Looking Ahead at Long-Term Care

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Costs of providing long-term care are already high, but a glimpse at future demographic projections leave a more troubling outlook. Combine increasing life expectancies with the aging of the baby boomers, and the once recognized age pyramid in the United States seems to be inverting. This declining ratio of young to old is leaving fewer individuals to cover the costs of health care for older Americans under traditional funding mechanisms. Current cost containment tactics rely heavily upon efforts to divert those in need of long-term care away from institutional settings toward less-costly, non-institutional alternatives. But will this be enough? The authors' doubt is expressed through discussions of various options which they contend should be considered by policy makers. By offering tax deductions for long-term care insurance premiums in 1997, Congress has already taken a step to encourage individuals to make arrangements to provide for themselves during their golden years. However, the authors assert that further action is required.

Introduction

Much ado has been made about health care reform, but when long-term care (LTC) is mentioned, the room suddenly clears. Other than the occasional tweaking of the present system and a lot of intergenerational grumbling, not much has been accomplished in the way of thinking "outside the box". Like a poor relation, the issue of LTC has been avoided, excused and passed around. In addition to its usual litany of ills, other predicaments are materializing. It is impossible today to read anything about LTC without being bombarded with evidence that the elderly population in the United States is accelerating at an amazing rate and expected to gain momentum well into the middle of the next century.

Will the future population really be different, not only in number but also in its characteristics? Will the next generation of retirees really be as unprepared as the direst predictions claim? Or will they be secure and populous enough to significantly change the way we define "old age" and the type of care that is offered? Will the same old bag of tricks still work? And how will we fund them? From a public policy perspective, it is important to consider not only the significant increase in the population, but also the associated issues.

Demographics

According to the U.S. Census Bureau, the rate of growth of persons aged 65 and older has far exceeded the growth rate of the population as a whole.[1] The number of elderly persons has increased by a factor of 11, from 3 million in 1900 to 33 million in 1994, while the total population has only tripled. Furthermore, the Bureau projects that the number of persons aged 65 and older will more than double by the year 2030 from 33

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[1] Frank Hobbs, *Sixty-Five Plus in the United States* (World Wide Web, 1996a), 1-2.

Of Ohio's total population in 1994, approximately 13.4 percent were 65 years of age or older

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million in 1994 to 80 million. Comparatively, 1 in 8 persons were over age 65 in 1994, with the ratio expected to jump to 1 in 5 by 2030. Even more remarkably, the number of persons aged 85 and older is growing at an even faster rate and is not projected to slow down. This group of the "oldest old" made up just over 1 percent of the total population in 1994 (about 3.5 million, which is 28 times larger than in 1900). However, from 1960 to 1994, this group increased an astounding 274 percent; those in the 65 and over bracket increased 100 percent; but the total population increased a "meager" 45 percent. This group of the "oldest old" will number about 19 million around 2050, comprising 24 percent of the elderly and 5 percent of all Americans.

In 1993, nine states had more than 1 million elderly persons: Ohio, California, Florida, New York, Pennsylvania, Illinois, Michigan, Texas and New Jersey. While Florida not only has a high elderly population, it has the highest proportion of this population at 19 percent, followed by Pennsylvania with 16 percent. California has a large number of elderly, but proportionally this group makes up only 11 percent of the state's total population.[2] Of Ohio's total population in 1994, approximately 13.4 percent were 65 years of age or older, which is slightly higher than the national average of 12.7 percent.[3]

According to *Population Projections, et al.*,[4] one of the most far-reaching trends within Ohio's population is its aging. In 1990, the largest group of people was aged 30 to 34. By the year 2000, the baby boomers will all be over age 35, making the largest number of people in Ohio age 40 to 44 years.

There are several reasons for this rise in population, including improved technology and medical advances, as well as overall improvement in health and higher education levels. Research has shown that the better educated tend to stay healthier longer and are better off economically. Additionally, medical advances have led us to expect fewer deaths in the future from the three leading causes of death among the elderly: heart disease, cancer and stroke.

In 1993, total LTC spending for the elderly was approximately $79.2 billion. Of this total, $20.6 billion was for home and community-based services. If current spending patterns continue, it is estimated that these expenditures will more than double by 2020. Additionally, the demand for government services may grow at an even faster rate as more women join the workforce, family size decreases, and geographic dispersal of families reduce the ability of informal caregivers to continue providing the current level of unpaid care.

Associated Issues

According to 1995 estimates, about 12 million people need LTC. Of this total, 57 percent are elderly while children and nonelderly adults make up the remaining 43 percent.[5] Although LTC encompasses people of all age groups, this report focuses on the elderly population (those 65 years of age and older). For public policy purposes, it is important not only to look at the increase in numbers of a certain population, but to also understand what else is happening.

Sex Ratio

As age increases, the number of males to females decreases. In 1994, elderly women aged 65 to 69 outnumbered elderly men by 6 to 5. At 85 years of age, the difference had grown to 5 to 2. This gap may narrow somewhat over the next 50 years as more men live to older ages through improved health and medical advances. In colonial

[2]Frank Hobbs, *The Elderly Population* (World Wide Web, 1996b), 2

[3] David Baer and others, *The State Economic, Demographic and Fiscal Handbook 1996* (Washington: Public Policy Institute, 1996), 338

[4] Ohio Department of Development, Office of Strategic Research, *Population Projections - Ohio and Counties by Age and Sex: 1990 to 2015*, by Jian He, 3 (1993).

[5] U.S. General Accounting Office, *Long-Term Care: Current Issues and Future Directions*, 7, (April 1995).

times, life expectancy at birth was a rough 35 years. This increased to 47 years in 1900; 68 years in 1950; and 76 years in 1991, with a 79-year life expectancy for women and 72 years for men.[6]

Poverty

For a ten-year span from 1984 through 1994, women experienced a poverty rate nearly twice that of their male counterparts.[7] Specifically, men aged 65 to 74 had a poverty rate of 7 percent while females in that age group had a poverty rate of 13 percent. Men aged 75 and over had a poverty rate of 11 percent while the rate for women in this age range was nearly 20 percent.[8]

During that same time period in Ohio, the number of people aged 65 and older, as well as their poverty rates, were nearly identical to national statistics.

