REPORT 6 OF THE REPORT OF THE COUNCIL ON MEDICAL SERVICE (I-05)
Policy Options for Addressing Medicaid Long-Term Care
(Reference Committee J)
(November 2005)

EXECUTIVE SUMMARY

The Medicaid program faces a number of challenges to the provision of long-term care, such as, the aging "baby boom" generation, the growth in health care costs, and the impact of reduced federal and state revenues. In April 2005, Congress directed the House Energy and Commerce and Senate Finance committees to find $10 billion in savings over fiscal years 2006-2011, the bulk of which may come from the Medicaid program. Due to the fact that long-term care accounts for over a third of Medicaid spending, the program has become a target for cost containment actions.

Over the years, the Council on Medical Service and the Board of Trustees have developed numerous reports on the uninsured and on various aspects of the Medicaid program. As an initial effort to explore Medicaid long-term care policy, Council on Medical Service Report 6 (I-05) reviews the current status of the Medicaid program, including the ongoing challenges facing the program; describes the program and financing of long-term care; summarizes federal and state Medicaid legislative developments; and highlights some selected strategies for improving the delivery and financing of long-term care.

In its review of the literature, the Council identified a series of proposed short- and long-term options for providing and financing long-term care that may lessen impact of current demographic and financial trends. Many of the options are based on the premise that individuals should be encouraged to privately finance their long-term care needs to the extent that personal income permits. These options include offering tax subsidies to purchase long-term care insurance products (LTCI); encouraging public and private partnerships to offer subsidized LTCI products; legislating more stringent eligibility criteria for homeowners; providing tax subsidies for care-givers; and increasing consumer-directed care programs.

The Council reaffirms that existing AMA policy should advocate for tax incentives for the purchase of LTCI. The Council realizes that for the middle to low-income individuals tax credits may not be enough to motivate purchase of LTCI. Therefore, the Council recommends encouraging further public/private partnerships that would offer alternative LTCI products. The Council also recommends encouraging states to continue to support the provision of medically appropriate treatment through programs similar to the Cash and Counseling program, and providing tax credits for caregivers to shift the burden from the Medicaid program and encourage those who are providing unpaid care to continue to provide care in the home.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6 - I-05
(November 2005)

Subject: Policy Options for Addressing Medicaid Long-Term Care

Presented by: Joseph P. Annis, MD, Chair

Referred to: Reference Committee J
(Iffath A. Hoskins, MD, Chair)

The Medicaid program was originally created to provide health benefits to people receiving public welfare assistance. Over the past two decades, however, the program has become the nation's primary payer for long-term care services. Today, the Medicaid program faces a number of challenges including: increases in enrollment, increases in health care costs, reduced federal and state funding, demographic pressures, and the impact of the new Medicare prescription drug benefit. In addition, due to the fact that long-term care accounts for more than a third of Medicaid spending, the program has become a target for cost containment actions.

In April 2005, Congress directed the House Energy and Commerce and Senate Finance committees to find $10 billion in entitlement program savings over fiscal years 2006-2011, the bulk of which most likely come from the Medicaid program. To provide advice in stabilizing and strengthening the Medicaid program, the Secretary of the Department of Health and Human Services (HHS) appointed a Medicaid Advisory Commission in July 2005, to offer short-term and long-term recommendations regarding the future of the program. American Medical Association (AMA) Immediate Past President John C. Nelson, MD, was appointed as a non-voting member of the Commission. Concurrently, the National Governors Association produced an initial set of Medicaid reform recommendations in June 2005.

Over the years, the Council on Medical Service and the Board of Trustees have developed numerous reports on the uninsured and on various aspects of the Medicaid program. Council on Medical Service Report 1 (I-03) established a long-term strategy for financing the provision of medical care to patients with low incomes, including individuals currently receiving acute care under the Medicaid program (Policy H-165.855, AMA Policy Database). The Council also indicated that later reports would address the difficult issues related to providing long-term care under the Medicaid program.

This report reviews the current status of the Medicaid program, including the challenges facing the program; describes the program and financing of long-term care; summarizes federal and state Medicaid legislative developments; and highlights some selected strategies for improving the delivery and financing of long-term care.

