

# REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1 - I-08

Subject: Medicaid Long-Term Care Financing

Presented by: David O. Barbe, MD, Chair

---

1 Medicaid long-term care financing is unsustainable and faces significant challenges. As the  
2 primary payer of long-term care services for those with low incomes and the “medically needy,”  
3 Medicaid accounts for 42% of all long-term care expenditures, and almost half of all nursing home  
4 care expenditures nationally. Jointly financed by the federal and state governments, the acute care  
5 portion of Medicaid is the fastest growing component of state budgets and long-term care costs  
6 continue to rise.

7  
8 The US Census Bureau projects that the population age 85 and over could grow from 5.3 million or  
9 1.8% of the US population in 2006, to nearly 21 million or 5% of the US population by 2050.  
10 Virtually all European countries have had far higher proportions than the US of people age 80 and  
11 older. Since the mid-1990s, several developed nations embarked on major reforms of their long-  
12 term care programs. The potential lessons from countries such as Germany, Japan, France and the  
13 United Kingdom illustrate opportunities and challenges with comprehensive reform.

14  
15 In the Council on Medical Service’s continuing assessment of long-term care and health care  
16 financing, this informational report to the House of Delegates provides background on Medicaid  
17 long-term care financing, explores comprehensive long-term care financing reforms in other  
18 countries, and reviews AMA policy related to long-term care.

## 19 20 BACKGROUND

21  
22 Long-term care includes the diverse spectrum of assistance, whether medical, personal or both, that  
23 people require when they are unable to manage common activities of daily living (ADLs) due to  
24 frailty, chronic illness, or mental incapacity. The sources of payment for long-term care come from  
25 public and private funds, with almost half of payments for people receiving nursing home care  
26 coming from public funds. Although individuals of all ages can require long-term care, half of  
27 those who use Medicaid long-term care services are aged 65 and older. Medicaid is a means-tested  
28 entitlement program that covers long-term care services for eligible individuals in both institutional  
29 settings (e.g., nursing homes and intermediate care facilities), and homes and other community-  
30 based settings (e.g., adult day care facilities). Although seniors and the disabled comprise about  
31 one quarter of the Medicaid population, they account for about 70% of Medicaid spending.

32  
33 Eligibility and services covered for long-term care vary between states. Only nursing home care  
34 and home health care for people who would otherwise qualify for institutional care are mandatory  
35 benefits under Medicaid. Most often, eligibility is based on income and personal resources. In  
36 general, beneficiaries are required to deplete their savings (i.e., spend down) to a certain income  
37 and asset level before Medicaid will pay for services. If the individual is married, the spouse is  
38 expected to contribute toward nursing home care if monthly income is above a certain level.

1 Americans are living longer than ever before, and older adults accumulate disease and disabilities  
2 as they age. With the aging of the baby boom generation, increasing life expectancy, and the rising  
3 costs of nursing home and home health care, there will likely be an increase in demand for long-  
4 term care that threatens to overwhelm Medicare and Medicaid, and may leave millions of  
5 Americans unprepared for both the heavy financial and non-financial burdens of providing long-  
6 term care for themselves or family members.

7  
8 **KEY ELEMENTS OF LONG-TERM CARE IN SELECTED COUNTRIES**

9  
10 In previous reports, the Council focused on long-term care in the US, whereas this report examines  
11 long-term care systems of Germany, Japan, France, and the United Kingdom. The appendix to this  
12 report contains a comparison of long-term care systems of selected countries in terms of key  
13 financing and delivery features. Many European governments provide access to basic long-term  
14 care services in both institutional and home settings regardless of income as a part of their  
15 universal health care systems, whereas Medicaid only covers people with income and assets below  
16 a certain level. Compared with European countries, the US relies more on private long-term care  
17 insurance. Yet, according to the Congressional Budget Office, private long-term care insurance in  
18 the US only covered three-to-four percent of total long-term care costs in 2004.

19  
20 Germany

21  
22 Approximately one-fifth of the German population is age 65 or older. In 1994, Germany enacted a  
23 universal coverage social insurance program for long-term care that replaced its means-tested  
24 system. The social insurance portion is funded through a payroll tax of 1.7%, divided equally  
25 between employers and employees. Higher income individuals can choose to purchase private  
26 insurance rather than participate in the public program. However, all workers must have some  
27 long-term care coverage.

28  
29 The German universal health insurance program provides long-term care benefits based on need for  
30 assistance with essential ADLs, which contrasts with the US system of Medicaid, which provides  
31 assistance for individuals based on income. Germany publicly funds basic benefits and spending to  
32 a certain capped amount. Beyond this budgetary limit, private long-term care insurance covers  
33 costs such as nursing home room and board.

