

Testimony on
Long-Term Care and Medicaid:
Spiraling Costs and the Need for Reform

by

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Good morning, Mr. Chairman and members of the subcommittee. I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national trade association representing nearly 1,300 private sector companies providing health insurance coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify about long-term care and the Medicaid program. We share your commitment to meeting the long-term care needs of our nation's aging population and, at the same time, ensuring that Medicaid's financial stability is not threatened by the high costs associated with long-term care.

In our view, it is time for a paradigm shift in the health care discussion. Our current health care system focuses primarily on treating episodes of acute illness, rather than managing chronic conditions. This is true despite the fact that 20 percent of all Medicare beneficiaries – chronically ill patients with five or more medical conditions – accounted for more than two-thirds of the Medicare program's costs in 2004. Likewise, long-term chronic care management is a key cost issue for Medicaid. Our tax system has followed a similar pattern by orienting incentives toward the coverage of acute care benefits. To meet these challenges, the nation needs to broaden the health care discussion to focus on the continuum of health care services that people need throughout their lives.

In the next 30 years, more than half the U.S. population will be living with at least one chronic condition. Chronic illnesses such as cancer, diabetes, Alzheimer's disease and hypertension complicate age-related health problems and increase the likelihood of needing long-term care. Currently, nearly half of all nursing home residents have Alzheimer's disease. By 2050, the Alzheimer's Association estimates that 14 million baby boomers, nearly one in five, will find themselves living with the disease. We need to make major adjustments to address 21st-century realities and our aging population. At the same time, we need to explore a range of public-private partnerships that could make long-term care costs more predictable and expand service options for consumers.

This should be a particularly important priority considering that Medicaid currently covers about 45 percent of all long-term care expenditures. Even though fewer than 10 percent of Medicaid beneficiaries use long-term care services, more than one-third of total Medicaid spending is devoted to long-term care.

My testimony today will focus on three areas:

- (1) What our members are doing to contain costs and improve quality in Medicaid by working in partnership with the states;
- (2) An overview of the long-term care insurance market and the role that long-term care insurance can play in relieving financial pressure on Medicaid; and
- (3) Tangible policy changes that could be pursued to assist families interested in saving for long-term care.

The activity in these areas will show that AHIP's members are actively engaged in providing consumers with both private and public options for meeting the challenges raised by long-term care and chronic conditions.

THE SUCCESS OF PRIVATE SECTOR STRATEGIES IN MEDICAID

Health insurance plans have made an important contribution toward making it possible for Medicaid programs to use their limited resources to expand access, improve quality, provide transportation services, and take other steps to better serve beneficiaries.

In a number of states, our members are participating in initiatives to improve the quality of long-term care while stretching Medicaid dollars. Most of these programs – including initiatives in Texas, Arizona, Massachusetts, Wisconsin, New York, Florida and Minnesota – seek to decrease the need for nursing home care, reduce hospitalizations, and increase the number of elderly and disabled who can be better served in home and community settings. For beneficiaries, this

means improved health outcomes and the opportunity to receive care in a familiar setting of their own choice.

These programs not only save money and improve the quality of care, but also deliver extremely high patient satisfaction. In Texas, the STAR+PLUS program saved the state \$17 million dollars in the first two years in just one county, and reduced emergency room use by 40 percent and inpatient admissions by 28 percent. In Minnesota Senior Health Options – which combines health care and support services into a seamless package – Medicaid enrollees report a 94 percent satisfaction rate with their care coordinators.

Further successes are documented in an July 2004 report¹, conducted by the Lewin Group, which provides a synthesis of 14 separate research studies that demonstrate the cost savings to states and the high quality health care offered by Medicaid managed care programs. These savings have been particularly important as states confront Medicaid funding shortfalls that have challenged their ability to deliver services without cutting benefits or eligibility.