HISTORY OF THE MEDICAID PROGRAM

As previously discussed in Council on Medical Service Reports 8 (A-03), 1 (I-03), and 1 (A-05), the Medicaid program was enacted as Title 19 of the Social Security Act (SSA) in 1965, as an afterthought to the enactment of the Medicare program. Medicaid's establishment as a joint federal and state venture, unlike Medicare's federal design, preserved state control over programs for the poor. In 1997, the State Children's Health Insurance Program (SCHIP) program was created to extend coverage to children in families with incomes too high for Medicaid eligibility, but too low to purchase their own coverage.

More than 52 million individuals receive services provided under Medicaid. Of the 52 million enrollees, 25 million are children, 13 million are low-income, uninsured adults (including pregnant women and some of the parents of covered children), and 15 million are seniors and persons with disabilities. The 15 million seniors and other individuals with disabilities (less than 30% of the total Medicaid recipients) account for more than 70% of Medicaid spending (Congressional Budget Office, March 2004 Baseline).

The federal, state, and in some cases county governments, finance Medicaid jointly, with the federal government matching state Medicaid spending for specific categories of individuals and benefits, based on a formula that compares each state's per capita income to the national average. The federal share of Medicaid spending varies by state, known as the Federal Medical Assistance Percentage (FMAP), and ranges from 50% to 83%, with an average of 57% of funding coming from the federal government. The formula used to calculate the FMAP seeks to narrow the gap between relatively wealthy and relatively poor states (measured as per capita income) by providing higher rates to poorer states. In order to receive federal matching funds, states are required to provide a set of mandatory benefits to a mandatory group of beneficiaries. Mandatory populations include children through age 5 at or below 133% of the federal poverty level (FPL); children aged 6-19 in families with incomes at or below 100% of FPL; certain adults in families with eligible children; pregnant women with incomes at or below 133% of FPL; disabled and elderly social security income (SSI) beneficiaries; working disabled whose assets are below a certain level (e.g. "medically needy" or those who "spend down" to state-set eligibility standards); and Medicare beneficiaries who are also eligible for Medicaid (i.e. dual eligibles).

Medicaid benefits vary widely from state to state. Within states, benefits also vary depending on age and other eligibility categories. The Medicaid statute requires participating states to provide certain mandatory benefits in order to receive federal matching funds. The statute also permits states to receive matching funds for statutorily defined optional benefits. Roughly two-thirds of all Medicaid spending is for optional benefits. Optional benefits include prescription drugs; intermediate care facilities for individuals with mental retardation (ICFs/MR); personal care services authorized by a physician; case management services; prosthetics; rehabilitative services; physical therapy; clinic services; and diagnostic, screening, and preventive services. More than half (56%) of the elderly who qualify for Medicaid, and thus long-term care, qualify through optional eligibility groups (Kaiser Commission on Medicaid and the Uninsured, March 2005).

States have wide discretion to determine which benefits to offer Medicaid beneficiaries, and they can institute "nominal" cost-sharing for beneficiaries other than children, pregnant women, any terminally ill patients receiving hospice care, and the medically needy who had to "spend down" to qualify for Medicaid.

KEY TRENDS IMPACTING MEDICAID

Enrollment and Demographic Changes

For the first time, total Medicaid spending in 2003 surpassed spending for primary and secondary education as the largest single state budget item, on average accounting for 22% of state budgets. The National Governors Association (NGA) and National Association of State Budget Officers Survey report that enrollment increases have played a major role in the increase in Medicaid spending. They indicate that the elderly and the disabled are the groups contributing the most to the increased costs from enrollment changes (The Fiscal Survey of States, June 2005). It should be noted, however, that they also found that the recent increase in expenditures is primarily attributable to the increased cost of providing acute care services, including prescription drugs and hospital inpatient services, not long-term care.

Nevertheless, future demographic trends are likely to alter the current cost drivers of the Medicaid program. The Government Accountability Office recently reported that the number of elderly 85 years and older – the age group most likely to need long-term care services – is projected to increase more than 250% from 4.3 million in 2000, to 15.4 million in 2040. Further, the total number of disabled elderly is estimated to increase to as high as 12.1 million by 2040 (Government Accountability Office, April 2005). With the aging of the baby boom generation, increasing life expectancy, and the rising costs of nursing home and home health care, there will likely be an increase in demand for long-term care that threatens to overwhelm Medicare and Medicaid, and may leave millions of Americans unprepared for both the heavy financial and non-financial burdens of providing long-term care for themselves or family members.