34  
35 An October 2007 study by the American Association of Retired Persons (AARP) Public Policy  
36 Institute notes that the German social insurance approach has provided universal access to services  
37 based on disability rather than income, promoted consumer choice, increased support of informal  
38 caregivers, relieved fiscal pressures on states by shifting the financial burden of long-term care to  
39 the national government without increasing spending, and developed more uniform standards of  
40 quality. Despite the success of the German program, long-term costs are expected to increase, and  
41 the country is engaged in an intense debate about future long-term care reforms.

42  
43 Japan

44  
45 Similar to Germany, approximately one-fifth of Japan's population is aged 65 years or older. In  
46 2000, Japan implemented its own publicly-mandated long-term care insurance program, modeled  
47 after the German program. However, while the German program covers the entire population, the  
48 Japanese plan is age-based, with benefits primarily limited to those over 65 years of age. The  
49 Japanese program covers home-based and institutional care.

1 Japan finances its program with a combination of user co-payment, premium contribution by  
2 enrollees and their employers, and governmental funds. Similar to the state and federal  
3 administration of Medicaid in the US, Japanese insurance is provided by each of its 3,200  
4 municipalities with eligibility and premiums varying by jurisdiction, while prices and co-payments  
5 are fixed by the central government. The Japanese system faces financial strains as a result of a  
6 significant increase in demand for home-based and nursing home care.

7  
8 France

9  
10 In 2002, France adopted a new system called the Personalized Independence Allowance that makes  
11 cash benefits available for consumer-directed home care. The program is financed with general tax  
12 revenues. Institutional care is provided through its health insurance program.

13  
14 The Allowance program for home care covers those aged 60 and older who are below a certain  
15 income level. Higher incomes are eligible for fewer benefits, regardless of medical need.  
16 Minimum eligibility criteria are restricted to those who need assistance with three or more ADLs.  
17 Under French civil law, adult children are obligated to care for their parents, and children must  
18 report their own income when their parents apply for social assistance. Tax deductions are  
19 provided for family caregivers. Participation and costs related to the program have been much  
20 higher than anticipated.

21  
22 United Kingdom (UK)

23  
24 The National Health Service universally covers the medical portion of community and nursing  
25 home care with no beneficiary cost-sharing. Non-medical long-term care or “social care” is  
26 provided by localities on a means-tested basis, with substantial variation among localities. In  
27 Scotland social care is provided with no beneficiary cost sharing to those who are assessed as  
28 having limited ADLs. Funding is primarily from general taxation, shared by local and central  
29 governments.

30  
31 Similar to the US, the UK has recently questioned the sustainability of its system. In April 2006,  
32 the Joseph Rowntree Foundation, a social policy research foundation based in the UK, issued a  
33 report critical of the UK program. The foundation advocated reforms based on principles of  
34 fairness in access and financing, support of early intervention and preventive measures, individual  
35 choice, personal responsibility, sustainability, and adequate supply of care givers.

36  
37 **EXPANDING MEDICARE TO PROVIDE LONG-TERM CARE SERVICES**

38  
39 In a June 2007 Urban Institute report, “A Proposal to Finance Long-Term Care Services through  
40 Medicare with an Income Tax Surcharge,” Leonard E. Burman, PhD and Richard W. Johnson, PhD  
41 proposed “Medicare Part E,” which would provide comprehensive long-term care and custodial  
42 nursing home care. Beneficiaries would share in the cost of services through deductibles and co-  
43 payments, but the program would include special protections for low-income adults. The program  
44 would be financed with a simple flat-rate surcharge on federal income taxes.

45  
46 The primary advantage of Medicare Part E would be that it would cover comprehensive long-term  
47 care services for all Americans with disabilities who qualify for Medicare. Burman and Johnson  
48 point out that a surcharge would distribute the burden of financing widely across the American

1 population. Such a proposal would significantly minimize the market demand for private long-  
2 term care insurance.

3  
4 PRIVATE SECTOR LONG-TERM CARE OPTIONS

5  
6 AMA policy supports measures to increase the purchase of private long-term care insurance  
7 (D-280.990, H-290.974[2], and H-165.852[7], AMA Policy Database). At its January 2008  
8 Meeting, the Council on Medical Service met with two long-term care industry experts, Stephen  
9 Moses and Paul Willging, PhD, both of whom advocated an aggressive restructuring of Medicaid  
10 so that individuals view long-term care as a personal responsibility. Moses supported incentives  
11 and policies that would encourage, and even require, the purchase of long-term care insurance  
12 (LTCI) by those who can afford it. Moses and Willging also advocated a complementary means-  
13 tested voucher or tax credit system to transfer Medicare, Medicaid, and Social Security funds  
14 currently used to finance long-term care to elderly individuals. As a way to help patients in their  
15 long-term care choices, Willging proposed the development of a clinical tool that would assess the  
16 needs of the patient and create a cost-effective individual plan for using long-term care services.