Perception of the elderly has gradually changed over the years to view the senior generation as wealthy oldsters. However, there is actually a wide variation among elderly subgroups. In 1992, the poverty rate was 15 percent for those under age 65 and rose with age among the elderly; elderly women (16 percent) had a higher poverty rate than elderly men (9 percent); and the rate was higher for elderly African-Americans (33 percent) and Hispanics (22 percent) than the overall rate for whites (11 percent).[9]

In constant 1992 dollars, median income for elderly persons more than doubled between 1957 and 1992 from $6,537 to $14,548 for men and from $3,409 to $8,189 for women. Overall, however, income disparity persists among elderly subgroups. For example, elderly white men had median income more than double that of elderly African-American and Hispanic women ($15,276 versus $6,220 and $5,968, respectively). As the following section points out, it is likely that the elderly population will continue to become more racially and ethnically diverse which could cause significant problems if such income disparity continues to exist.[10]

Racial and Ethnic Diversity

Of those 65 and older in 1994, almost 30 million were Caucasian; 2.7 million were African-American; 1.5 million were Hispanic; 137,000 were American Indian, Eskimo and Aleut; and 615,000 were Asian and Pacific Islander. It is projected that the elderly population will become even more racially and ethnically diverse, with the Hispanic population increasing from less than 4 percent of the elderly population to 16 percent by the middle of the next century.[11]

Disability

Perhaps the greatest concern should lie in the growing number of persons over the age of 85. Despite medical advances and the corresponding delay in poor health, there are still higher rates of disability and LTC utilization by the 85-and-over population. Fourteen percent of the elderly aged 65 to 74 were considered disabled in 1985 with more than 58 percent in that category for people over the age of 85.[12] To be considered disabled, there are limitations to performing one or more activities of daily living (ADLs), such as eating, dressing, toileting, bathing, transferring, and incontinence or "instrumental" activities of daily living (IADLs), such as doing housework, preparing meals, managing money, shopping and using the phone. Long-term care is defined as assistance with these basic activities and routines of daily living. Skilled and therapeutic care that treats and manages chronic conditions is also included.

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[6] (Hobbs 1996a, 2,4)

[7] 1996 poverty level income for a single person is below $7,740; income level for a two-person is below $10,360.

[8] (Baer and others 1996, 217)

[9] (Hobbs 1996a, 7)

[10] Hobbs 1996a, 7)

[11] (Hobbs 1996b, 1, 2)

[12] U.S. General Accounting Office, *Long-Term Care - Projected Needs of the Baby Boom Generation,* 2, (June 1991).

Can the United States afford to support its current offerings of "old age" entitlements and programs?

The Boomers

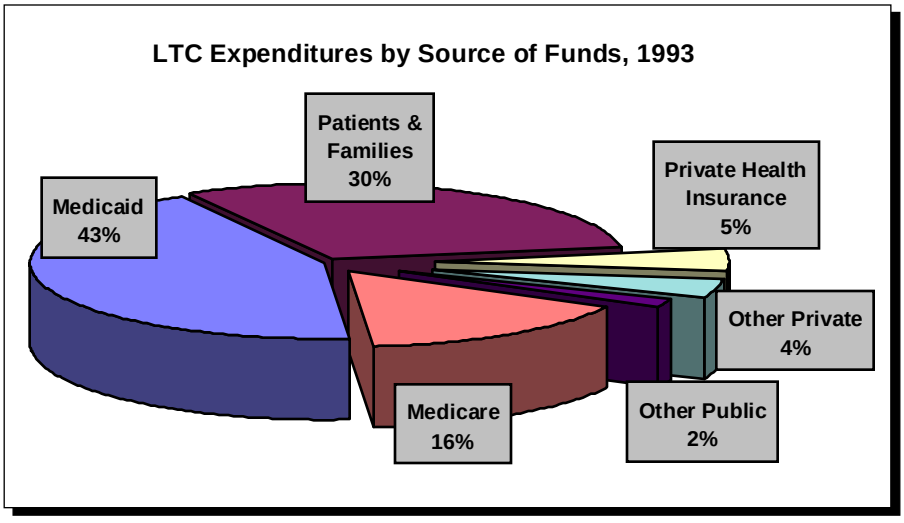
Since the number of elderly are increasing and the baby boomers are such a huge portion of the "near elderly", a look at future needs is required. Many policy discussions treat them as a uniform group, but because of their number, there is speculation that the boomers will redefine "old" and have a significant influence on our current social, economic and political frameworks for providing services to the "old". The baby boomers are the first generation in which an overwhelming number have been affected by divorce and remarriage and made the "blended" family more "normal" than traditional family structures. These observations beg a number of questions, including: Will stepchildren have the same concern and obligation for their parents that is displayed by biological children? How will this affect the demand for caregiver services that are currently provided to parents by their children? Will a labor force increasingly made up of baby boom women and the rise in the number of private pension plans provide greater income security? Will healthier lifestyles and medical advances significantly delay the onset of serious disability for the elderly in the future?[13] Additionally, current debate focuses on whether the United States can afford to support its current offerings of "old age" entitlements and programs, and if not, how can they be made more affordable. To further complicate the issue, we must project how a future system should look for a population that looks much different than when the present structure of Social Security and Medicare were laid out.

Economics and Financing Issues

Researchers at the Brookings Institution estimated expenditures for nursing home and home care services for the elderly in 1988 to be nearly $42 billion. These costs (in 1987 dollars) are predicted to nearly triple to $120 billion by 2018 and nearly triple again in 2048 to over $350 billion.[14]

Overall, national health expenditures in 1993 totaled more than $884 billion. LTC costs made up 10 percent of the total, topping $90 billion. The following graph illustrates LTC expenditures by source of funds:[15]

In 1960, there were 5.1 workers to support each Social Security recipient. Today there are 3.3 and by 2040, there will be between 2.0 and 1.6.[16] A similar ratio is seen based on the number of disabled elderly. Both of



[13] Carol J. De Vita, review of *Demography of Aging*, by Linda G. Martin and Samuel H. Preston, *The Gerontologist* 35 (1995): 422.