Growing Health Care Costs and Reduced State Revenues

In the aggregate, the cost of meeting acute and long-term care needs of the poor, elderly, and disabled under Medicaid is growing faster than current state tax revenues. A study by the Kaiser Commission on Medicaid and the Uninsured (KCMU) indicated that in Fiscal Year (FY) 2004 overall Medicaid spending increased on average by 9.5%, while tax revenue increased 3.4%. In response to pressure to control Medicaid costs, every state in the nation, including the District of Columbia, implemented at least one new Medicaid cost containment strategy in 2004. In FY 2005 more states planned to implement cost containment strategies directed at the elderly and disabled through disease management programs and long-term care initiatives (Kaiser Commission, March 2005).

The KCMU study also reported that between FY 2002 and FY 2005:

- All 50 states froze or reduced health care provider payment rates and implemented prescription drug cost controls;

- 38 states imposed eligibility restrictions;

- 34 states reduced benefits; and

- 20 states imposed new or higher beneficiary co-payments.

FINANCING LONG-TERM CARE

Long-term care is the assistance, whether medical, personal, or both, that people require when they are unable to manage common activities of daily living due to frailty, chronic illness, or mental incapacity. Many Americans are unaware that nearly one of every two individuals age 65 or older is likely to spend at least some time in a nursing home, and the cost of one year of this care could entirely deplete personal savings. Medicaid has become the primary payer of long-term care services. In FY 2003, federal and state Medicaid spending totaled $275.5 billion. Total spending on long-term care services was over $97 billion (36% of total Medicaid spending).

The likelihood that a person over the age of 85 will require long-term care is about 55% (Congressional Budget Office, Financing Long-Term Care for the Elderly, April 2004). The 2004 average daily rate for a private room in a nursing home is $192 or $70,080 annually (MetLife Mature Market Institute, 2005). According to a recent Kaiser Family Foundation (KFF) poll, 30% of respondents indicate that insurance would be the main source of funds if they or a family member needed nursing home care. Few reported that personal savings (16%) or government programs such as Medicare or Medicaid (13%) would be the main source of financing such care (Kaiser Health Poll Report, May/June 2005). Yet, Medicaid accounted for 46% of national nursing home care spending in 2003.

Private long-term care insurance (LTCI), which was thoroughly addressed in Council on Medical Service Report 5 (I-04), is a small, but growing source of coverage for nursing and home-based care costs. In 1989, LTCI was offered to 3% of full-time employees in private industry with 100 or more employees; by 2003, 19% of full-time workers in private industry were offered this benefit (Department of Labor, 2004). Despite the increased availability, fewer than 10% of Americans age 65 and older have purchased LTCI, and pre-retiree penetration rates are even lower (Office of Personnel Management, 2004).

Nonetheless, LTCI is proving to relieve some of the pressure on public programs. In 1995, private insurance paid $700 million or 0.8% of long-term care services for seniors. It is estimated that in 2004, LTCI covered $6 billion or 4% of long-term care services (Congressional Budget Office, 2004).

For the individual, the primary benefit of LTCI is that it minimizes the use of personal savings to pay for long-term care needs. LTCI provides protection of retirement savings, reduces financial hardships for spouses and other family members, and promotes greater financial independence. From a societal perspective, the primary appeal of private LTCI coverage is that it may fund a substantial portion of the long-term care needs for many Americans. Furthermore, widespread LTCI coverage has the potential to shift a substantial share of the funding responsibility from the Medicaid program to individuals.

POLICY OPTIONS FOR PROVIDING LONG-TERM CARE

In its review of the literature, the Council identified a series of proposed short- and long-term options for providing and financing long-term care. Many of the options are based on the premise that individuals should be encouraged to privately finance their long-term care needs to the extent that personal income permits. These options include offering tax subsidies to purchase LTCI products; encouraging public and private partnerships to offer subsidized LTCI products; legislating more stringent eligibility criteria for homeowners; providing tax subsidies for care-givers; and increasing consumer-directed care programs. The options presented in this report are by no means comprehensive, especially given that the Medicaid Advisory Commission and the NGA will be continuing to develop and refine Medicaid reform proposals. Rather, it is the intent of the Council that this report serve as a beginning of a more comprehensive effort to explore Medicaid long-term care policy.

