of the Kennedy-Kassenbaum bill in 1996, setting up the tax qualified category and affording it specific tax treatment, long-term care insurance benefits had for 30 years not been taxable to the individual beneficiary.

Studies have been done on consumers who purchase long-term care insurance and the potential benefit to the beneficiary and to the public treasury from the purchase of long-term care insurance. Following are the reported results from a number of those studies.

- ✓ Purchasers of long-term care insurance who live in the community are more likely than non-purchasers to have cognitive impairment and less likely to need help with ADL's. Purchasers are more likely to live alone, at some distance from family members and to rely on formal services. Middle and upper income Americans may benefit from long-term care insurance. Further efforts are needed in educating the public about the use of long-term care insurance and the potential need for long-term care.[14]

- ✓ Assisted living residents who have private long-term care insurance, as compared to residents without private insurance, are more likely to be younger, male and married, and to have higher income, have functional impairments and have cognitive impairments. Twenty-eight percent of the insured living in assisted living are likely to report that their needs are not being met. Nursing facility residents who have private long-term care insurance, as compared to residents without private insurance, are more likely to be younger, male and married, and to have higher income and a college education. Forty-six percent of the insured living in a nursing facility are likely to report that their needs are not being met.[15]

- ✓ Nationally long-term care insurance paid less than $5,000,000 for facility-based and home-based long-term care in 2000. Expenditures by long-term care insurers for facility-based care are anticipated to rise to $5,500,000 in 2010 and $10,200,000 in 2020. Similarly their expenditures for home-based care are anticipated to rise to $16,700,000 in 2010 and $36,200,000 in 2020.[16]

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[13] "Tax Qualified Long-term Care Insurance: 2 Years Later," Clifford P. Ryan, CLU, ChFC, CFP, RHU, 2002. See Appendix F.

[14] "The Impact of Private Long-term Care Insurance on Claimants: Formal and Informal Care in the Community," The Center for Home Care Policy and Research, Visiting Nurse Service of New York, Spring 2002.

[15] "The Use of Nursing Home and Assisted Living Facilities Among Private Long-term Care Insurance Claimants: The Experience of Disabled Adults," The Center for Home Care Policy and Research, Visiting Nurse Service of New York, Spring 2002.

[16] See footnote 7 above.

- ✓ Long-term care insurance provides benefits to policyholders, family caregivers and the Medicaid and Medicare programs.[17]

    - o Long-term care beneficiaries report that their insurance allows them to stay at home and out of an institution and makes them feel more secure about the future. They spend less out of pocket and are less likely to have to spend down to Medicaid eligibility.

    - o Family caregivers of beneficiaries of long-term care insurance suffer less stress and are more likely to be able to remain employed.

    - o Medicare savings are estimated at $1609 per beneficiary per year. Medicaid savings are estimated at about $5000 per beneficiary per year. These savings together on a national scale total about $30,000,000,000 per year.

- ✓ Savings accrue to the Medicaid program, in 1990 real dollars, at the rate of $3500 to $6854 per long-term care policyholder. Current expenditures are not greatly affected by current purchases, particularly when younger persons are buying policyholders. The benefits accrue over time. Over 25 years the benefit to the Medicaid program of a million policyholders who purchase and renew their policies through entry to nursing facilities is between $3,500,000,000 and $6,900,000,000.[18]

6. The ostrich effect

Given that we are living longer and the long-term care is extraordinarily expensive, one might think that Americans would be learning about their long-term care options and preparing for the future. Maybe. But that's not what Americans are doing. Even if the news is bad and we could do something about it, we would prefer not to know. It's the ostrich effect.

"The Costs of Long-Term Care: Public Perceptions Versus Reality," a study undertaken by the American Association of Retired Persons in 2001 revealed that Americans are imitating the ostrich on the subject of long-term care.[19] Based on a survey of 1,800 adults ages 45 and older, the study found that only 60% of respondents said that they were somewhat familiar with their long-term care options, and only 15% could estimate the costs within 20%. Fifty-one percent underestimated nursing facility costs and nearly twenty-five percent had no idea of cost. Forty-six percent reported that they were not very prepared or not at all prepared to pay for long-term care. Although Medicare's long-term care coverage is very limited, a quarter of respondents who

[17] "Benefits of Long-term Care Insurance: Enhanced Care for Disabled Elders, Improved Quality of Life for Caregivers and Savings to Medicare and Medicaid," by Marc A. Cohen, Health Insurance Association of America, September 2002, Fall 1994.
[18] "Long-term Care Insurance and Medicaid," by Marc Cohen, Nanda Kumar and Stanley Wallach, *Health Affairs*, Fall 1994.
[19] "Most Americans Unprepared for Long-term Care Costs," American Association of Retired Persons, news release, December 20, 2001. See Appendix G.

classified themselves as very familiar with their options intended to rely on Medicare. AARP concludes that Americans have a false sense of financial preparedness regarding long-term care.

In "Can Medicaid Long-term Care Expenditures for the Elderly Be Reduced?" author Joshua Weiner, PhD, analyzes ways to save on Medicaid long-term care expenditures and explores encouraging the purchase of private long-term care insurance. The author observes that younger people do not purchase long-term care insurance because the risk of needing care is too distant and they have more immediate needs for their resources: child care, mortgage payments and college education. Dr. Weiner concludes that there are 3 reasons why so few older people purchase private long-term care insurance:[20]

- ✓ First and most importantly, long-term care insurance is too expensive for most of the elderly, with a high-quality policy unaffordable for all but 10% to 20% of the elderly.

- ✓ Second, many older people believe that Medicare will take care of their long-term care needs. They think they already have coverage.

- ✓ Third, although older people may admit that they may eventually need hospital and physician care (which they get from the Medicare program), they are unwilling to admit that they face a significant lifetime risk of becoming disabled and thus needing extensive care at home or in a nursing facility.

Like the ostrich, we prefer not knowing.

III. RECOMMENDATION

The commission supports the provisions of LD 2220, the supplemental budget bill that will be considered by the 120th Legislature in a Special Session on November 13, 2002, that impose a licensing fee on nursing facilities and intermediate care facilities and that increase reimbursement for long-term care services, provided the fees and reimbursement increases are tied together. The commission acknowledges that this is a short-term fix for a system that is in crisis due to perennial underfunding. The commission will continue to work through 2003 to identify funding and structural issues in long-term care and to propose new approaches to financing that will ensure a fiscally healthy long-term care system.

[20] "Can Medicaid Long-term Care Expenditures for the Elderly Be Reduced?" by Joshua Weiner, PhD, *The Gerontologist*, volume 36, number 6, 1996.

APPENDIX A

Authorizing Joint Order

APPENDIX B

Membership list, Name of Study Commission

APPENDIX C

APPENDIX D

APPENDIX E

APPENDIX F

APPENDIX G