

Questions for the New Federal Commission on Long-term Care to Address Prior to Legislative Recommendations

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The Community Living Assistance Services and Supports (CLASS) Act, which had directed the federal government to establish a voluntary, public long-term care insurance program as part of the health care reform law, was repealed earlier this year. Prior to the repeal, the Obama Administration had stopped the implementation of the CLASS program, owing to its many flaws. In addition to repealing the CLASS Act, the fiscal cliff law mandated the establishment of a 15-member commission to recommend a legislative “plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the availability of long-term services and supports for individuals in need of such services and supports.” The President recently appointed the final three individuals to this new federal commission on long-term care, completing the congressionally mandated roster of fifteen persons (see Appendix for member listing). Therefore, while the commission’s budget and timetable are being finalized, it is appropriate to now consider what information the commission should gather and what questions it should answer before it makes any recommendations.

Questions Indicated by Aggregate Data

A good place to begin an investigation of this nature is at the aggregate level – at trends and changes in national spending and sources of funding for long-term care (LTC) over time and in recent years. In particular, the commission will want to answer questions raised by looking at aggregate data.

One source of aggregate LTC data is the Center for Medicare and Medicaid Services (CMS)’ National Health Expenditure Accounts (NHEA). Although LTC is not used or defined as a discrete terms in the NHEA, a straightforward and meaningful way to define long-term care, consistent with the data sources as well as with the provisions of tax-qualified LTC insurance policies, is as paid assistance with basic activities of daily living for, or non-medical care to protect, individuals with long-term disabilities. Using the NHEA, this definition would generally correspond with the sum of spending on home health care and nursing home care. This approach, however, does ignore the real differences between younger disabled and elderly retired people who both use these kinds of services (an issue to which we will return below). It, correctly, does not distinguish between the lengths of time of use of services (for example, an elderly person who is a resident of a nursing home for only two months before her death versus five years), or between sources

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Table 1: Expenditures on Long-term Care; Aggregate, Annual Percent Change, Components (Shares) of Spending and Financing: Selected Calendar Years, 1961-2011

	<u>1961</u>	<u>1971</u>	<u>1981</u>	<u>1991</u>	<u>2001</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>
Total LTC (billions of dollars)	0.868	4.745	20.281	64.558	125.201	169.900	184.186	194.862	205.801	214.170	223.676
Change (%) from Prior Year	3.9	11.54	14.92	12.36	6.51	5.41	8.41	5.80	5.61	4.07	4.44
Share of GDP (%)	0.17	0.42	0.65	1.08	1.22	1.27	1.31	1.36	1.47	1.48	1.48
<u>Share of Total LTC (%)</u>											
Spending: Home Health Care Exp.	6.57	4.09	14.49	23.50	27.49	30.95	31.37	31.97	32.68	33.23	33.24
Financing: Out-of pocket	65.08	45.42	36.11	32.51	27.23	23.43	23.13	22.55	21.55	21.09	20.34
Health Insurance	0.44	35.09	53.49	55.89	66.06	70.64	70.68	72.06	73.27	73.73	74.62
Private	0.22	0.40	3.48	9.71	11.57	8.83	8.28	8.03	7.91	7.91	7.84
Medicare	0	3.65	5.75	10.23	18.56	25.56	26.68	28.09	29.27	29.83	31.49
Medicaid	0	29.23	42.16	34.17	34.19	34.43	33.78	33.86	33.90	33.71	32.94
Federal	0	16.65	23.56	18.86	20.52	19.17	18.79	19.62	22.43	22.63	19.74
State & Local	0	12.56	18.60	15.10	13.67	15.27	14.98	14.23	11.48	11.08	13.20
CHIP	0	0	0	0	0.01	0.01	0.01	0.01	0.01	0.01	0.01
Department of VA	0.22	1.83	2.10	1.78	1.73	1.81	1.95	2.07	2.18	2.26	2.33
Other Third-Party Payers	34.48	19.47	10.40	11.61	6.71	5.93	6.18	5.38	5.18	5.19	5.04
Other Private Revenues	10.20	5.73	6.08	7.66	4.00	3.62	3.90	3.25	3.16	3.22	3.06
General Assistance	0.44	0.38	0.12	0.15	0.15	0.28	0.32	0.25	0.25	0.25	0.25
Other Federal Programs	11.09	5.96	0	0	0	0	0	0	0	0	0.01
Other State & Local Programs	12.75	7.40	4.21	3.89	2.56	2.03	1.97	1.89	1.77	1.72	1.73