The studies examined by this report attribute significant cost savings to Medicaid managed care. One study, for example, found that Michigan's Medicaid managed care program yielded cost savings of 14 percent in FY 2002, 16 percent in FY 2003, and 19 percent in FY 2004. Another study, focusing on Wisconsin, measured savings of 7.9 percent in 2001 and 10.2 percent in 2002.

A number of other studies focus more narrowly on specific services or population subgroups. One study found that Arizona's managed care program, which fully capitates prescription drug costs, delivered pharmaceuticals to the aged, blind and disabled at a per-member, per-month cost of \$112.21 in 2002, the lowest figure in the nation and 38 percent below the national average. Another study found that cost savings of approximately 10 percent were achieved by moving adult women in Hennepin County, Minnesota from fee-for-service coverage to Medicaid managed care coverage.

¹ The Lewin Group, *Medicaid Managed Care Cost Savings – A Synthesis of Fourteen Studies*, July 2004

The report notes that these cost savings are largely attributable to decreases in utilization of inpatient hospital services. For example, preventable hospitalizations in California were found to be 38 percent lower in managed care than in fee-for-service for mothers and children enrolled in Medicaid – and 25 percent lower in managed care than in fee-for-service for Supplemental Security Income (SSI) recipients.

The report further states that in addition to achieving cost savings on behalf of beneficiaries, Medicaid managed care programs have improved access to care for Medicaid beneficiaries in most cases. It also indicates that both state programs and individual managed care organizations have earned high satisfaction ratings from enrollees.

Another report², released by AHIP in March 2005, outlines numerous examples of how health insurance plans serving Medicaid beneficiaries have implemented programs that are improving the health care of beneficiaries and providing value to state governments through innovative and cost-effective programs. The progress achieved by these pioneering programs is evidenced by this sample of the report's findings:

- **Access to Care:** Medicaid beneficiaries served by health plans in New York City report that they have better access to care than patients in the fee-for-service program, and are more likely to have a regular source of care and to seek care at a doctor's office rather than in emergency rooms. As a result, these beneficiaries are more likely to receive the appropriate primary care and preventive services than their counterparts in the fee-for-service program.
- **Prenatal Care:** Infant mortality rates in Rhode Island have dropped dramatically – from 4.5 deaths per 1,000 births to 1.9 per 1,000 – since health insurance plans began providing care for pregnant women enrolled in the state Medicaid program.
- **Asthma:** Children with asthma enrolled in Medicaid health insurance plans in Wisconsin are significantly less likely to require hospitalization than asthmatic children in the state's fee-

² AHIP, *Innovations in Medicaid Managed Care, March 2005*

for-service programs. The lower hospitalization rate for these children means that they are enjoying better health and are likely to have fewer absences from school.

- **Diabetes:** Among Medicaid participants with diabetes in North Carolina, those served by health insurance plans are three times more likely to properly monitor and control their blood glucose levels. This translates into better health status for diabetes patients – with fewer complications that otherwise would increase the threat of blindness, amputations, and other health problems.

Our members have designed programs that work for Medicaid beneficiaries and also for the states. The successful programs implemented by health insurance plans demonstrate quality improvement and cost containment through innovative outreach programs that meet budgetary needs and provide access to more coordinated and effective health care.

THE ROLE OF PRIVATE LONG-TERM CARE INSURANCE

The number of individuals purchasing long-term care insurance has grown dramatically in recent years. Since 1996, the number of policies purchased has more than doubled, increasing from 4.9 million to about 10 million policies sold.

Policies contain a wide range of benefit options at moderately priced premiums. For example:

- Long-term care insurance plans offer coverage of nursing home, assisted living facility, home health care, hospice care, respite care, and certain alternate care services not listed in the policy.
- Other common benefits include: care coordination or case management services, support with activities of daily living, medical equipment coverage, home-delivered meals, spousal discounts, survivorship benefits, and caregiver training.

