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*Medicare, Medicaid
and Managed Care*



**THE ISSUE OF AFFORDABILITY
PUBLIC AND PRIVATE FINANCING**

1

This module will address major sources of funding for seniors' housing:

Medicare: A huge, broad-range entitlement program that has revolutionized seniors' health care over the past 35 years.

Medicaid: By far the largest funding source for long-term care, Medicaid has had a major impact on both the accessibility of such care and the development of the industry. Major question: what kinds of programs will Medicaid fund in the future and with what regulations?

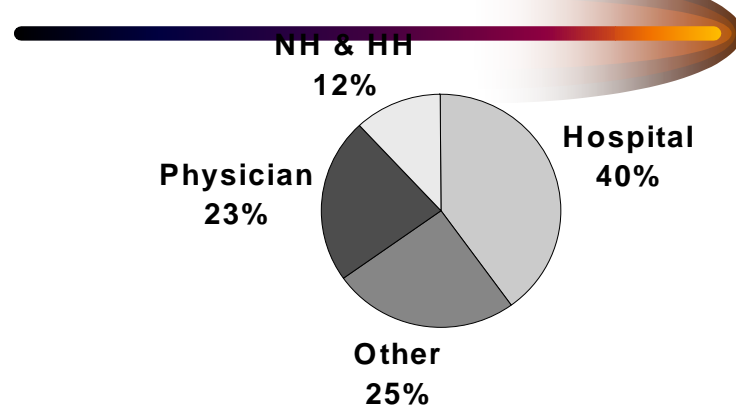
Managed Care: The new player on the block has become a major—and controversial—funder of medical care. How will managed care fit in with Medicare, Medicaid, and private funding?

Long-term Care Insurance: Currently a minor source of funding, but could influence the market by broadening choices available to seniors needing long-term care.

NOTES:

The Johns Hopkins Bloomberg School of Public Health
 “Managing Long-Term Care Services for Aging Populations”

Spending on Personal Health Care



2

The American population as a whole spends the percentages shown for different types of health care. As might be expected, use of hospitals and nursing facilities increases with age.

On a dollar basis, the average senior spends much more on health care as he or she gets older:

Age 65 – 69	\$5,864
Age 75 – 79	\$9,414
Age 85 and older	\$16,465

- Health care for individuals in institutions averaged \$38,906; those in the community averaged \$6,360.
- A small group of seniors consume a disproportionate amount of health care resources:

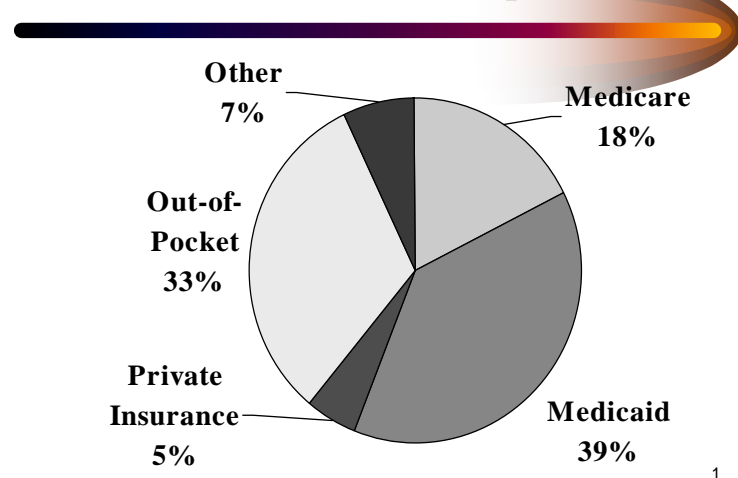
The top 1% of consumers use 13% of funding

The top 5% of consumers use 37% of funding

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LTC Expenditures



The Milbank Memorial Fund provides the following figures on seniors’ long-term care by source of funds:

Out-of-pocket	33%
Private insurance	5%
Other private funds	5%
Medicare	18%
Medicaid (federal)	22%
Medicaid (state)	17%
Other public funds	2%

Public funding sources include the following:

- **Supplemental Security Income (SSI)** provides financial assistance to aged, blind, and disabled persons whose income falls below established levels. Most states provide supplemental funding; 35 provide benefits for individuals in community-based non-medical residential facilities, such as assisted living.
- **Older Americans Act** provides states with funding for a wide range of supportive, noninstitutional services for the elderly. As the program’s funding is around \$1 billion per year, it is not a major factor in seniors’ overall health care costs.
- **Social services block grants** (part of the Social Security Act) provide grants for community-based or home-based care to prevent unnecessary institutionalization. However, the funding is primarily designed to support local social services and is not targeted specifically to the elderly, so the grants provide negligible funding for seniors’ health care.
- **State funding.** Most states provide some additional level of funding, but amounts vary greatly.

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Medicare: The Essentials

- All Elderly (34 Million + Five Million Disabled) Are Covered
- Part A (Institutional) and Part B (Services)
- Entitlement Based on Payroll Taxes
- Minimal Cost Sharing Required
- Acute Care Orientation
- Freedom of Choice Critical Component of Program

4

Coverage: Not surprisingly, the Federal Government’s Health Care Financing Administration predicts that these numbers will increase to 46 million elderly and 9 million disabled by the year 2017.