Source: Author, based mainly on data from the National Health Expenditure Accounts, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary.

of funds paying for the service, for example, by arbitrarily removing Medicare, as some analysts do, on the notion that Medicare pays only for short-term care.² In particular, the recent agreement by the Obama Administration to settle a class-action lawsuit by allowing Medicare beneficiaries to receive skilled nursing and home health care, even if their medical conditions are not expected to improve, argues for the inclusion of Medicare spending in the definition of LTC; indeed, the Administration has stated that this legal settlement simply clarifies existing policy.

The top panel (first three rows) of Table 1 shows the trends and changes in total spending on LTC since 1961 (every ten years) and since 2006 (annually) through 2011. Total spending on LTC has grown steadily and, at times, rapidly over this period; in 2011, it totaled nearly \$225 billion. The annual rate of growth in the 70s, 80s, and 90s, following the establishment of the Medicare and Medicaid programs in the late 1960s, was rapid, at 12 percent or so. More recently, the pace of expansion has slowed to around 5 percent, still faster than economic (GDP) growth, as indicated by the growing share of LTC spending in GDP, from less than 0.2 percent of GDP in 1961 to almost 1.25 percent of GDP in 2001 to almost 1.5 percent in 2011. It is helpful to consider spending in light of the economic resources available to society (often measured by GDP) to support such spending. **What has caused this rapid growth in LTC spending? With strong evidence, found in many and diverse studies, that rates of disability among the general population and especially among the elderly have declined, what role is played by demographics? What role is played by the creation of government funded social insurance and welfare programs? Other factors? Will the rapid growth continue into the near future? The next twenty to thirty years? Over the horizon used by the Trustees of the Social Security and Medicare programs?**

The bottom panel of Table 1 shows the trends and changes in the components of spending on, and sources of funds for, LTC. Home health care makes up an increasing share of total LTC spending; the share was only about 7 percent in 1961, but was a third in 2011. **In light of a reported trend in up-coding as well as recent discoveries of outright fraud on Medicare arising from the home health care industry, is growth in this component of spending a source of concern? Can home health care be an efficient replacement of nursing home services, saving the government money, or does it replace free care provided by families and friends and volunteers? Are recent initiatives launched by health care reform to coordinate medical and home health care (“managed Medicaid”) likely to work, that is, to reduce costs and improve health outcomes of the poorest and most severely disabled persons?**

The rest of the table shows the sources of funds for LTC. Out-of-pocket spending has declined steadily and noticeably, from more than 65 percent of spending in 1961 to only 20 percent in 2011. This trend is mirrored by increases in spending funded by insurance, especially government programs, from less than

² One disadvantage of this general definition is that it ignores long-term care services provided by hospitals, through home and community-based programs financed through Medicaid waivers, and residential care facilities for persons disabled through substance abuse and intellectual frailties. While these additions to long-term care spending are significant (estimated, based on unpublished data, to be over \$50 billion in 2011), data on non-Medicare/Medicaid financing for these activities is not available through the NHEA and therefore we have excluded these categories of spending from our analysis. Assisted living, a growing component of LTC, is included in the nursing homes category, when on-site nursing care is provided.