[14] (U.S. General Accounting Office, 1991, 12)

[15] Katharine R. Levit, et al., "National Health Care Expenditures, 1993," in *Health Care Financing Review* (Fall 1994): 247-294.

Note: This information represents nursing home and home health care expenditures from the National Health Accounts. They include expenditures for acute care (generally not considered LTC) custodial care. Not included is an additional $4.1 billion from by facility-based (generally in hospitals) home health agencies, LTC costs incurred outside of home health agencies or nursing homes, or costs for informal (unpaid) LTC.

[16] Peter G. Peterson, "Will America Grow Up Before it Grows Old?" *The Atlantic Monthly*, May 1996, 57.

these declining ratios would suggest that it will become increasingly difficult to convince the present workforce to finance future long-term care expenditures. How much of a burden will be placed on today's workers will depend on a number of factors, including economic growth, cost distribution between public and private sources and relative earning power.[17]

Conversely, improved financial status of the elderly could result in a larger share of the costs being borne by the elderly rather than by the working population. This could not only serve to benefit the workers, but also the elderly by giving them more power in regard to choice and the ability to pay for the type of services they receive.

There are four main sources of income for those over the age of 65: continued employment, government benefits (primarily Social Security, Medicare and Medicaid), private pension income and personal savings. It is estimated that less than half of all private-sector workers are covered by pensions and that even these will be inadequate. In addition, the net national savings rate fell to 7.2 percent in the 1970s and then plummeted to 3.9 percent in the 1980s and stood at 2.3 percent in the 1990s.[18]

Institutional Care

Based on projections by the Brookings Institution, the rapidly growing population aged 85 and over is expected to cause a sharp rise in the number of elderly who utilize formal, paid care since currently, higher rates of utilization are found in the 85-and-over population.[19] The Institution predicts that the number of elderly using nursing homes over the course of a year will increase by 76 percent over the next 30 years from approximately 2.3 million in 1988 to 4.0 million in 2018. Additionally, the overall number of elderly is expected to increase by 61 percent. Researchers at both the Urban Institute and Duke University forecast that for the first few decades of the 21st century, the number of elderly using nursing homes will increase from 3 to 5 million.[20] These projections assume that the current rate for nursing home use will continue in the future and does not address appropriateness of, or preference for, this type of care. Also to note, the use of nursing homes varies widely across the United States.

According to the National Conference of State Legislators (NCSL), Medicaid pays for roughly half of all nursing home care and 16 percent of home health care costs and supplements Medicare for about 10 percent of the elderly.[21] In 1994, of the 36 million people covered under Medicare, 32 million were elderly and 4 million disabled. The total cost of this coverage was $163 billion. Although Medicare coverage leaves only about 1.2 percent of the elderly uninsured, the program does not exist to address a basic need of the elderly, specifically, long-term care. It also does not take care of basic needs that often arise in old age, such as coverage for eyeglasses and prescription drugs. Conversely, Medicaid remains the largest third-party payer of nursing home costs for the aged, although it was never intended for that purpose.

During the 1970s, Certificate of Need legislation began to control growth in the number of nursing home beds. However, some researchers argue that with such a significant anticipated growth in the number of elderly, efforts by states to cut costs by restricting the number of nursing home beds may not be feasible when faced with such an increase in demand. The future of nursing home care is also unpredictable in light of the proliferation of alternative services, such as assisted living, congregate housing, continuing

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[17] (U.S. General Accounting Office, 1991, 13)

[18] (Peterson 1996, 64)

[19] (U.S. General Accounting Office, 1991, 8)

[20] (U.S. General Accounting Office, 1991, 8, 9)

[21] National Conference of State Legislatures, *Long-Term Care for the Elderly*, legisbrief by Shelda Harden, vol.4, no.4, January 1996

Spending from ... Medicaid ... totaled approximately $1.7 billion ... for FY 1996.

care communities, and board-and-care facilities.[22]

In Ohio, over 900 providers accounted for approximately 90,000 Medicaid-reimbursed nursing home beds. Spending from the Department of Human Service's Medicaid line item for nursing home facilities totaled approximately $1.7 billion in actual spending for FY 1996. This number is projected to grow about 5.5 percent to roughly $1.8 billion in FY 1997. Overall, nursing home services accounted for 73 percent of Ohio's Medicaid LTC expenditures in 1993 and for 29 percent of the total Ohio Medicaid expenditures, compared to a national average of 21 percent.[23]

It is interesting to note that Texas and California are among the states with the lowest population of elderly (under 12 percent), yet they have the highest number of nursing home beds. In 1993, four states (with elderly populations of 12-13 percent) accounted for 25 percent of the total number of nursing home beds in the country: California, Illinois, New York and Texas. Ohio, with 13.4 percent elderly, followed closely in fifth place in number of beds. Most notably, the twelve states with the highest elderly population (14 percent or greater), with the exception of Pennsylvania, had the lowest number of nursing home beds.[24]

In 1994, the majority of nursing home care was paid for by Medicaid (58 percent) and private pay sources (34 percent); Medicare accounted for 5 percent; veterans affairs and private insurance 1 percent each; HMOs less than 1 percent; and other sources (including grants, dues, donations, etc.) less than 1 percent.[25] According to figures from NCSL, the average cost of a year in a nursing home in 1993 was $39,000. [26]

Non-Institutional Care

Informal Caregivers (Unpaid)

There have been numerous anecdotal accounts regarding the extent of paid home care services available in the private sector, both nationwide and in Ohio, but there remains to be a validated source for this information. In general, since there is no singular formal mechanism for tracking private pay home care, it is difficult to grasp their full contribution or absence in the LTC spectrum.