- Plans contain provisions that guarantee their renewability, have a 30-day “free look” period, cover Alzheimer’s disease, provide for a waiver of premiums once a claim is processed, and give policyholders the option of covering nursing home stays without limits or caps.
- Age limits for purchasing coverage also are expanding. Our members now offer individual policies to people as young as 18 and as old as 99. In addition, recognizing that consumers want to plan ahead for their long-term care needs, plans offer inflation protection for the dollar value of a purchased benefit at an annual 5 percent compounded rate, funded with a level premium that stays the same from one year to the next. Companies also offer plans that have a non-forfeiture benefit that allows beneficiaries to retain some benefits if they lapse their policy.

The growth in employer-sponsored plans is especially encouraging, since individuals with employer coverage will not be forced primarily to depend on their states for assistance in meeting their long-term care expenses. The average age of the employee electing this coverage is 45 – compared to an average age of 60 for persons who buy long-term care insurance outside of the employer-sponsored market. To date, close to 2 million policies had been sold through more than 5,600 employers, and accounted for one-third of the sales in 2002.

Premiums for long-term care insurance policies depend on multiple factors, including the entry-age of the policyholder and comprehensiveness of the benefit package selected. At the same time, the committee should be aware that average premiums have remained stable over time. AHIP estimates that a vast majority of long-term care policies currently in effect today have never experienced a rate increase. In addition, within the past few years there have been significant enhancements to long-term care insurance (for example, prior hospitalization requirements have been eliminated and benefits have been expanded to include coverage in assisted living facilities, adult day care and home health care, in addition to nursing home care), and therefore that give buyers more benefits for their premium dollars.

Table 1 on the following page illustrates the average cost of long-term care premiums, depending on when the policy is purchased.

Table 1: Average Annual Premiums for Leading LTC Insurance Sellers in 2002

Age of Purchaser	Base	With 5% Comp. Inflation Protection (IP)
40	\$422	\$890
50	\$564	\$1,134
65	\$1,337	\$2,346
79	\$5,330	\$7,572

NOTE: Premiums are generally for a \$150 daily benefit amount, four years of coverage, and a 90-day elimination period.

Consumer Protections – Strengthening the Market

A vital component of this effort to strengthen the market for long-term care insurance is the adoption of robust standards for consumer protection. Because we recognize that consumer protections are critical toward engendering confidence in the market, AHIP and our member companies are committed to providing quality products, transparency in our products, and consumer choice. We view these protections as key to giving consumers confidence, expanding the market, and providing viable solutions to work hand in hand with Medicaid coverage for the poor.

In the past, there have been questions about post-claims underwriting. Our position is that this is never justifiable. On the other hand, efforts to detect and prevent fraud should not be viewed as post-claims underwriting. AHIP supports the strong stand taken on this issue by the National Association of Insurance Commissioners (NAIC). We also support the NAIC’s most recent Long-Term Care Insurance Model Act and Regulations and the Health Insurance Portability and Accountability Act’s (HIPAA) consumer protections for long-term care insurance.

To give the committee a broad picture of the value of the HIPAA provisions, below are some of the key requirements:

- requiring policies to guarantee renewability;

- specifying the only circumstances when coverage could be canceled or rescinded, such as when the applicant committed fraud to obtain coverage;
- requiring “free-look” periods immediately after issue and grace periods for premium payments;
- limiting the circumstances where benefits need not be provided, such as in the case of alcoholism or drug addiction;
- requiring numerous disclosures, including an outline of coverage, and building in notice and other safeguards to prevent unintended lapses of policies; and
- establishing minimum standards for home health benefits; and requiring that policies be offered with inflation protection and non-forfeiture of benefits provisions.

In addition, federal legislation enhancing the tax treatment of long-term care insurance contracts should include components of the 2000 NAIC Models. As an example, AHIP recommends that the Model provisions relating to the benefits consumers are to receive if they choose not to continue their policy and required disclosure to consumers relating to rate stability be added as new standards for tax-enhanced long-term care insurance contracts.