0.5 percent of spending in 1961 to almost 75 percent in 2011. **In light of the well-established tendency (commonly called moral hazard) for insurance provision to encourage over-spending, is this shift in the sources of funding for LTC efficient, both in terms of government spending and outcomes?** Among government sources of funding, the biggest initial growth was in Medicaid, which replaced, and expanded upon, other federal and state and local programs and other private revenues (including endowment income supporting charitable care) over the 70s and early 80s. More recently, however, the Medicaid share has stabilized at a third, with the majority paid by the federal government. By contrast, Medicare's share of LTC spending has grown rapidly over the entire period, from less than 4 percent in 1971 to nearly a third in 2011. **How significant is growing LTC spending in Medicare's long-standing and deepening deficits and its poor future prospects?**

Although a relatively small share of funding for LTC, veterans' programs have grown recently, from 1.7 percent of spending in 2001 to 2.3 percent in 2011. **How significant are the absence of look-back periods and other constraints on program eligibility for the growth in spending by the VA on LTC?**

Outside of the entitlement programs, government budgeting, including for LTC, is done on annual basis. Yet, as an economic activity presumably influenced by demographics and partly financed through large intergenerational transfers coursing through semi-permanent entitlement and other programs, taking a long horizon approach to measuring sustainability of the federal LTC programs makes sense. In particular, using the Social Security and Medicare Trustees' Reports as a model to understanding the provision and financing of LTC seems to be a useful additional or alternative measurement. **Combining all sources of federal government spending on LTC, and taking a Trustees long horizon approach to evaluating the sustainability of spending and financing, what is the long-term projected status of current law federal government support of LTC?**

A particular interest of many legislators and analysts is the current and potential future role of private insurance in the funding of LTC. According to the NHEA data, this source grew from almost nothing in 1961 to almost 12 percent in 2001, but has since declined to about 8 percent. **What part of private health insurance corresponds to private LTC insurance and what to other insurance sources like Medigap?**

Questions Suggested by Various Avenues of Interaction between Public Insurance and Private LTC Insurance and Out-of-Pocket Spending

Continuing a focus on private long-term care insurance, prominent economic researchers, beginning with Mark Pauly of the University of Pennsylvania, and, more recently and comprehensively, Jeffrey R. Brown of the University of Illinois at Urbana-Champaign and Amy Finkelstein of MIT, have asserted that the existence of Medicaid crowds out private long-term care insurance for most of the working population, at least those below the seventieth or eightieth income percentiles.³ In addition, Brown and Finkelstein assert that Medicaid is an inferior type of insurance, especially to the middle-class

³ Mark V. Pauly, "The Rational Non-Purchase of Long-Term Care Insurance," *Journal of Political Economy*, 1990, 98(1): 153 – 168. Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," *American Economic Review*, 2008, 98(3): 1083-1102.

population, because it requires the spend-down of assets and use of Medicaid-accepting nursing homes, thereby removing any possibility of bequests and making the financing of non-Medicaid (and non-Medicare) sources of LTC, such as assisted living or non-Medicaid nursing homes, more difficult to afford. This work is largely based on theoretical economic models. **What is the evidence, empirical or logical, that the Medicaid crowd-out explanation for the (growing but still) relatively moderate size of the private LTC insurance market⁴ is the (largely) correct one?**

Another explanation sometimes given to the moderate-size market for private LTC insurance is that individuals can qualify for Medicaid while still transferring their financial and real assets, legally or otherwise, to family and friends. Successive rounds of legislation have tightened the Medicaid eligibility rules, especially the look-back period, but the enforcement of these rules by the states, and in particular, the attachment of homes from decedent estates, is often doubted. Indeed, the large presence of “Medicaid planning” services from attorneys and others on the Internet would seem to be prima facie evidence for this type of behavior. **What is the empirical evidence on asset shifting to gain Medicaid eligibility for LTC services? How strong is state-level enforcement of these rules, including collection efforts? What are the administrative systems in place to police compliance with these rules?**

A recent working paper authored by economists at the Federal Reserve Bank of Chicago claims that well-to-do households, who are also typically longer lived than poorer households, actually receive considerable resources through the LTC funding aspects of Medicaid – indeed, nearly as much as that received by the poor.⁵ This is a surprising finding, given the spend-down structure of Medicaid eligibility. It would help to better understand the assumptions, methodology and potential implications of this research. **In particular, does the empirical finding that the well-to-do and long-lived qualify for Medicaid to a surprisingly high degree imply that significant asset transference activity is taking place, or, alternatively, that these households are inadequately protected financially for longevity?**