According to data from NCSL, the average home health care visit costs $80 for nursing care of physical therapy.[27] Costs can obviously run into hundreds of dollars per day depending on the needs of the client and helps to underscore the importance of unpaid, informal caregiving.

It is estimated that about 95 percent of those over age 65 and 80 percent of those over 85 live at home and the majority of those with impairments live in the community, often in their own home.[28] A study by GAO revealed that the elderly prefer home and community-based services over nursing home care and about 75 percent of those needing LTC live outside nursing homes. In large, their care is provided today by family and friends, mostly women.[29] It is estimated that 80 percent of home eldercare is given by a family member and 75 percent of these caregivers are female, with adult daughters accounting for 29 percent. Of all caregivers, those who are solely responsible for providing the care make up about 33 percent; 25 percent are between 65 and 75 years of age; and 10 percent are over the age of 75. Their average age is 46 and about 66 percent are married.[30]

Those receiving care are usually a housebound relative with a chronic

[22] (U.S. General Accounting Office, 1991, 9)

[23] Richard Fortincky, *Policy Indicators for Nursing Facility Services in Ohio*, presentation as part of an Ohio Department of Human Services Medicaid forum, Columbus, OH, 28 August 1996.

[24] Marion Merrell Dow, *Managed Care Digest: Long-Term Care Edition* (Colorado: The Business Word, Inc., 1994), 7.

[25] (Marion Merrell Dow 1994, 15)

[26] (National Conference of State Legislators, 1996)

[27] (National Conference of State Legislators, 1996)

[28] P.E. Ruskin and others, *Caregivers of the Elderly* (World Wide Web), 1.

[29] U.S. General Accounting Office, *Long-Term Care Reform - States' Views on Key Elements of Well-Designed Programs for the Elderly*, 1, (September 1994).

[30] (P.E. Ruskin and others, 1)

condition. Their average age is 77 with 25 percent over age 85. About 4 hours per day of care is delivered with roughly 66 percent of the time spent on daily personal care needs. Management of dementia, including Alzheimer's, is also part of the care given.[31]

Additionally, caregivers are responsible by default for an array of higher-level medical care. This includes injections, naso-gastrointestinal feedings, catheter care, tracheotomy care, oxygen therapy, dressings, special diets, etc. In addition to the caregiver role provided 24 hours per day, most also fulfill roles in at least a dozen other areas, such as mother, spouse, housekeeper, cook, etc. Adult day care centers, respite care, support groups, and professional support have increased in number, especially over the past few years, but adjunct care is often quite expensive.[32]

With lower birth rates, smaller family size, increased labor force participation rates (specifically for women), geographic scattering and an increase in the number of "nontraditional" family arrangements, it is hard to predict how much society can continue to rely on unpaid caregiving. Traditionally, most LTC has been provided by informal (unpaid) caregivers, most of whom are women. However, it is estimated that the number of elderly living alone could be as high as 46 percent in 2030 as compared to 38 percent in 1990. Clearly, with less family support, there will be an increased need for formal, paid care, perhaps in the form of a home health worker. Estimates of the needed number of these workers go as high as double their number in 1985. That is, from around 200,000 to about 484,000 in 2040. However, some estimates as high as 1.3 million in 2040 have been indicated if there is indeed a significant shift away from informal, unpaid caregiving by family and friends.[33]

PASSPORT

The Pre-Admission Screening System Providing Options and Resources Today (PASSPORT) is a Medicaid Waiver program that provides an array of in-home services to elderly individuals who are both poor and in need of nursing home level-of-care. The program allows such elderly individuals to remain in their home rather than be institutionalized. The following services may be provided as part of the PASSPORT program: case management; personal care; homemaker; home-delivered meals; adult day care; respite care; registered nurses; speech, occupational, and physical therapy; emergency response systems; home chores and home repairs; medical supplies and equipment; and adaptive and assistive equipment.

To be eligible for the PASSPORT program, individuals must meet the following requirements:

- be Medicaid eligible,
- sixty years old or older;
- in need of nursing home level-of-care,
- in need of services not readily available from other community resources,
- evaluated periodically to determine need and eligibility for services,
- under a physician-approved service plan,
- adequately assured of health and safety living at home,
- not have elected to use Medicaid or Medicare hospice benefits.

The Health Care Financing Agency (HCFA) restricts the number of individuals a state may serve. The table below shows the maximum number of unduplicated PASSPORT Waiver clients that may be served between FY 1994 and FY 1998, as well as the

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[31] (P.E. Ruskin and others, 1)

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[33] (U.S. General Accounting Office, 1991, 11)

Fiscal Year	Waiver Limit for Unduplicated Clients	Actual/Estimated Number of Unduplicated Recipients
1994	13,968	9,516
1995	16,501	15,864
1996	17,958	17,958
1997	18,796	18,796
1998	19,279	Not yet appropriated

number of individuals that the department will be able to serve, given appropriations.

The PASSPORT program has shown rapid growth in the 1990's. The Department of Aging provided PASSPORT services for about 2,700 people in FY 1991 and FY 1992. In FY 1993, the department served about 5,000 elderly Ohioans through the program. Significant increases in funding allowed the department to increase the number served to 15,864 in FY 1995, 17,958 in FY 1996, and 18,796 in FY 1997.

Plans to proceed with an assisted living waiver have been abandoned.

With the exception of FY 1994, state GRF funding for PASSPORT has grown from FY 1992 through FY 1997. In FY 1994, the Legislature enacted a nursing facility bed tax, the revenues from which are used to supplement funding of both the PASSPORT and Residential State Supplement programs. (In FY 1994, the infusion of these new dollars actually supplanted GRF appropriations for PASSPORT.) Nursing facility franchise fee revenue has remained constant at about $26.0 million per fiscal year.

