

Financing Reform for Long-term Services and Supports

Hallie Zwibel, DO

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Address correspondence to Hallie Zwibel, DO, New York Institute of Technology College of Osteopathic Medicine, Department of Family Medicine, Northern Blvd, PO Box 8000, Old Westbury, NY 11568-8000.

E-mail: hzwibel@nyit.edu

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Long-term services and supports (LTSS) are a system of accommodations for persons who cannot perform activities of daily living (ADLs) or instrumental ADLs for more than 3 months.¹ Activities of daily living are activities that are essential for fundamental functioning, such as grooming, dressing, and cleaning oneself. Instrumental ADLs are activities that allow one to live independently in a community, such as cooking, cleaning, and managing money and medication.^{1,2} Therefore, these persons require assistance in the form of supportive care and supervision, adaptive technology, and housing. As of 2013, it is estimated that over 12 million people in the United States rely on LTSS.¹ In persons older than 65 years, approximately two-thirds will use these services during their lifetimes.³ In this demographic group, it is predicted that by 2050, the population of people aged 65 and 85 years will double and triple, respectively, from 2012.³

The most pressing problem elderly persons and their families face is the financing of LTSS. Most elderly persons exclusively receive care from some 42 million family members, the majority of whom are women.⁴ The estimated value of the care that family members provide is \$450 million per year in the United States, but family members receive no reimbursement.⁴ Instead, because of the lost productivity from missed and shorter work days, our economy loses \$34 billion annually, and family caregivers earn \$300,000 less in their lifetime.¹ One could instead choose to place his or her loved one in a nursing home, but these costs can range from \$41,000 to \$100,000 annually, depending on the state of residence and the type of room (eg, shared vs private).⁴ Community-based care with home health aides is another, less expensive option. A typical family pays close to \$20 per hour for approximately 30 hours per week, which equates to an estimated

\$30,000 per year.⁴ With the average total assets of a retired family being only \$64,000,⁴ and the anticipated growth in the number of elderly persons needing LTSS, the lack of affordable options for these vital services is a challenge. In this article, I review the current financing model and stakeholders for long-term care and offer guidance for osteopathic physicians toward a potential solution for LTSS.

History and Background

Under the current health care system, people receive coverage for skilled medical care (ie, physicians, nurses) through private insurance or Medicare. Unfortunately, these insurance products do not cover services directed toward ADLs.³ Additionally, the setting for LTSS has shifted, largely to the home and community, as a result of the Olmstead decision, which decreed that everyone is entitled to noninstitutional care if it meets a person's needs.⁵ The Older Americans Act, through the Administration on Aging, aids in this process by funding nutritional services (Meals on Wheels), case management, employment opportunities, and transportation, which enables older adults to remain in the community.^{6,7} However, these initiatives receive less than \$2 billion per year from the federal government and often have waiting lists.^{6,7} Therefore, one must finance and navigate a patchwork of home- and community-based options for LTSS.²

In the United States, \$310 billion goes toward LTSS expenses annually.³ From this total, only 19% is from a family's private savings and earned income.³ Private long-term care insurance is another option that families use to pay for LTSS.³ However, despite being available for more than 3 decades, less than 10 million people in the United States have this coverage, and it accounts for less than 8% of the total funds toward LTSS.³ This

coverage is underused because the annual premiums are expensive and the underwriting is prohibitive.¹ The largest player in the LTSS financing patchwork is Medicaid, which represents 51% of the nation's expenditures.⁴ Medicaid is a means-based system with income and asset requirement thresholds, which must be crossed before one can receive any benefits.⁴ In most states, people can qualify with incomes at or below 300% of the federal poverty level.⁴ Furthermore, they must have less than \$2000 in assets, excluding their home.⁴ This requirement results in a situation called the "spend down," where families deplete their life savings on LTSS expenses to qualify for coverage through Medicaid.¹

Stakeholders

The Federal Government's Commission on Long-Term Care, which convened in 2013, proposed several options for LTSS financing reform.¹ These options included many private sector initiatives as well as transforming the long-term care insurance marketplace, supporting new combination policies such as a "life care annuity," and offering tax-preferred health care accounts to public programs, such as the creation of an LTSS benefit through Medicare.¹ The State of Minnesota also supports exploring innovation in long-term care insurance, such as term life insurance policies converting to LTSS plans at retirement, tax-advantaged accounts, and coverage through Medicare Advantage.⁸ The Bipartisan Policy Center, a nonprofit think-tank, recommends the creation of a long-term insurance plan with a limited benefit that begins after a specified personal expenditure amount or waiting period.⁹

Physician organizations such as the American Osteopathic Association and the American College of Physicians support programs that would make LTSS more efficient to ensure adequate care¹⁰ and subsidies for low-income beneficiaries,¹¹ respectively. Groups representing elderly patients requiring LTSS, such as the American Association of Retired Persons, the SCAN Foundation, and LeadingAge, advocate for the

creation of a mandatory universal insurance product that would cover expenses for catastrophic events.¹²

Recommendation

It is evident that with the growing need for LTSS and high associated costs, action must be initiated to assist elderly persons and their families with this financial burden. The most appropriate solution may be the development of a catastrophic coverage plan under Part A of Medicare. Under such a program, all costs associated with LTSS would be covered after a specified time or expenditure amount (eg, 3 years or \$50,000). With the choice of \$50,000 as a cap for personal liability, less than 20% of participants would ever require the use of this catastrophic coverage plan.¹ The benefit to this program is that it establishes a maximum defined cost to a person of \$50,000. Knowing this fixed cost, the liability long-term insurance that companies are responsible for is limited, which makes policies more accessible and affordable. Additionally, the government can create tax preferential savings vehicles for families to save toward their anticipated LTSS costs. This insurance vehicle can be financed through the savings to Medicaid, by raising premiums for Medicare progressively, or combining both approaches.

To ensure this program's success, policy makers should heed the lessons from the Medical Catastrophic Coverage Act of 1988, which was repealed less than 2 years after its passage.¹³ This program sought to limit expenses for extended hospital stays and provide prescription drug coverage. However, it failed because most Medicare beneficiaries already had superior private supplemental coverage.¹³ The proposal for an LTSS benefit is substantially different from the failed act because few elderly persons have private coverage or adequate savings for their long-term care needs.¹³ Indeed, a program to finance LTSS without a spend down to qualify for Medicaid is not unprecedented. The US Department of Veterans Affairs currently offers funding for LTSS through the Aid and

Attendance and Housebound Improved Pension, in the amount of \$2019 per month, per veteran and spouse.¹⁴ This benefit, which has existed for more than 60 years, is specifically intended to help pay for the costs of LTSS, including family caregivers, home health aides, and nursing homes.¹⁴ Therefore, based on the average cost and use of professional home health aides, families need only spend \$481 per month.

The osteopathic philosophy is distinguished by its comprehensive approach to patient care.¹⁵ Osteopathic physicians are trained to consider the psychosocial and environmental needs of patients to foster better overall health.¹⁵ As an extension, the osteopathic representative body, the American Osteopathic Association, continues to advocate for health care reforms that would benefit patients.¹⁰ A better understanding of the long-term care needs for older adults and the inadequacies of the current LTSS financing model require osteopathic physicians to continue to advocate for reforms such as the additional Medicare benefit detailed above. (doi:10.7556/jaoa.2017.087)

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