17  
18 The Georgetown University Long-Term Care Financing Project analyzes prominent policy  
19 approaches for long-term care. In the project's June 2007 report "Long-Term Care Financing:  
20 Policy Options for the Future," Judith Feder, PhD, et al., highlight ways to make private long-term  
21 care insurance more affordable including:

- 22
- 23 • Linking an optional long-term care benefit in Medicare to the purchase of private LTCI;
  - 24 • Creating federal catastrophic insurance for LTCI;
  - 25 • Using a small portion of Social Security benefits to finance a basic public long-term care trust-  
26 fund; and
  - 27 • Encouraging voluntary and federally administered deductions for a cash benefit to purchase  
28 LTCI.
- 29

30 Advantages of such policy proposals include enhancing the attractiveness of private LTCI coverage  
31 for individuals with lower risk and low- to middle incomes. However, none of these options  
32 eliminate the need for Medicaid coverage for those who are poor and those with extensive long-  
33 term care needs.

34  
35 A June 2007 article, "Forced Savings as an Option to Improve Financing of Long-Term Care,"  
36 written by James Knickman, also with the Georgetown University Long-Term Care Financing  
37 Project, describes an approach of mandatory savings for LTCI. Knickman's proposal would  
38 require contributions of 1.5% of total employee wages that would be collected through the social  
39 security tax collection mechanism. The money raised through the tax would be credited to a  
40 savings account in the employee's name and an annual statement of revenues and earned interest  
41 would be provided to the individual.

42  
43 Knickman also advocates the establishment of a standard for "required long-term care resources."  
44 When an individual's savings account reaches the resource standard, no further payroll taxes would  
45 be assessed to the individual. In the likelihood that proposed 1.5% savings does not result in  
46 sufficient resources, Knickman suggests that Medicaid dollars be used to supplement the savings.  
47 The advantages of a forced savings program include a broad requirement for individual  
48 responsibility for long-term care, limited intergenerational transfers, and personal choice in the use

1 of accrued savings. One disadvantage of the savings program is an implicit reliance on Medicaid  
2 funds to subsidize low-income individuals.

3  
4 PUBLIC/PRIVATE PARTNERSHIP FOR LONG-TERM CARE

5  
6 One mechanism for encouraging individuals to invest in long-term care insurance is the Partnership  
7 for Long-Term Care, which was described previously in Council on Medical Service Report 6-I-05.  
8 Through the Partnership program, states promote the purchase of private long-term care insurance  
9 by offering Medicaid as “wrap around” coverage along with the private plan. This incentive  
10 structure may help delay or possibly avoid the need for Medicaid to pay for long-term care by  
11 encouraging individuals to take responsibility for the initial phase of their long-term care through  
12 private insurance.

13  
14 The original demonstration model of the Partnership program has been underway since 1992 in  
15 California, Connecticut, Indiana and New York. The Deficit Reduction Act of 2005 included a  
16 number of reforms related to long-term care, including allowing all states to apply for Long-Term  
17 Care Partnership programs. Advantages of the Partnership program include the promotion of  
18 policies that are more affordable, and the ability to attract individuals with moderate incomes. As  
19 with other options for expanding private long-term care insurance, a disadvantage includes the  
20 implicit reliance on Medicaid to provide coverage for low-income individuals.

21  
22 AMA POLICY AND REPORTS

23  
24 As noted previously, AMA policy supports measures to increase the purchase of private long-term  
25 care insurance (H-290.974[2], D-280.990, and H-165.852[7]). AMA Policy H-290.974[2]  
26 advocates that any tax treatment applied to health insurance for individual ownership should also  
27 be applied to LTCI to encourage prospective financing of LTC. In addition, individuals who can  
28 afford private insurance premiums to cover their long-term care costs should be incentivized to  
29 prospectively finance their LTCI. Policy D-280.990 encourages the American public to become  
30 better informed about the possible future need of long-term care services, including the importance  
31 of early preparation through saving, investing, and the option to purchase long-term care insurance;  
32 supports legislative proposals that provide targeted tax incentives that encourage individuals and  
33 families to save, invest and insure for their future long-term care needs; encourages the insurance  
34 industry to continue to develop innovative programs and insurance products to cover the provision  
35 of long-term care services; and encourages the American public to consider using health savings  
36 accounts as a supplemental savings mechanism to cover the future provision of long-term care  
37 services. To achieve universal access and coverage and freedom of choice in health insurance,  
38 Policy H-165.852[7] supports legislation promoting the establishment and use of HSAs and  
39 allowing the tax-free use of such accounts for health care expenses, including health and long-term  
40 care insurance premiums and other costs of long-term care. In addition, AMA Policy D-280.990[3]  
41 supports legislation that encourages partnerships between public and private entities for the  
42 purpose of providing LTCI products.