Tax Subsidies for LTCI Premiums

A large portion of Medicaid beneficiaries, especially those receiving long-term care benefits, are not on welfare (e.g. Temporary Assistance for Needy Families or Supplemental Security Insurance), but are individuals who have high medical bills. These individuals can be described under the Medicaid category of "medically needy," but may have the means to pay for at least a portion of their long-term care. According to the Center for Long-Term Care Financing, nearly one-third of Medicaid long-term care costs — $20 billion annually — is for seniors who could have purchased their own insurance to pay for their care (National Center for Policy Analysis, July 12, 2005).

The cost of LTCI is a considerable barrier for many middle- and low-income individuals. It was recently reported that "only 10% of people over 65 own policies, with many holdouts saying that they are intimidated by high costs and the bewildering array of benefit levels, deductible periods and other features" (The New York Times, July 24, 2005). Further, a recent KFF study found that nearly one third (32%) of people without LTCI indicate that it is not something they have ever thought about (Kaiser Health Poll Report, May/June 2005).

Some federal tax deductions are currently available for those who have purchased LTCI. To qualify for a federal tax deduction, an individual must posses a LTCI contract that provides coverage for qualified long-term care services; is guaranteed renewable; provides that refunds (except refunds due to death or complete cancellation of the policy) and dividends are used only to reduce premiums or increase benefits; does not provide for a cash surrender value or money that can be borrowed; and does not pay items already reimbursed under Medicare. State tax incentives are also offered in 23 states (National Governors Association, Center for Best Practices, June 2004).

Tax incentives provide two critical incentives to encourage the purchase of LTCI. The American Academy of Actuaries contends that the tax savings that long-term care subsidies achieve increase the affordability of the product. Equally important, the existence of a tax subsidy provides another opportunity for the federal government to publicize and educate the public about their option to pre-fund their own long-term care (American Academy of Actuaries, 2001).

In general, supporters of federal tax subsidies argue that promoting the purchase of LCTI earlier in life will both protect consumers against financial losses and ultimately save the federal government money by reducing Medicaid outlays. Opponents argue that the current structure for tax deductions provides little or no assistance to most low- and middle-income families, while disproportionately assisting high-income individuals who already would have been inclined to buy LCTI.

Public-Private Partnerships for LTCI

The Partnership for Long Term Care provides an alternative to "spending down" or transferring assets to meet Medicaid eligibility by forming a partnership between Medicaid and private long term care insurers. Currently, four states (California, Connecticut, Indiana, and New York) operate a public-private effort with the Robert Wood Johnson Foundation to sell affordable long-term care policies. Consumers in these states are able to purchase private insurance polices to cover the first one to three years of long-term care benefits and still have a level of asset protection. When their private coverage expires, individuals can apply for Medicaid coverage, but they do not have to spend down all of their assets. For instance, if an individual buys a policy that covers $100,000 of expenses, he or she can protect an extra $100,000 in assets and still be eligible for Medicaid.

By design, the Partnership policies are Medicaid budget-neutral. While states must forgive part of the insured's potential spend-down, the insurance companies absorb costs for long-term care that would have been the responsibility of the Medicaid program. The effectiveness of the Partnership is illustrated by the extremely small percentage of policy-holders accessing Medicaid because they have exhausted their long-term care through these plans (National Program Office, University of Maryland, 2004).

The Partnership for Long-Term Care is a model that is considered ripe for expansion by state legislatures. Federal law currently prohibits the expansion of the Long-Term Care Partnerships beyond the four states currently in the program. However, the Bush Administration has proposed eliminating the expansion ban, and according to the NGA, 17 states have passed legislation to enable them to begin similar programs in case federal law is repealed.

Reverse Mortgages and Delayed Medicaid Eligibility

A home is the principal financial asset for many older Americans. The National Council on Aging estimates that about half of the nation's households 62 and older could access an average of $72,128 from reverse mortgages. In total, the National Council on Aging estimates that $953 billion could be available from reverse mortgages for immediate long-term needs and to promote aging at home (National Council on Aging, "Use your Home to Stay at Home," April 2004).