HOW TO SUPPORT FAMILIES THAT WANT TO SAVE FOR LONG-TERM CARE

A. Federal Tax Incentives

AHIP supports federal legislation to enact both an above-the-line tax deduction for long-term care insurance premiums – which means that they would be deducted directly from a taxpayer’s adjusted gross income (the “line”) – and a tax credit of up to \$3,000 for those with long-term care needs or their caregivers. This legislation has been introduced in every legislative cycle

since 1999-2000 and the current level of support reflects growing congressional interest in this issue.

The proposal for an above-the-line tax deduction would allow taxpayers to claim a tax deduction regardless of whether they itemize their deductions and regardless of whether they have other medical expenses. For example, a person who pays \$1,500 in premiums for long-term care insurance could reduce his or her taxable income by the full \$1,500 under this proposal.

By contrast, current law allows taxpayers to deduct premiums for long-term care insurance only if they itemize deductions and only to the extent that their medical expenses exceed 7.5 percent of their adjusted gross income. In other words, a person with an adjusted gross income of \$40,000 must have \$3,000 in medical expenses before he or she can claim any tax deduction for long-term care insurance premiums or any other medical expenses. Because this threshold is so high under current law, fewer than five percent of all tax returns report medical expenses as itemized deductions. An above-the-line tax deduction would eliminate this 7.5 percent threshold and allow all long-term care insurance policyholders to claim a tax deduction.

AHIP also supports legislative provisions that would enable employers to offer long-term care insurance as an option under cafeteria plans, which allow employees to customize their benefits packages, and under flexible spending arrangements, which allow employees to use pre-tax dollars to pay for medical expenses not covered by health insurance.

Allowing employees to purchase long-term care insurance on a pre-tax basis through these popular employee benefit arrangements would allow more families to purchase coverage. Moreover, this would put long-term care insurance on a level playing field with other employer-sponsored benefits – such as 401(k) contributions – that are not taxed.

As Congress considers federal tax incentives, we urge lawmakers to recognize that more than 20 states have enacted enhanced tax incentives for the purchase of long-term care insurance. These states are: Alabama, California, Colorado, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Minnesota, Missouri, Montana, New York, North Carolina, North Dakota,

Ohio, Oregon, Utah, Virginia, West Virginia, and Wisconsin. These state laws have taken an important first step to enhance the affordability of long-term care insurance. By enacting an above-the-line tax deduction at the federal level, Congress can create a more powerful incentive – with the states working in partnership – for all Americans to protect themselves against the financial risk of long-term care needs.

B. Partnerships

AHIP also supports the expansion of public-private long-term care “partnerships” similar to those that currently operate in New York, California, Connecticut, and Indiana into a nationwide program. These partnerships allow consumers in these states to purchase long-term care insurance with the understanding that if their policy benefits are exhausted, the government will cover the costs of their continuing care through Medicaid without first requiring them to “spend down” their life savings and become impoverished. There are two partnership models:

- The “dollar-for dollar” model allows beneficiaries to protect a specified level of assets equal to the amount of long-term care insurance they purchase. If a beneficiary purchases \$100,000 of coverage, he or she is assured that \$100,000 of his or her assets will be exempt from any Medicaid “spend down” requirements that otherwise would apply.
- The “total asset protection” model allows beneficiaries to protect all of their assets, provided that they purchase a long-term care policy for a minimum number of years, typically three or four years.

AHIP envisions that a partnership model implemented on a national basis would encourage the growth of the long-term care insurance marketplace in a more effective and cost-efficient manner. This national or federal model should mirror HIPAA long-term care tax-qualified requirements and would allow Medicaid protection in all states, regardless of where one purchases a long-term care policy.

Among more than 180,000 partnership policies that have been sold in these states since 1992, only 89 individuals have exhausted their private benefits and accessed Medicaid benefits, and almost 30 percent of policyholders surveyed said they would not have purchased a long-term care policy in the absence of the partnership program.