43  
44 In previous reports, the AMA has identified a series of short-term and longer-term options for  
45 providing and financing long-term care that may lessen the impact of current demographic and  
46 financial trends. As previously discussed in Council on Medical Service Report 5-I-04, “Private  
47 Sector Options for Financing Long-Term Care,” LTCI, health savings accounts, reverse mortgages,  
48 and continuing care retirement communities continue to receive attention as potential options for  
49 privately funding long-term care. Council on Medical Service Report 6-I-05, “Policy Options for

1 Addressing Medicaid Long-Term Care,” provided key strategies for improving the delivery and  
2 financing of Medicaid long-term care including offering tax subsidies for the purchase of LTCI,  
3 more stringent “spend-down” eligibility for homeowners, providing tax subsidies for caregivers,  
4 and increasing consumer-directed care programs. Council on Medical Service Report 1-I-02  
5 addressed Medicaid spend-down eligibility criteria, and concluded that the spend-down  
6 appropriately responds to the needs of those determined to be permanently disabled, the vast  
7 majority of whom remain permanently disabled.

8  
9 CONCLUSION

10  
11 In its study of long term care in other countries, the Council found that Germany and Japan have  
12 been relatively successful in reforming their financing related to long-term care, but both have  
13 significant concerns about rising costs. In light of demographic and workforce pressures, as well as  
14 sharing concern about costs, the Council believes that prospectively financing long-term care is  
15 imperative. The Council has discussed several promising policy options that merit further  
16 demonstration and review. For example, the Georgetown University Long-Term Care Financing  
17 Project promises solutions that could be tested in both the public and private sectors. In addition,  
18 the ongoing Partnership for Long-Term Care has the potential to delay or possibly avoid the need  
19 for Medicaid to pay for long-term care by encouraging individuals to take responsibility for the  
20 initial phase of their long-term care through private insurance. Such partnerships and prospective  
21 financing of long-term care are consistent with AMA policy.

22  
23 Recent trends in the provision of long-term care in the US include less institutionalized care, more  
24 reliance on home-care and community based alternatives, greater reliance on technologies that  
25 assist with ADLs, and a greater emphasis on prevention and strategic planning. The Council  
26 recognizes that addressing Medicaid financing of long-term care requires facing several complex  
27 policy challenges that are not related to financing, particularly the provision of infrastructure for  
28 institutional and community based care (e.g., nursing homes, extended care facilities, and assisted  
29 living facilities). The Council believes that any comprehensive reform of long-term care financing  
30 should be made in the context of broader health system reform.

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

APPENDIX

**International Long-Term Care System Features by Country**

	<b>Key Features</b>	<b>Funding Sources</b>	<b>Socioeconomic Issues/Challenges</b>
<b>United States</b>	Means-tested, social services/institutional care, limited cash pilot programs.	Public – General revenue funds for Medicaid (49%), Medicare (19%) private (7%), individual out-of-pocket (19%), other public and private funds combined (6%).	Growth in long-term care costs are driving substantial increases in government health expenditures. Patchwork system makes it difficult to control costs and coordinate care.
<b>Germany</b>	Social service insurance provides cash, services, or both. No means testing.	Payroll tax of 1.7% divided equally between employees and employers.	Maintaining current standards of care will require significant payroll tax increases in the coming years.
<b>Japan</b>	Social service insurance provides services. No means testing.	Pay-as-you go funded with premium contributions for those 65+, payroll tax of 0.9% divided equally between employers and employees. General tax revenues divided among central government and municipalities.	System faces financial strain in light of increasing demand for skilled nursing facilities and paid long-term care services.
<b>France</b>	Hybrid of income-related coinsurance for LTC services and universal health care for the provision of institutional care. Benefits tied to income. Income of adult children is considered in assessing benefit eligibility.	General revenues and co-payments.	Personalized “Independence Allowance” faces higher than anticipated participation and program costs. Government has imposed longer eligibility waiting period, restrictions on how the benefit may be spent, and a reduction in the income ceiling.
<b>United Kingdom</b>	The National Health Service covers nursing home care. Non-medical social care is means-tested.	Local taxes, federal grants, co-payments.	Rising demand for skilled care and heavy reliance on immigration has resulted in work force shortages.