Yet another explanation for the apparent relative lack of insurance and advance financial planning is the lack of public knowledge about what is and is not covered by public insurance. Preliminary results from surveys conducted by Jeffrey Brown and his colleagues and by Howell Jackson of Harvard Law School and his colleagues are reported to indicate confusion among many households about Medicare, Medicaid and other government programs for LTC, and the extent to which they cover comprehensively the LTC risk. **How economically significant are the survey results of public confusion about government program coverage for LTC. That is, does lack of knowledge account for why there is not more saving and insurance provision among those for whom advance planning may be possible and sensible (middle class population and above)? If this explanation is important, what are its**

⁴ According to a November 2012 presentation to the NAIC by Marc A. Cohen, the number of LTCI insured lives has grown from 1.7 million in 1992 to 7.3 million in 2010, while annualized premium has increased from \$4.2 billion in 1999 to \$10.6 billion in 2010 and incurred claims increased from \$1.6 billion to \$6.4 billion.

⁵ Mariacristina De Nardi, Eric French, and John Bailey Jones, “Medicaid Insurance and Redistribution in Old Age,” working paper presented at annual conference of the retirement research consortium, August 2 -3, 2012, Washington, DC.

implications? In particular, can public information campaigns or private marketing help alleviate the knowledge gap?

One public policy innovation that has been put forward is a sharing of risk and cost between personal and public sources of funds for LTC spending. It is called a partnership LTCI policy, whereby initial levels of costs are paid by a less-than-comprehensive insurance policy and subsequent levels of LTC costs, should they arise, are paid by Medicaid, while some household financial and real assets are set aside, protected from the Medicaid spend-down rules. This innovation was circumscribed geographically by legislation for some time, but more recent legislation has opened it up. One requirement of a partnership policy is that it contain a 5% automatic annual increase in benefit levels to account for the expected rate of inflation in future LTC costs. **Do partnership policies save or cost the government (state and federal) money? Do they expand the LTCI market beyond what it would be otherwise in a leveraged way, for example, through marketing of partnership policies, thereby increasing public knowledge of the limits and deficiencies of public insurance? In the current low inflation environment, is the 5% automatic increase feature for partnership policies still a reasonable requirement? Are there other non-insurance private sources of individual funds of LTC spending whose accumulation can be encouraged? Can Medicaid and Medicare be better structured to incent the wider use of private insurance and/or personal savings accumulated over a working lifetime for LTC?**

Federal Reserve policy has, aggressively and for an extended period, lowered interest rate levels. This has wreaked havoc with the actuarial assumptions underlying the pricing by, and profitability to, insurers of LTCI. As a result, many insurers have exited the market, and, both for already sold and newly marketed policies, premium levels have increased noticeably. The macroeconomic success of the Federal Reserve policy is debatable, as is its future possible negative repercussions; the current harmful consequences for long duration fixed premium and guarantee insurance products and pensions, however, are clear. State insurance law allows for the increase in premiums on blocks of existing LTCI policies through a sometimes lengthy regulatory process across more than fifty states and jurisdictions. **Does the state regulation of LTCI strike the right balance between protecting the rights of policyholders and the need of insurers for solvency, adequate capital and reasonable profits? Would an expanded federal role, beyond tax policy, in the regulation of LTCI help or hurt? Are more flexible products, akin to variable life insurance, a possible answer to the problem of product volatility? Would more favorable tax treatment of current LTCI be worth the cost in lost tax revenues in exchange for a reduction in Medicaid spending?**

One major drawback to private LTCI is the existence of strict underwriting. That is, the underwriting is the mechanism used for the reasonable need for insurers to protect themselves and their products from immediate and large claims from individuals who are already disabled, cognitively impaired, or likely to become so in the near future. Yet among the older age populations where LTCI has traditionally been marketed, underwriting removed a fifth or more of the potential population, cutting the market and preventing some from getting desired and needed LTCI protection. More recently, the insurance industry has addressed this problem, both in the individual and group markets, by marketing to younger potential insureds, where underwriting is less impactful because people are then generally healthier.