With the enactment of the last state biennial operating budget, the Department of Aging estimated that appropriations for the program would allow them to serve 17,958 persons in FY 1996 and 18,796 persons in FY 1997, the maximum number of slots previously approved by HCFA. However, about halfway through FY 1996 the department revised its estimates and projected that all approved PASSPORT slots would be filled approximately two weeks prior to the end of the fiscal year. Thus, new enrollment would have to be closed the final two weeks of the fiscal year, despite the availability of state appropriations. Rather than closing the program, the department chose to seek federal approval to expand enrollment. Given the availability of state funds, HCFA approved a total of 4,005 new slots that the state may fill between FY 1996 and the end of FY 1998.

The table below shows the number of slots previously approved, the new number of approved slots, and the new slot totals through FY 1998.

Fiscal Year	Previously Approved Slots	Newly Approved Slots	Total Slots
1996	17,958	338	18,296
1997	18,796	1,418	20,214
1998	19,279	2,249	21,528

The PASSPORT waiver, originally approved in late-1992, is scheduled to expire on June 30, 1998. The state will have to seek a new waiver at that time if it wishes to continue the PASSPORT program.

Assisted Living

The Department of Aging was to have begun administering an Assisted Living program in FY 1997. The program was to be funded using both state GRF dollars and federal Medicaid Waiver reimbursement moneys to serve an estimated 1,320 individuals by the end of FY 1997. Originally, the department planned to request a single Medicaid Waiver service from HCFA called assisted living. Under such a waiver, assisted living would have included any services, within established limits, that an eligible person would need to continue to live

in a residential care facility. In order to be eligible for the waiver, persons would have to be age 60 or older, require a nursing home level-of-care, and also be Medicaid eligible.

In FY 1994, the Legislature earmarked a portion of the nursing facility franchise fee revenues to be used for an Assisted Living program. However, disagreements between the department, Legislature, and long-term care providers regarding how the program should be designed derailed all attempts to implement a program anytime during the FY 1994 - FY 1995 biennium.

In Am. Sub. H.B. 117 of the 121st General Assembly, the Legislature appropriated $70,000 for Assisted Living in FY 1996 and $4,430,000 in FY 1997. The Legislature authorized the Department of Aging to use these moneys to fund services and room and board subsidies for eligible waiver participants.

The department has announced that they no longer plan to proceed because they have been unable to design a program that would be a cost effective alternative to nursing home care. The department recently received Controlling Board approval to transfer $1,529,673 of the Assisted Living appropriation to the Senior Community Services Block Grant program and $883,852 of the appropriation to the Long-Term Care Ombudsman program. The remaining $2,016,475 will be lapsed at the end of FY 1997.

Residential State Supplement (RSS)

Ohio's Residential State Supplement program provides cash assistance to aged, blind, and disabled adults who live in an adult foster care home, adult care facility, or a rest home; and who have significant financial burdens due to a medical condition. In FY 1996, the program's name was changed from Optional State Supplement to Residential State Supplement. In order to be eligible for the program, the individual's income may not exceed the RSS payment standard. Furthermore, the individual's medical condition must be at a level that does not require institutionalization. RSS recipients are eligible for Medicaid services such as doctors' visits and prescriptions.

Beginning in FY 1994, the Department of Aging took over administration of the RSS program from the Department of Human Services. Although the Department of Aging now administers the RSS program, the Department of Human Services still issues the warrants to recipients. The Department of Aging transfers its RSS appropriations to the Department of Human Services for that purpose.

When the Department of Aging took over control on July 1, 1993, there were about 865 recipients enrolled in the program. By the end of FY 1995 there were about 2,684 recipients enrolled in the program (a 210 percent increase).

Total funding for the RSS program has increased each year from FY 1994 through FY 1997. In addition to state GRF funding, the RSS program receives a portion of the nursing facility bed tax moneys. FY 1996 and FY 1997 appropriations allow the Department of Aging to maintain the RSS program at 2,684 recipients.

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Options for Elders

The Options for Elders program began in FY 1990 to provide a single point-of-entry for persons seeking information and/or services about the aging care network. The Legislature funded two pilot program sites, one in Franklin County which served as the urban pilot program, and a consortium of nine rural counties in Southeastern Ohio which

served as the rural pilot program. However, after two years, the Legislature chose to phase-out funding for the program.

In FY 1992, the state began to phase out the service delivery portion of the Options program, but retained the information and assistance portion as a part of the PASSPORT program. Clients enrolled in the Options for Elders program were re-enrolled, when possible, in the PASSPORT or the Residential State Supplement programs. State GRF moneys were appropriated to maintain those clients who were enrolled before July 1991 and for whom no other care alternatives were available.

In June of 1992, Franklin County began using revenues from a newly passed Senior Services and Facility Levy to fund its Options for Elders clients who were still part of the program. However, there are still Options for Elders clients in the rural pilot project who need services. The Legislature has appropriated $397,312 in state GRF funding for FY 1997 to serve those individuals.

A UPAR screening can result in authorization of a Medicaid payment for nursing home care, placement in an Adult Care or Assisted Living Facility, referral to community services providers, or enrollment in the PASSPORT Home Care program.

Universal Pre-Admission Review

In December 1994, the Department of Aging initiated a new program known as Universal Pre-Admission Review (UPAR). The purpose of the program is to provide individuals seeking nursing home care placement and their families with information regarding alternatives to nursing home placement. Under the program, each individual who applies for nursing home placement is screened to assess need. A UPAR screening can result in authorization of a Medicaid payment for nursing home care, placement in an Adult Care or Assisted Living Facility, referral to community service providers, or enrollment in the PASSPORT Home Care program.

Federal Funding Streams

In 1994, Medicare paid for nearly 61 percent of all home care services; Medicaid 10.5 percent; private insurance 10 percent; patient payment 7 percent; state and local government 4 percent; HMOs 4 percent; other (such as charity and United Way) 2.5 percent; and bad debt 1 percent (Marion Merrill Dow).

There a several sources of federal funding for the elderly including, but not limited to the following: Title III, Nutrition and Support Services; Social Services Block Grant; Title V, Individual Service Programs; and the Omnibus Budget Reconciliation Act (OBRA).

