Long-Term Care in Hawaii: Issues and Options

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RTI International
Washington, DC
RTI International Project for LTCC: First Year

- Review of available published information
- Survey of adult population on long-term care issues
- Conduct stakeholder interviews: Government officials, providers, consumers, researchers
- Develop options for Commission decisionmaking
Introduction

• Long-term care major component of health spending
• Major component of state health and Medicaid spending
• Heavily publicly financed through Medicaid and Medicare
• Aging of the population = higher expenditures
• How should long-term care be organized?
• How should long-term care be financed?
Goals of Long-Term Care Reform

- Treat long-term care as a normal life risk rather than unexpected event
- Protect against catastrophic out-of-pocket costs
- Prevent dependence on welfare
- Increase consumer choice by providing more options for home and community-based services while providing needed institutional care
- Finance care in a way that is affordable for individuals and government
Nursing Home Residents per 1000 People Aged 75 and Older

Year


Nursing Home Residents per 1000 75+

United States Hawaii
Average Nursing Home ADL Index

ADL Group Index Score

2008

- United States
- Hawaii
Percent of Nursing Home Residents who are Medicare Beneficiaries, 2008

- Hawaii
- United States
Assisted Living & Residential Care Beds per 1000 Persons 75+

Population data is for 2008

Hawaii

United States
Delivery System Reform

- States implementing LTC reform have focused on delivery rather than financing
- Three main critiques:
  - Not enough home and community-based services; too much emphasis on institutional care
  - Fragmented delivery system makes entry, coordination, and transition difficult
  - Consumers do not have enough control over the services they use
Medicaid and State HCBS Expenditures per 1000 People 75+, 2007
Medicaid HCBS Expenditures per 1,000 People Aged 75 or Older

Medicaid HCBS Expenditures per 1,000 People Aged 75+

United-States
Hawaii
Percentage of Medicaid LTC Expenditures for HCBS 2008

- Percentage
- Hawaii
- United States
Fragmented Delivery System

- Single point of entry programs, such as Aging and Disability Resource Centers
- Money Follows the Persons: Transition people in institutions back to the community
- Integration of long-term care: Wisconsin’s Family Care
- Integration of acute and long-term care: Arizona Long-Term Care System, Minnesota Social Health Options, Texas Care+Plus
Average Medicare Spending per Enrollee Age 65 and Older, by Functional Limitations, 2005

Note: ADLs = activities of daily living. Amounts shown are spending for Medicare Parts A and B only, for enrollees in fee-for-service Medicare who are not residing in nursing homes or other institutions.

SOURCE: Komisar, Tumlinson, Feder & Burke. Long-Term Care in Health Care Reform: Policy Options to Improve Both. The SCAN Foundation. 2009.
Consumer-Directed Home Care

- Most home care provided by agencies, which hire, train, schedule, monitor, and fire employees
- Consumer-directed home care give those responsibilities to consumers or their agents
- Promoted by Centers for Medicare & Medicaid Services, a growing number of states are using this approach
- Studies find quality the same or better as agency-directed services
FINANCING
Long-Term Care is Expensive

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Hawaii</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year in nursing home care (private room)</td>
<td>$131,400</td>
<td>$79,935</td>
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<tr>
<td>Year in assisted living facility</td>
<td>$54,900</td>
<td>$37,572</td>
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<tr>
<td>Home health aide (per hour)</td>
<td>$23</td>
<td>$21</td>
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## Nursing Facility Resident Payer Sources, 2009

<table>
<thead>
<tr>
<th>Source of Payment</th>
<th>Hawaii</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>11</td>
<td>14</td>
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<tr>
<td>Medicaid</td>
<td>70</td>
<td>64</td>
</tr>
<tr>
<td>Other Payer</td>
<td>19</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
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</table>
Public and Private Expenditures on LTC for Older People as Percentage of GDP, 2000

Source: OECD, 2005.
Projected Public Long-Term Care Expenditures (All Ages) in Selected Countries, as a Percentage of GDP, 2005 and 2050

Source: OECD, 2006.
Means Testing vs. Universal Financing

- Unlike health care, many countries means test (e.g., United Kingdom, New Zealand)
- Countries with universal coverage (Austria, Germany, Japan, Netherlands, Sweden, Luxembourg)
- Private insurance not a major source of financing
- Public and private insurance sometimes blurred (e.g., Germany)
Private Sector Initiatives: Private Long-Term Care Insurance