Yet, this early issue approach has its own problems, related to the discussion above about product volatility. Earlier issue ages lead to long product durations, in turn, causing volatility, as it is quite hard for actuaries to forecast, and insurers to guarantee, interest rates, policy lapse rates, benefit claims, and so on, many years in the future. Partially in response to these issues, the present author has proposed the *life care annuity*, a combination of an immediate annuity and LTCI, which empirical research has shown would almost eliminate the need for underwriting, while slightly lowering the all-in costs of the products, compared to the two components sold separately, to those at older issue ages, 65 and above.⁶ In addition, the industry has recently seen growth in other types of combination policies of LTCI with permanent life insurance and deferred annuities. The LTCI rider to life insurance is an accelerated death benefit, generally denominated as a percentage of the policy face amount, is issued at fairly young ages, and is estimated to have grown to nearly a sixth of LTCI solutions sold. **Would the insurance industry have an interest in marketing the life care annuity, particularly if it could be offered through employer-sponsored retirement plans or IRAs, not possible under current tax law? Can other combination policies serve as part of the system for LTC services and supports?**

Other Important Questions

The utterly inept design and unsustainability of the CLASS program, as voluntary, guaranteed-issue, widely available insurance, was noted by many analysts relatively early in the legislative process as well as soon after the passage of the health reform law.⁷ Some have speculated, somewhat cynically, that program failure was in fact the intent of the advocates of the CLASS legislation and the Obama Administration. That is, it is asserted that advocates knew that the program would fail, but had expected that the program would be set up anyways and then later be bailed out by the federal government, as many other federal insurance and guarantee programs have been, some repeatedly. In a similar vein, it is asserted that the Obama Administration knew that the program could not even be set up but was happy to use the surprisingly large \$70 billion in net funds that the Congressional Budget Office (CBO) had projected the CLASS program would produce in its first ten years of existence (as premiums collected exceeded claims paid); the Administration used these projected funds from the scoring to finance other aspects of health care reform. There is no way of knowing whether these cynical interpretations are true.

But still it is worth better understanding the competence and capability of the CBO in this process, which is quite non-transparent, because the CBO will continue to play a role in any future legislation in this area. Indeed, the CMS Actuary in its own scoring disagreed strongly with the CBO, estimating about half the amount of net funds produced. Moreover, the CMS Actuary consistently questioned the viability of the CLASS program. The nub of the disagreement between these organizations seemed to be what would be the ultimate popularity and marketability of the program. **On what basis did the CBO believe that the CLASS program would achieve significant penetration among the population? Has its**

⁶ Christopher M. Murtaugh, Brenda C. Spillman, and Mark J. Warshawsky, "In Sickness and in Health: An Annuity Approach to Financing Long-Term Care and Retirement Income," *Journal of Risk and Insurance*, 2001, 68(2): 225 – 254.

⁷ See, for example, Mark J. Warshawsky, "Will the "CLASS" Program Succeed? Is It Sustainable?" *Watson Wyatt Insider*, December 2009.

modeling improved with new data sources, expertise, review processes, and so on? Are there other sources of data and expertise on LTC in the federal government, such as CMS and the Treasury Department?

Both in the design of CLASS, as well in many policy discussions of LTC, various disparate populations are thrown together – the elderly retired, poor, middle-class and well-to-do, young and middle-aged disabled workers, and so on. **Given the different needs and circumstances of the various populations in LTC policy discussion and design, does it make better sense to address them separately?**

Some policy analysts and advocates have long proposed a mandatory social insurance program for LTC expenditures, in addition to Medicare and Medicaid. Presumably this approach would feature an administration structure, including adjudication, rule-making, and post-entitlement review, similar to the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. Yet experience in the last decade with SSDI is sobering. Enrollment and expenditures in that program have exploded, increasing significantly beyond the SSA actuary's projections. A sizeable group of Administrative Law Judges had processed large numbers of SSI and DI appeals, granting the vast majority of claims to be paid; in a few instances, collusion between the judges and the representative attorneys is suspected.