Title III, Nutrition and Support Services, serves approximately 200,000 elderly individuals annually. Services provided under the program include: chores, counseling, adult day care, education, employment, escort, friendly visitor, health services, home health aide, home maintenance, homemaker, information and referral, legal services, nutrition and meals, outreach, protective services, recreation, respite care, telephone reassurance, transportation, and volunteer.

The Senior Community Services Block Grant serves approximately 17,000 elderly individuals annually. Services provided include home maintenance, medical transportation, home-delivered meals, and care coordination.

Title V provides funding for the Senior Community Services Employment program which served over 1,000 elderly individuals in FY 1995 and the Senior Volunteers program that provided volunteer opportunities for over 5,700 elderly during the same year.

LTC Insurance

LTC insurance can be purchased through a group policy; as a rider to life insurance; or through a privately purchased policy. Types of coverage generally include home and community based care and nursing home care. Home and community based care includes home health care services, adult day care centers, home hospice care, and respite home care. Under most LTC policies, nursing home care includes nursing facilities (and Alzheimer Centers); assisted living facilities; hospice facilities; and respite care in a facility.[34]

Age	Annual Premium	Total Cost to Age 85	Present Value*
50	$420	$14,700	$5,819
55	$559	$16,770	$7,422
60	$760	$19,000	$9,477
65	$1,102	$22,040	$12,492
70	$1,671	$25,065	$16,285
75	$2,685	$26,850	$20,178
79	$4,230	$25,380	$21,574

**The amount which, if invested today at 7 percent, will pay the premiums through your age 85.*

Premiums vary widely and depend greatly on the age at which a policy is purchased and on the type of coverage included. The chart above compares typical LTC policy premiums at different ages: [35]

Benefit amounts are commonly $30 to $250 per day. The benefit periods offered are typically 2 years, 3 years, 5 years,, 6 years, and some have unlimited time periods. Inflation protection may be offered and a common "trigger point" for coverage is the inability to perform certain ADLs and sometimes includes cognitive impairment.[36]

A profile of the "average" purchaser of LTC insurance in 1990 reveals that the average age was 43; 56 percent were female; 61 percent were married; 61 percent had household incomes of more than $50,000; 60 percent were college graduates; and 37 percent had total liquid assets of less than $20,000. It is interesting to note that the next largest group at 27 percent had liquid assets totaling more than $100,000.[37]

In 1993, approximately $108 billion was spent nationwide on LTC (footnote definition). The federal government paid 40 percent ($43.1 billion); private sources 36 percent ($38.5 billion); state government 24 percent ($26 billion); and LTC insurance less than 1 percent.[38]

On the business side, a survey of the 8 major carriers that provide nearly all the group LTC policies shows that more than 900 companies offer these policies, and about 500,000 people (including about 8 percent of eligible employees) are enrolled. Some predict this number will grow as businesses realize that custodial care can keep workers on the job when someone at home needs care.

According to some reports, the sale of LTC insurance policies has picked up over the past few years, but most reports conclude that the market remains largely untapped. The primary reasons for people not purchasing LTC policies include: 1) the government will provide LTC for them, i.e. they can always apply for Medicaid; 2) they are unsure about the policies available; 3) policies are unaffordable; 4) they think they will never need it; and 5) they are waiting for a better policy to be developed.

A twist on the concept of LTC insurance is the development of the Partnership for LTC program. This is a public-private LTC insurance program that combines private insurance with Medicaid to share the cost of LTC. As a

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[34] Steven Shagrin, *Retirement Issues: Planning for Long-Term Care*, presentation as part of the annual meeting of the American Society of Aging, Anaheim, CA, 16-19 March 1996.

[35] (Shagrin 1996)

[36] (Shagrin 1996)

[37] Cheryl McNamara, "Key Points to Consider in the Design and Delivery of Group Long-Term Care Insurance Services," *Benefits Quarterly* 1st qtr. (1993): 41.

[38] (U.S. General Accounting Office, 1995, 8).

Note: The HHS Assistant Secretary for Planning and Evaluation estimate for 1993 spending on LTC care. This estimate includes most LTC spending by Medicare, Medicaid, the Older Americans Act and the Department of Veterans Affairs. It does not include LTC spending from such programs as the Social Services Block Grant, the Rehabilitation Act, state vocational rehabilitation or the Maternal and Child Health Block Grant.

public/private venture, consumers buy partnership-approved policies and then are covered by private insurance until the policy runs out. Medicaid then pays for their care without forcing them to spend down or transfer assets. The theory is to not only save the clients from impoverishing themselves, but also to save Medicaid money by forestalling entry into the Medicaid program. Since the average length of stay is less than 3 years, the aim is for the client's private policies to cover them for the duration of a nursing home stay and never use Medicaid. Premiums vary widely, depending on coverage and age at which you purchase the policy.

There are two basic types of policies in the partnerships. The "total assets" model requires the purchase of a policy that covers a certain number of years of LTC. If coverage is used up, then the state disregards all assets in determining Medicaid eligibility. In the "dollar-for-dollar" model, the amount of coverage equals the amount of assets that will be disregarded.

Case management is often used in partnerships, such as that used in Connecticut. Connecticut Community Care, Inc. (CCCI) was formed in 1980 and is a private, non-profit, nonstock corporation that provides LTC case management services for publicly funded and private consumers.[39] The Robert Wood Johnson Foundation awarded a grant to CCCI who worked in conjunction with the National Advisory Committee to formulate guidelines for LTC case management. As a result, the National Case Management Partnership (NCMP) was created and exists as a division of CCCI. This partnership operates on a dollar-for-dollar basis.

