



## **The Future of Long-Term Care: What is its Place in the U.S. Health Reform Debate?**

by Howard Gleckman

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### **Introduction**

The health reform law signed on 23 March by President Obama includes fundamental changes in the way the U.S. finances long-term care (LTC). Today, most paid care is funded by government, through Medicaid and other programmes. Less than 10 per cent is financed by private long-term care insurance, and much of the rest is paid for out-of-pocket by families themselves.

The new law creates a national, voluntary LTC insurance programme called the Community Living Assistance Services and Supports (CLASS) Act. At the same time, Congress would expand home- and community-based benefits under Medicaid, a means-tested programme operated jointly by the federal government and the states.

The CLASS Act would be a significant departure from both current U.S. policy and from the social insurance LTC model adopted by most other developed nations. As a voluntary programme, a number of questions have been raised about participation rates, premium costs, and adverse selection. This paper reviews the current LTC financing model in the U.S., as well as several potential alternatives, including the CLASS Act.

### **Financing LTC in the U.S.**

As the U.S. population ages, demand for LTC supports and services is growing. Today, 10 million frail elderly and adults with disabilities require such care. Nearly 80 per cent is provided at home, much of it by family members and friends. In 2007, the cost of paid services was estimated at US\$230 billion, while the economic value of informal care may have approached US\$375 billion. As the Baby Boomers age, both demand for this care and its costs are expected to increase dramatically.

Despite the considerable resources devoted to long-term services, many in the U.S. continue to receive poor quality care. At the same time, public programmes are putting significant financial pressure on both the federal and state governments. The combined federal and state shares of this programme are projected to grow from about 2.9 per cent of Gross Domestic Product today to 6.5 per cent by 2045. The federal share alone would increase from about 1.6 per cent of GDP to 3.7 per cent.<sup>1</sup> As a result, policy-makers are pursuing major changes in the way assistance is both delivered and financed.

In an effort to reduce pressure on Medicaid, government has taken numerous steps to encourage purchase of private insurance. These have included new state and federal tax incentives, a federally-funded marketing campaign to encourage consumers to purchase coverage, offer of group coverage to federal employees, and an expansion of the Partnership Program. This programme makes Medicaid

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<sup>1</sup> Richard Kronick and David Rousseau, 2007, "Is Medicaid Sustainable: Spending Projections for The Program's Second Forty Years" *Health Affairs* Vol. 26, No. 2 (2007): w271-w287 (published online 23 February 2007).

benefits more readily available to consumers who purchase designated LTC insurance policies. However, none of these efforts have significantly increased purchase of private LTC insurance policies.

As a result, Congress has approved several proposals for substantial reform. These fall under three categories: shifting the focus of Medicaid long-term benefits to home care, expanding the LTC and geriatric workforce, and restructuring the means of finance.

The least controversial of these are proposals to create new incentives to encourage workforce growth. The second set of initiatives would accelerate Medicaid's shift from institutional to community care. While these proposals would help serve an unmet need, they would also require creation of a greatly expanded home care infrastructure, including more aides, more adult day programmes, better transportation, and more accessible housing.

Such steps appear to be quite responsive to the public's desire for more home care and greater flexibility in care settings. However, some state Medicaid officials are concerned about what is known as the woodwork effect. Their fear is that low-income families who now provide informal care at no cost to the state would seek assistance from a more widely available Medicaid home care benefit.

Expanding community care could be quite costly. The Congressional Budget Office estimates that expanding mandatory home and community services under Medicaid could cost as much as US\$5 billion annually.<sup>2</sup> However, it is likely that Congress will adopt some measures to encourage states to expand these programmes under Medicaid, even as new curbs are imposed on Medicare funding of post-acute care.

### Reforming LTC financing

Current initiatives to reform LTC financing in the U.S. are built on three models. The first would further enhance private LTC insurance in an effort to make this product more attractive. The second would build a core government insurance model. The third incorporates various public/private hybrids.

To further expand private insurance in a more comprehensive way, a plan called Medi-LTC<sup>3</sup> would allow private carriers to sell simplified LTC benefit packages through Medicare, similar to the way Medicare Supplement (Medigap) health insurance is marketed today.

Other researchers have designed models to replace the current welfare-like Medicaid system with universal tax-funded insurance. However, while tax-funded LTC insurance programmes have been broadly accepted in most major industrialised countries, such as Germany, Japan, and France, it is unlikely that voters in the U.S. would support such a design.

As a result, other options focus on the use of alternatives to tax increases. In these models, monthly contributions are fixed regardless of income (except for a low-income subsidy). Thus, they may feel more like a premium than a tax.

The Community Living Assistance Services and Supports (CLASS) Act creates a government insurance benefit and explicitly anticipates the purchase of private supplemental coverage.<sup>4</sup> Enrollment would be automatic starting at age 18, but with an opt-out option. Those who chose not to purchase initially would pay higher age-related premiums if they decided to enroll at a later time.

The CLASS Act would provide cash benefits, much as Social Security disability insurance does today, and as Germany permits. Such a benefit design gives the elderly and disabled the flexibility to spend funds for such purposes as supporting family caregivers, renovating a home to accommodate a wheelchair, or obtaining assistive devices without having to navigate complex government regulations or limitations of private insurance contracts.

A crucial question will be the behavioural response to an opt-out, especially among those in their 20s and 30s. It seems likely, however, that if the programme permits an opt-out, adverse selection would result in higher premiums than in a mandatory programme.

<sup>2</sup> CBO (2008) *Budget Options*, Vol. 1: Health Care.

<sup>3</sup> John Cutler, Lisa M. Shulman, and Mark Litow (2007) *Medi-LTC A New Medicare Long-Term Care Proposal*, Georgetown University Long-Term Care Financing Project.

<sup>4</sup> [http://help.senate.gov/BAI09A84\\_xml.pdf](http://help.senate.gov/BAI09A84_xml.pdf).

The CLASS Act would retain a substantial Medicaid programme. Because the benefit would cover significantly less than all LTC costs for many beneficiaries, the sponsors expect consumers to purchase supplemental private insurance.<sup>5</sup>

### Conclusion

The broader health reform debate in Washington has created a rare opportunity for policy-makers to rethink the relationship between medical treatment and the LTC needs of the chronically ill and those with disabilities. It is, for instance, an ideal environment to better coordinate LTC with medical treatment. Broad health reform also presents an opportunity to review the bifurcated structure of Medicare and Medicaid that often works to the detriment of those eligible for both programmes. It allows policy-makers the chance to alter the balance between institutional and home- and community-based care. As policy-makers redesigned health coverage, they have taken some key—though incomplete—steps to improve payment mechanisms for LTC.

This is an abridged version of an Urban Institute working paper. The full paper is available at <http://www.taxpolicycenter.org/publications/url.cfm?ID=411908>.

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<sup>5</sup> [http://help.senate.gov/BAI09A84\\_xml.pdf](http://help.senate.gov/BAI09A84_xml.pdf).