A reverse mortgage, or home-equity conversion, pays the homeowner a fixed sum each month. The amount of money disbursed each month is dependent on the homeowner's age at the time the loan is applied for, the equity of the home, the type of loan, and current interest rates. Eligibility is based on the age of the borrower (usually 60 or older) and the type of residence (i.e., single-family homes, including condominiums, but not co-operatives). A feature called "life tenure" can be added so that the equity conversion does not exceed the value of the home when it is sold.

The Center for Long-Term Care Financing has suggested that by replacing the home equity exemption with a requirement that people first use the equity in their homes prior to applying for Medicaid, the federal government could potentially save the Medicaid program billions of dollars per year. Currently, there is little incentive for individuals to use reverse mortgages because regardless of the value, a home is an excluded resource for determining Medicaid eligibility. Not only would a requirement for people to use the equity in their homes prior to accessing the Medicaid program potentially save money, it also would potentially provide a disincentive for individuals to transfer assets and "spend down" to meet Medicaid eligibility criteria.
An alternative to privately financed reverse mortgages is the Home Equity Conversion Mortgage Program (HECM), which provides federally insured reverse mortgages backed by the Federal Housing Administration (FHA). The FHA insures HECM loans to protect lenders against loss if amounts withdrawn exceed equity when the property is sold. One disadvantage of a federal

government loan is that although it may offer more protection, it does not have the flexibility of providing larger loan amounts.

There are potential disadvantages for accessing home equity, especially for elderly women. In general, women live longer than men. When a woman has used the equity in the family home to finance long-term care services for a spouse, she may not only need to access Medicaid, but she could possibly lose the family home.

Tax Credits for Caregivers

It is difficult to quantify the amount of assistance that the elderly with long-term care needs receive from family and friends. In terms of financial cost, it has been estimated that caregivers typically spend $12,500 annually on expenses related to their care-giving responsibilities (NGA, 20 Actions Governors Can Take, 2004). These expenses are usually uncompensated. A tax credit for caregivers is one way to shift the burden from the Medicaid program and encourage those who are providing unpaid care to continue to provide care in the home.

Although some states offer a deduction for expenses, usually up to $2,400, most offer a credit instead. According to the NGA, at least 28 states and the District of Columbia have refundable or nonrefundable dependent care tax credits. Tax credits generally benefit low-income taxpayers and are often viewed as the most equitable way of providing caregiver tax incentives. State caregiver tax credits generally range from $500 to $1,500.

Consumer-Directed Care Waivers

Traditionally, disability-related support services at home have been restricted to human assistance with personal care and homemaking provided by licensed agencies. Waiver programs have offered additional limited services; however, a case manager typically is responsible for deciding if these services are needed. In recent years, states increasingly are offering beneficiaries and their families the opportunity to obtain “consumer-directed care” services from individual providers.

The “Cash and Counseling” project is an expanded model of consumer-directed support services. It provides a flexible monthly allowance for consumers to hire their choice of workers, including family members, and to purchase long-term care goods and services. Cash and Counseling requires that consumers develop spending plans that show how they would use the allowance to meet their needs for disability-related services. These spending plans are based on the consumer’s personal care plan or previous claims history for personal care and homemaking provided by licensed agencies. Consumers who are unable to manage their allowance or hiring responsibilities may designate a representative, such as a family member, to assist them.

From 1998 to 2000, The Robert Wood Johnson Foundation and HHS began to implement the Cash and Counseling Demonstration and Evaluation Project in the states of Arkansas, New Jersey, and Florida. According to a research study by Mathmatica Policy Research, “the state of Arkansas demonstrated that states can design a cash and counseling program that meets recipients’ needs better at no greater cost per month of service than historically incurred under the traditional agency approach” (Stacey Dale, et al, Health Affairs, November 2003).

In 2002, the Bush Administration announced a new Medicaid waiver initiative called Independence Plus. Independence Plus is a method of funding that allows available funds to move with the individual to the most appropriate and preferred setting as needs and preferences of the individual change. The intent of the program is to give states the flexibility to offer people with disabilities and the elderly greater control and choice in identifying, accessing, and managing certain long-term care services and supports. As an alternative to long-term care services managed by the Medicaid program, participants receive an individual budget that is tied to a plan of care that is tailored to the needs of the Medicaid beneficiary. At the time that this report was written, Independence Plus waivers had been approved for the states of Florida, Louisiana, New Hampshire, and South Carolina.