Connecticut was the first state to adopt the program in 1992. Since that time, the Robert Wood Johnson Foundation has provided start-up money to six additional states. Four of those six states are operational with the remaining two nearly ready to start. Sales of these policies have shown steady growth, but represent a very small part of the total LTC insurance market. Only 21,000 applications were received in 1995 in California, Connecticut, Indiana and New York combined. A similar pattern of steady, yet modest growth is seen in the private LTC insurance market with 300,000 to 400,000 policies sold per year over the past few years, yet only about 5 percent of those 65 and older are covered by this type of insurance.[40]

The following is a chart of the average annual premiums for a basic one-year policy in the California Partnership for LTC.

Age	Facility-Only Policy	Integrated Policy
50	$339	$468
55	$436	$586
60	$607	$782
65	$822	$1,021
70	$1,173	$1,422
75	$1,697	$2,041

The basic policy has a lifetime maximum benefit of $36,500, enough to cover the cost of one year of nursing home care. The policy includes a $100 a day nursing home benefit; a $1,500 monthly home care benefit (for the integrated policy); and has a 30-day elimination period. The policy also includes a mandatory inflation protection feature that increases the lifetime maximum benefit by 5 percent annually.[41]

It has been difficult to judge the overall cost-effectiveness of these partnerships. Some scholars have expressed keen skepticism not only in regard to their economic feasibility, but their political viability as well, citing that a Medicaid recipient is unlikely to be able to purchase a LTC policy. Some researchers conclude that private LTC insurance does little to spread

[39] Beatrice Arneson, *Managed Care in LTC Insurance*, presentation as part of the annual meeting of the American Society of Aging, Anaheim, CA, 16-19 March 1996.

[40] Kreier, Rachel, "Experimental Long-Term Care Plan Still Just That," *American Medical News*, 10 June 1996, 10.

[41] Philips, Dale, *California partnership for Long-term Care*, presentation as part of the annual meeting of the American Society of Aging, Anaheim, CA, 16-19 March 1996.

financial risk since premiums are high compared to the incomes of many potential purchasers.[42] However, others counter that premiums are highly sensitive to types of coverage chosen and the age of the purchaser. Additionally, some believe that LTC insurance will never realize its full market potential as long as people believe that the government will pay their way through long-term care. But beyond this argument lies the question of how long the government can continue this way.

Federal Policy

Although there has been significant interest in federal action on Medicaid reform, very little discussion has taken place in regard to LTC. A small exception to this would be in the area of LTC insurance, which was affected by the Health Insurance Portability and Accountability Act of 1996.

The jury is still out on whether this legislation will help or hinder the LTC insurance market. The act allows for the deductions of LTC insurance premiums in 1997. Specifically, all or a portion of the premium costs can be written off as unreimbursed medical expenses. These costs can be deducted to the extent they exceed 7.5 percent of adjusted gross income. Additionally, employers will be able to deduct the premiums they pay through employee-benefit programs. The real benefit, however, goes to those already in nursing homes or paying for qualified care at home. In 1997, they will be able to deduct this cost as a medical expense.[43]

However, federal language defining eligibility for LTC benefits is more restrictive than what is currently in place in many states. The conflict lies specifically around the level of disability a policyholder must meet in order to collect benefits. It is already known that laws in Kansas, Texas and California are less restrictive in regard to this, but how many other states will be in conflict with federal law is unknown. Policies that have been issued by the end of 1996, that have met current standards in each state, will be eligible for tax deductions, but policies issued in 1997 could have trouble. Unless states tighten eligibility rules to conform to federal standards, residents may not be able to purchase policies that qualify for the tax break. But if standards are tightened, then it could be more difficult for residents to qualify for benefits.[44]

In other areas, a report released in August of 1996 by the Congressional Budget Office (CBO), identifies two primary reasons for the accelerated growth in Medicare's costs in relation to national income: the increase in the number of beneficiaries and the increase in cost per beneficiary. CBO discussed a number of options to limit Medicare's long-term costs, including raising the age of eligibility; increasing the cost-sharing requirements for beneficiaries; and restructuring the Medicare market to provide more competition and create greater incentives to make cost-effective health care choices.

Additionally, the National Conference of State Legislators reports that states are paying more for LTC than 10 years ago, mostly in increased Medicaid costs.[45] Despite the fact that legislators express interest in developing LTC insurance and other funding mechanisms, the elderly still have a significant amount of uncovered liability and rising out-of-pocket costs, all in addition to the indirect and unmeasured cost to family and friends.

According to Gail Wilensky, senior fellow at Project HOPE and former senior health policy advisor in the Bush administration, one of the biggest

Elderly still have a significant amount of uncovered liability and rising out-of-pocket costs, all in addition to the indirect and unmeasured cost to family and friends.

[42] Christine E. Bishop, review of *Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance*, by Joshua A. Wiener, Laurel Hixon Illston, and Raymond J. Hanley, *Journal of Health Politics, Policy and Law* 20 (1995):812.

[43] *Columbus (Ohio) Dispatch*, 11 October 1996.

[44] *Wall Street Journal* (New York), 29 August 1996.

[45] (National Conference of State Legislators, 1996)

roadblocks to Medicare reform is that there is nothing in the immediate future to force the issue. She also noted that if Medicare reform is not addressed in 1997, it will likely be avoided until the beginning of the next century. "Neither side has told the public how hard it will be to buy one more decade (of Medicare)...and as each year without reform goes by, reform options will dwindle."[46] States could infer from this that they should be opening their own policy window.

Options

Current projections on the growth, size and diversity of the future LTC population have implications for how public and private policy is formed for programs, care delivery and funding mechanisms. Studies have shown that most people of all ages who need LTC live in the community, not in institutions.[47] Therefore, home care options will become increasingly important. Additionally, Medicare and Medicaid funding at their present levels cannot be guaranteed, therefore creating and encouraging funding mechanisms that are independent of state or federal dollars also gain importance.

The current system has been accused of encouraging people to purposely "spend down" and "estate plan" in order to qualify for Medicaid benefits. Although the extent of this has yet to be proven, the argument still exists that if innovation is to be introduced into LTC, it is important to remove the ability to "fall back" into the old system.