Decades-old DI regulations regarding 50 and above as “advanced age,” thereby giving those claimants a lower hurdle to qualify for benefits, have remained unchanged, despite the general improvement in health of the population, the extension of working lives, the expanded role of personal technologies in supporting people with disabilities, and the smaller role of physical labor in the economy. Similarly, even with the longstanding already implemented and scheduled increases in the normal retirement age from 65 to 67 for retirement benefits, disability benefits still convert to retirement benefits at an unreduced rate, thereby increasing the incentive to file for disability rather than early retirement benefits. Finally, in tight budget times, post-entitlement reviews seem to be the first administrative activity to be cut back, despite the acknowledgement that many beneficiaries improve and no longer qualify for the program and indeed would benefit themselves and the economy if they returned to work. **What are the implications of these negative aspects of recent experience with the SSDI program for the viability of any mandatory public LTC insurance program that might be proposed?**

As mentioned at the beginning of this essay, while all members have been named, the commission has yet to start its work, and even the basics of its budget and deliberative process are still in flux. The six-month deadline for the commission's recommendations has been questioned as inappropriately short, given the broad and deep nature of the LTC issue, the large number of questions outstanding, and the current lack of any new policy ideas in this area. Similarly, the appropriateness of a simple majority for legislative recommendations (found in current law) has been questioned, given the need for a political consensus if it will be at all possible to turn any of the commission's recommendations into viable and sustainable law and regulations. Finally, it is universally recognized that for a fair and complete factual record to be created for, and by, the commission, it is essential that an intelligent, savvy, efficient, non-ideological and nonpartisan staff be hired. **How can these common sense process reforms for the Commission be implemented?**

Conclusions

The repeal of the CLASS program, and the creation of a new federal commission on long-term care, creates a new opportunity to examine this important topic of LTC in a more analytical and less ideological way, hopefully more removed from interest group politics and budget scoring games. The commission has a large job ahead of it, examining carefully and thoroughly the current system of providing and financing long-term care, answering many essential questions, and discovering whether and how the system can be improved for everyone's benefit, in particular, through support of lifelong household awareness and planning for long-term care needs.

Appendix: Members of the Federal Commission on Long-term Care

- Majority leader Senator Harry Reid chose
 - Judy Feder, Georgetown University Public Policy Institute;
 - Laphonza Butler, labor union executive of California's United Long-Term Care Workers Union; and
 - Javaid Anwar, a Nevada internist.
- House minority leader Nancy Pelosi appointed
 - Bruce Chernof, chief executive of the SCAN Foundation, which advocates for the elderly;
 - Judith Stein, Center for Medicare Advocacy; and
 - George Vrandenburg, retired corporate lawyer who supports Alzheimer's causes.
- House Speaker John Boehner selected
 - Stephen Guillard, chief executive officer (CEO) and president of Belmont Nursing Center Corporation;
 - Judith Brachman, former director of the Ohio Department of Aging; and
 - Grace-Marie Turner, president of the Galen Institute and noted writer on health care.
- Senator Mitch McConnell, the minority leader, decided on
 - Bruce Greenstein, Louisiana's secretary of health and hospitals;
 - Neil Pruitt, CEO of United Health Services-Pruitt Corporation, which operates nursing homes and other senior care facilities; and
 - Mark Warshawsky, Director of Retirement Research of Towers Watson and inventor of the life care annuity.
- President Barack Obama appointed
 - Henry Claypool, Executive Vice President of the American Association of People with Disabilities and a top aide at the Department of Health and Human Services from 2009-2012;
 - Dr. Julian Harris, a physician and the Massachusetts Medicaid director; and
 - Carol Raphael, the Vice Chair of the AARP board and former CEO of the Visiting Nurse Service of New York.