PROS

• Consistent with current health insurance system for most people (but not older people)
• Reflects general principle of personal responsibility
• Allows for competition

CONS

• Market has not taken off and proposals to jump start market unlikely to work on broad basis
• Products are too expensive for most people
• People who have medical problems cannot enroll
Private Long-Term Care Insurance

• “The Dream”

• Affordability:
  – Good quality policy: $2,300 at age 60
  – 10-20 percent can afford

• Thinks Medicare covers it

• Denial of risk

• Medical underwriting
Options to Encourage Private Long-Term Care Insurance

- Tax incentives
- Partnership for LTC
- Employer-sponsored LTC insurance
Tax Incentives for Private Long-Term Care Insurance

- Income tax deductions or credits
- HIPAA and 36 states and DC offer tax incentives
- Incentives are small, not substantially reducing price
- Sentinel effect?
- Only about 40% of federal taxpayers itemize and many older people pay no federal taxes
- Recent study by Stevenson find little effect
- Efficiency vs. equity
Public-Private Partnerships

- Allows higher level of protected assets under Medicaid to people who buy state-approved policy
- Lowering amount of insurance needed
- Connecticut, Indiana, California, and New York
- Market penetration very low—less than 3 percent of older people
- Premiums still high
- Asset protection not draw people
- Not want to be on Medicaid
- Deficit Reduction Act of 2005: 30 States
Promoting Employer-Sponsored LTC Insurance

- Lower premiums due to younger ages and economies of scale—Federal plan: $950 for a 40 year old
- Idea to have federal and state employees to prime the pump—not worked
- Very small market, but growing, approximately 1,000,000 policies in place
- Federal tax incentives comparable to health insurance
- Employee pay all
- Low market demand—6-7% take-up
Public Sector Options: Expand State Programs for Home Care

- Most states have small state-funded programs for long-term care
- Often associated with U.S. Administration on Aging-funded programs
- Easy to control expenditures through appropriation process, rather than open-ended entitlement
- Requires additional state funds
Public Sector Options: Expand Medicaid

- Expand Medicaid by covering more middle-class people or by expanding coverage of home and community-based services or institutional care
- Technically easy, incremental approach
- Requires additional public spending
- Unless economy improves greatly, financed either by higher taxes or cutting other programs
- Continues reliance on welfare program
Public Insurance for LTC

PROS

- Medicare already provides funding for limited nursing home and home health care
- Creates a level playing field with medical care
- If mandatory, only approach that will achieve universal coverage
- If mandatory, spreads the risk broadly over entire society
- Insurance premiums provide new benefits, which may be more attractive than tax increases
- Reduces two-tiered system between private pay and Medicaid
CONS

• Some oppose increase in role of government and expenditures
• Some oppose mandatory participation
• Voluntary program subject to adverse selection
• More than very modest benefits require premium subsidies to moderate and low-income people
• Provides coverage to some people who can afford to pay for their own care
Community Living Assistance Services and Supports (CLASS) Act

- Voluntary government long-term care insurance program, originally developed by Senator Kennedy
- Part of health reform bills passed by Senate and House and endorsed by President Obama
- No medical underwriting
- Cash benefit of an average of $50 per day
- Lifetime benefit
CLASS Act (cont.)

- Self-financed by insured, estimated premium over $100 per month
- No premium subsidy for middle or low-income people
- “Saves” $72 - $102 billion over 10 years
CLASS Act (cont.)

• Major issue of adverse selection
  – Automatic enrollment unless opt out
  – 5 year vesting before eligible for benefits
  – Initial enrollment limited to the working population
    • Minimalist definition of “working”
    • Excludes retired elderly who do not work
    • Excludes current population with disabilities who do not work
Conclusions

• Hawaii has fewer services and spends less on long-term care than country as whole
• Long-term care expenditures sure to grow, but are relatively small percentage of total health spending
• Long-term care financing is primarily public or quasi-public sector in almost all developed countries
• Unsubsidized private LTC insurance unlikely to play a major financing role
Conclusions (cont.)

• How should the long-term care system be structured?
• How should we finance the large increase in spending that is coming?
• Who is responsible for long-term care?
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