The following are policy options to consider:

- *Foster incentives for the purchase of LTC insurance.* (See section on LTC insurance, specifically recent federal legislation.)
- *Create LTC Savings Accounts,* similar to Medical Savings Accounts (MSAs) and/or enable those with MSAs to convert a portion of the savings to payment for LTC.
- *Determine if existing LTC Insurance Partnerships are cost-effective.* If so, develop this option in Ohio.
- *Require mandatory pensions or personal retirement accounts.* This would entail a fully funded, privately managed and portable system of retirement accounts. The Competitiveness Policy Council (a publicly funded bi-partisan group) reported that giving tax favors for saving did not increase net savings (the savings beyond the cost of the tax incentive that encourages them). The net effect from this approach has been marginal largely because so much of the money funneled into IRAs was shifted out of other investments.[48]
- *Create a system that requires a LTC provider,* such as nursing homes, home health care services, etc. that receive state or federal funds, *to enter a competitive contract bidding process with the state in order to provide those services.*
- *Research Social Health Maintenance Organizations (S/SHMOs) to determine if they are cost-effective.* If so, develop this option in Ohio. The concept of S/SHMO began in 1985 and is credited to Brandeis University. Similar to HMOs, these organizations provide services for a fixed, monthly pre-paid fee. In order to retain profitability, the S/SHMO emphasizes usage of adult day care, home care and support services rather than institution-based care (which would be capped). Case management is also utilized.

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[46] CCH Chicago Bureau, "Medicaid, Not Medicare, Reform More Likely in 1997," *Medicare and Medicaid Guide* (Commerce Clearing House, Inc.), no. 924 (1996): 4-5.

[47] (U.S. General Accounting Office, 1995,1)

[48] (Peterson 1996, 80, 82)

- *Encourage the establishment of employee assistance programs for caregivers.* In a 1982 survey of more than one million family caregivers with jobs, 21 percent worked fewer hours to meet their home caregiving duties; 19 percent took leave without pay; and 9 percent quit their jobs to become full-time caregivers (internet cite)

- *Integrating Medicaid/Medicare Funding.* According to the federal government, there are an estimated 3.7 million elderly nationwide who are dual eligible for Medicare and Medicaid. In current practice, Medicare is the primary source of funding for acute care for the elderly, while Medicaid is the primary source of funding for long-term care. Currently, both programs pay for a variety of home care services, but at different rates.[49]

  In August 1996, American Medical News reported that HCFA has approved a new waiver for the State of Minnesota to integrate Medicare and Medicaid payment systems in a managed care setting. Minnesota is in the final stages of planning, and five vendors are seeking the program contract. One of five will be selected to operate the program, which is scheduled to start in January 1997.[50]

  Minnesota's program is the first and only such waiver to be granted by HCFA. However, other states such as Wisconsin, Colorado, New York, and a consortium of six states in New England have all expressed interest in implementing an integrated Medicare/Medicaid HMO program. However, it should be noted that took Minnesota five years to negotiate its waiver with HCFA before finally receiving approval. The State of Arizona reportedly negotiated for two years with HCFA regarding a similar program, but chose to withdraw from the waiver approval process out of frustration.[51] However, advocates for the new concept hope that Minnesota has blazed the way for other states to negotiate their waivers in a shorter time frame.

- *Assisted Living - Nursing Task Delegation.* As stated earlier, Ohio's Department of Aging has decided not to implement an Assisted Living program due to cost concerns. According to the University of Minnesota's National Long-Term Care Resource Center, states such as Oregon have been successful in keeping the cost of its assisted living program at about two-thirds of the cost of nursing home placement, in part, due to successful nursing task delegation. Oregon allows unlicensed staff in assisted living facilities to perform routine nursing tasks, thus, reducing the cost of care.[52]

- *Sliding Fee Scales for In-Home Care.* As stated earlier, PASSPORT is a Medicaid Waiver program. Thus, it is designed to serve elderly individuals who are both frail and poor. The goal of the program is to allow poor elderly individuals to receive the care they need while remaining in their own homes, at a cost lower than that of nursing home care. The state will serve over 18,000 frail and poor elderly through the PASSPORT program in FY 1997. But what about the frail and low-income elderly who are ineligible for PASSPORT because they do not meet the Medicaid income requirements? Many such individuals end up in nursing homes sooner than is necessary. Because they have little income, they spend down their assets quickly and thus become Medicaid eligible, but not until after being admitted to a nursing home. The Department of Aging has

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[49] Page, Leigh, *New Approach to Long-Term Care for the Elderly*, American Medical News 1996, v39n30, August 12, p. 3

Page, Leigh, *New Approach to Long-Term Care for the Elderly*, American Medical News 1996, v39n30, August 12, p. 27[50]

[51] Ibid.

[52] *Oregon Keeps Assisted-Living Costs Down*, Public Health Reports 1996, v111n3, May, p. 189.

recommended the creation of a home care program for frail, low-income elderly. However, they have had to reluctantly withdrawal their proposal each biennium due to lack of funding. In addition, the department and the Legislature have agreed that serving the state's frail and poorest elderly population, not the frail and low-income (non-Medicaid eligible) elderly population, is the highest priority. However, the department believes that the demand for PASSPORT services is leveling off. Furthermore, at least one Area Agency on Aging, which includes Franklin County, is using local levy dollars to fund home care services for persons who are both frail and low-income using a sliding fee scale. Perhaps that program could serve as a model for program for other service areas. However, additional alternative funding would be needed.

- *Legislated Reduction in the Number of Nursing Home Beds.* While states like Ohio have placed a moratorium on the construction of new nursing home beds, at least two states, Washington and Oregon, have been successful in reducing their number of nursing home beds by law. According to the Public Policy Institute of the American Association of Retired Persons, Washington State authorized special time-limited payment incentives in 1995 to be given to nursing facilities that were willing to convert to assisted living and required that the number of nursing home beds in the state be reduced by 750. Furthermore, both Washington and Oregon have set goals in law regarding the number of nursing home beds per 1,000 individuals age 65 and older. All of these measures have been successful.

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