C. Other Strategies

To meet the challenges presented by long-term care, policymakers should focus broadly on as many bold and creative ideas as possible. In addition to the proposals already discussed, a number of other innovative approaches may be worth pursuing as part of a multi-faceted strategy for financing the growing costs associated with long-term care:

- State-based and national education campaigns could play an important role in making consumers aware of their options for protecting themselves from the risks associated with long-term care costs. The existing CMS Long-Term Care Awareness Campaign, developed for five states, could be expanded to other states using resources jointly provided by CMS, state Medicaid programs, long-term care insurers, long-term care providers, and other stakeholders.
- Any number of innovative new partnerships between long-term care insurers and Medicaid programs could be explored. One possibility would be a partnership in which long-term care insurers would manage a state's Medicaid long-term care population. Another option would be to expand state Medicaid managed care programs to cover the entire continuum of health care services including acute care and long-term care.
- State-based CMS demonstration programs could be expanded to help states meet their long-term care costs in Medicaid. This approach would allow states to test innovative partnerships as part of an incremental approach to developing broad-based solutions.

Consumer Education and Transparency

As the market grows and adapts to consumer needs and expectations, the private sector and government at all levels should encourage a broad consumer education campaign. The NAIC Models could also serve to enhance the ability of consumers to compare products and make more informed decisions about need and suitability. In fact, the NAIC models provide guidance on suitability to help consumers select appropriate products and to ensure that agents are in turn selling products compatible with a consumer's particular needs.

Finally, I would like to mention that AHIP actively works with federal and state long-term care education campaigns, and we produce and regularly update a "Guide to Long-Term Care Insurance." The *Guide* includes advice on how families should evaluate their long-term care needs, what the costs are, and how to choose long-term care insurance coverage. To date, we have distributed over 1 million copies of the Guide.

We have also partnered with the General Services Administration's Federal Consumer Information Center (FCIC), which has identified this publication as its "guide of choice" on long-term care insurance. The *Guide* is available to consumers, at no charge, through the FCIC by phone [1-888-8 PUEBLO], on the web at www.pueblo.gsa.gov/cic_text/health/ltc/guide.htm.

CONCLUSION

We hope this information about the long-term care market, what our members already are doing to partner with states under Medicaid, and policy solutions for providing expanded access to coverage are useful to the committee. If these recommendations are implemented, there will be tangible benefits³ for consumers and for Medicaid and Medicare:

³ LifePlans, Inc., *Benefits of Long-Term Care Insurance*, September 2002

Potential Benefits to Consumers

Having long-term care insurance allows those with chronic illnesses and the disabled to remain in their homes. Approximately half of patients and family caregivers interviewed by trained nurses and social workers said that in the absence of their long-term care insurance benefits, the patients would not be able to remain in their homes and would have to seek institutional alternatives.

We know that consumers with private long-term care insurance receive an average of 14 more hours of personal care per week than similarly disabled non-privately insured elders. Consumers with long-term care insurance are 66 percent less likely to become impoverished to pay the costs of long-term care, and long-term care insurance reduces the out-of-pocket expenses of disabled elders. The average reduction in out-of-pocket nursing home costs is between \$60,000 and \$75,000 and can total more than \$100,000.

Potential Benefits to Medicaid and Medicare

Long-term care insurance can reduce state and federal Medicaid expenditures and federal Medicare home health expenditures. Medicaid savings are projected to total about \$5,000 for each policyholder with long-term care insurance and Medicare savings are estimated to exceed \$1,600 per policyholder.

Aggregate savings to Medicare and Medicaid for the current number of policyholders are estimated at about \$30 billion. These savings will grow as more people acquire policies and the average age of purchasers continues to decline.

AHIP and our member companies look forward to working with the subcommittee to address the challenges associated with long-term care and Medicaid. We are eager to share our ideas and contribute to a constructive debate on this issue. We also support efforts to establish a Bipartisan

Commission on Medicaid. If Congress provides for such a commission, we will be pleased to work with this body to contribute to the discussion about steps that can be taken to strengthen Medicaid to better meet the health care needs of beneficiaries.

We appreciate the opportunity to testify on these important issues and look forward to your questions.