FEDERAL AND STATE MEDICAID LEGISLATIVE DEVELOPMENTS

In September 2005, the Medicaid Advisory Commission submitted its first report to the Secretary of HHS. Among its key recommendations were the following:

- Reform the Medicaid prescription drug reimbursement formula to more accurately reflect the actual price for drugs;

- Extend the Medicaid drug rebate program to Medicaid managed care;

- Provide states with the flexibility to define co-payment requirements for prescription drugs;

- Change the start date of the penalty period for persons transferring assets for Medicaid eligibility; and

- Extend the asset transfer look back period from three to five years.

Specific to long-term care, the Bush Administration's FY 2006 budget also included a proposal to reform existing rules regarding asset transfer. Other Administration proposals affecting the elderly population receiving long-term care included a federally financed 5-year demonstration project to allow individuals to move from institutional care to at-home care, and a proposal to allow states to presume that individuals who are discharged from hospitals are eligible for community care, as well as nursing home care. In addition, the Administration proposed to eliminate the ban on new partnership programs to allow any state in the nation the option of implementing a LTCI partnership program.

Federal legislation introduced during 2005 has emphasized rebalancing the long-term care framework by shifting nursing home care to home and community based care. For example, a key provision of the Ronald Reagan Breakthrough Act of 2005 (H.R. 1262), introduced by Reps. Edward Markey (D-MA), Chris Smith (R-NJ), and Michael Burgess (R-TX), and its Senate companion bill (S.602) introduced by Sen. Barbara Mikulski (D-MD), would increase the amount of assistance under a demonstration project to provide tax-credits of up to $3,000 for family members caring for Alzheimer's patients. Similarly, a key provision of the Long-Term Care Retirement and Security Act of 2005 (H.R. 1244), introduced by Rep. Nancy Johnson (R-CT), would provide eligible caregivers tax credits for providing care to family members with long-term care needs. A provision of the Long-Term Care Financing Act (S. 1602), introduced by Sens. Charles Grassley (R-IA) and Hillary Clinton (D-NY), would provide an above-the-line tax credit for LTCI premiums, which would be phased in over the next 4 years, for up to $3000.

Governors and state lawmakers also have proactively worked to develop proposals and recommendations to address Medicaid. In a draft Medicaid reform proposal developed in June 2005, the National Governors Association included several policy options for addressing Medicaid long-term care, including:

- Federal tax incentives for LTCI, such as targeted tax credits to low-income individuals and deductions for higher-income individuals in higher tax brackets for purchasing LTCI.

- A requirement that all employers who provide 401(k) and other pensions provide an option to convert a portion of an annuity into LTCI.

- Encouraging long-term care partnerships between Medicaid and the LTCI industry. As previously stated, four states (California, Connecticut, Indiana, and New York) currently allow individuals who have purchased and exhausted benefits under their LTCI to access Medicaid and still protect their assets equal to the benefits paid by the policy.

- Rebalancing the long-term care system by improving access to home and community based care. As previously discussed, the states of Arkansas, Florida, and New Jersey have implemented a demonstration project know as “Cash and Counseling.” In contrast to a one-size-fits-all approach, Medicaid beneficiaries who are eligible for personal care services are encouraged to exercise greater consumer choice and flexibility.

- Supporting several proposals regarding asset transfer such as changing the rules regarding penalties for individuals who transfer assets, increasing the look-back period for asset transfer from three to five years, limiting the amount and types of funds that can be sheltered in an annuity, trust or promissory note, and allowing some threshold below which asset transfers would be exempted (e.g. $50,000).

At the time that this report was written, it was unclear if Congress would act on its instruction to find $10 billion in entitlement program savings by the end of 2005. In September 2005, Congress allocated over $60 billion in aid to assist in the Hurricane Katrina relief efforts.

AMA POLICY

The AMA has established several policies that address the future need for long-term care services. Policy H-165.985[9] promotes the development of improved methods of financing long-term care expenses through a combination of private and public resources, including encouragement of privately pre-funded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family care giving.

Policy D-280.990 encourages the American public to become better informed about the possible future need of long-term care services, including the importance of early preparation through saving, investing, and the option to purchase long-term care insurance; supports legislative proposals that provide targeted tax incentives that encourage individuals and families to save, invest and insure for their future long-term care needs; encourages the insurance industry to continue to develop innovative programs and insurance products to cover the provision of long-term care services; and encourages the American public to consider using health savings accounts as a supplemental savings mechanism to cover the future provision of long-term care services.

Policy H-280-991[9] advocates that programs to finance long-term care should create tax incentives to allow individuals to deduct the cost of long-term care coverage from income tax…and [10] authorize a tax deduction or credit to encourage family care giving. Policy H-165.871 advocates that any tax treatment applied to health insurance for the purpose of encouraging individual ownership also apply to long-term care insurance.

DISCUSSION

Medicaid has become the largest payer of long-term care services in the United States, accounting for more than 42% of such care (Kaiser Commission on Medicaid and the Uninsured, 2004). Over the past several years, virtually all state Medicaid programs have faced considerable financial challenges due to a decline in state revenues and the continued growth in the number of older Americans, which is expected to reach 70 million by 2030. The Council on Medical Service is encouraged, however, that more states have become engaged in addressing the growth in long-term care. According to the National Academy for State Health Policy, in FY 2005, 17 states were focusing on long-term care Medicaid costs, a significant increase from only 10 states in 2003 (Council on Health Care Economics and Policy, April 2005).

As Americans age, early awareness of the possible need for long-term care and its potential costs is critical to helping individuals adequately prepare for future long-term care needs. As a result, the Council believes that the AMA should continue to encourage Americans to become better informed about their potential need for long-term care and its associated costs. As discussed within this report, LTCI protects retirement savings, reduces financial hardships for family and friends, and promotes financial independence.

However, the cost of LTCI is prohibitive for many elderly and disabled. Consistent with AMA Policy H-280.991[9], the Council continues to believe that the AMA should support legislative proposals that provide tax incentives to purchase LTCI. The Council believes, however, that policy should be broadened to include tax credits as well as deductions, thereby allowing for a full range of tax incentives.

The Council also is aware that for the "medically needy," tax credits may not be enough to motivate purchase of LTCI. Therefore, the Council believes that the most politically viable solution for achieving some level of progress may be to encourage further public/private partnerships that would offer alternative LTCI products.

At the same time, the Council believes that states should be encouraged to continue to support the provision of medically appropriate treatment through programs, similar to the Cash and Counseling program. The Council believes that such programs allow those who are receiving Medicaid services the opportunity to individualize the services which, in turn, may have the potential to improve the quality of patient care.

Finally, it has been estimated that caregivers typically spend $12,500 annually on expenses related to their long-term caregiving responsibilities. The majority of these expenses are usually uncompensated. The provision of a tax credit for caregivers would be one way to shift some of the financial burden from the Medicaid program and encourage those who are providing unpaid care to continue to provide care in the home. The Council believes that the AMA should support the provision of tax credits to eligible caregivers for providing care to family members with long-term care needs. In supporting this recommendation, however, the Council is cognizant of the need for some level of documentation to show that a physician or other health care provider has significant input in the development of plan for providing such care.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That the American Medical Association reaffirm Policy D.280.990[1], which encourages the American public to become better informed about the possible future need for long-term care services, including the importance of early preparation through saving, investing, and the option to purchase long-term care insurance. (Reaffirm HOD Policy)

2. That the AMA modify Policy H-280.991[9] by addition and deletion to read as follows:

   The AMA believes that programs to finance long-term care should…(9) create tax incentives to allow individuals to ~~deduct~~ prospectively finance the cost of LTC coverage ~~from income tax~~, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses. (Modify HOD Policy)

3. That the AMA support legislation that encourages partnerships between public and private entities for the purpose of providing long-term care insurance products. (Directive to Take Action)

4. That the AMA encourage states to support consumer-directed care programs within Medicaid, such as the Cash and Counseling demonstration project. (Directive to Take Action)

5. That the AMA support legislation that provides tax subsidies to family caregivers of long-term care. (Directive to Take Action)

6. That our AMA support federal demonstration projects that would allow nursing home residents to be moved to home- and community-based care programs with approval of the patient or patient surrogate, attending physician and under protocols approved by the facility medical director.

References for the report are available from the AMA Division of Socioeconomic Policy Development.

Fiscal Note: Support legislation that facilitates the provision of long-term care at an estimated total cost of $1,859.