Medicare funding sources: Part A, primarily hospital costs, is financed through the Medicare Trust Fund, through payroll withholding. Part B, physicians’ care, is nominally paid by

individual premiums (approximately \$50 per month) but is further subsidized out of general tax revenues.

Payroll withholding: Medicare withholding is currently 2.9% of all salary/wages or self-employment earnings. That amount is paid on the first dollar earned, unlike income tax, and is paid on all income, unlike social security taxes.

Cost sharing: Co-payments (20%) and deductibles (about \$800 for hospital stays) are applied to most Medicare services.

Acute Care: Medicare tends to fund acute care over preventive and long-term care

Freedom of Choice: Seniors have considerably more latitude in selecting physicians and facilities than do many younger people with more restrictive health plans.

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Medicare Pluses



- \$\$\$\$\$
 - In 1960, 55% of Costs Were Out-of-Pocket
 - Today, 48% Are Out-of-Pocket
- Provides Peace of Mind for Most Elderly
- Serves As Critical Component of Financial Support Mechanisms for Elderly
- Allows Access to Mainstream Medicine

5

Medicare has successfully met many of its objectives, such as reducing seniors’ out-of-pocket medical expenses.

By virtually any measure, the introduction of Medicare has led to a dramatic increase in seniors’ overall quality of life. For example, the significant decrease in the number of elderly people in poverty has dropped from 28% in 1960 to the current 10%; the fact that Medicare has enabled many people to avoid depleting their assets to fund medical care may be a significant cause of this change.

Two developments have significantly affected Medicare:

- Dramatic improvements in the number, range, and effectiveness of pharmaceuticals—and their cost.
- The expansion of types of long-term care available to seniors, but not covered by the program.

Still, Medicare continues to provide seniors a level of medical security previously unknown in the U.S.

NOTES:

Medicare Minuses



- Inverse Correlation Between Coverage and Chronicity
- Can Actually Stimulate Inappropriate Care
 - Doesn’t Cover Long-Term Care, Drugs
 - Bias toward Institutionalization
- Less Comprehensive than Medicaid
- Incredible Geographic Variation
 - \$1,768 annually in Wyoming vs. \$4,557 in California

6

As seniors get older, they require different types of coverage, including addressing the previously discussed tendency for seniors to require care for chronic, not acute, conditions. However, Medicare is structured as if recipients needed only short-term care.

Medicare does not cover many forms of treatment or (at this time, at least) some prescription drugs that might prevent later, more extreme and costly care. As a result, a recipient may need to be hospitalized either because of inadequate preventive


care or because he or she does not have the resources to pay for alternative forms of treatment.

Neither is Medicare designed to pay for long-term care. The patient must begin treatment within 30 days after a three-day (or longer) hospitalization for an acute condition. The program will cover up to 100 days in a nursing facility, but the \$99.50/day co-pay makes the benefit of little value to most seniors. As a result, only 1% of Medicare’s budget pays for long-term care.

Because of these and other regulations, Medicare covers only 52% of beneficiaries’ health costs. Further, the cost of care varies dramatically by state. Benefits vary accordingly; for example, in Wyoming, Medicare pays on average \$1,768 in annual benefits per beneficiary, compared to California’s \$4,557.

NOTES:

Medicaid (Title XIX)



Plays Three Critical Roles:

- Makes Medicare Affordable for Low Income Elderly
- Covers Benefits Medicare Doesn't
- Virtually Only Public Source of Financing for Long Term Care

7

Because Medicare covers barely half of seniors' medical costs, lower-income elderly people often need additional assistance to obtain adequate health care. This is a significant population: 43% of seniors—13 million people—have incomes below \$15,980 for one senior living alone, \$20,150 for two seniors in one household (these figures represent 200% of the poverty level.) Clearly, individuals in this income range could not afford long-term care without significant financial support.

Seniors in this income range also have greater health needs, perhaps because of poorer nutrition, life-long lack of adequate preventive health care, less healthy living conditions, and other factors.

Medicaid has successfully met its intended goal of providing greater access to health care to low-income seniors: such seniors without Medicaid pay 35% of their income for health care; those who are eligible for both Medicare and Medicaid pay only 8%.

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Medicaid Essentials



- Means-Tested
- Entitlement
- 51 State Programs/Four Population Groups
 - Low Income Families (73%, but 27% of \$\$)
 - Disabled (15%, but 31% of \$\$\$)
 - Elderly (12%, but 28% of \$\$)
- \$9,300 per Elderly Beneficiary; \$1,200 per Child; \$2,100. per Low Income Adult

8

Entitlement programs, such as Medicare and Social Security, are available to all individuals who meet a given criteria (such as being 65 or older.) Medicaid is a “means-tested” program; eligibility is based at least partially on income. Such programs are more difficult and expensive to administer.

Medicaid covers 4 million Americans over 65, 10% of the elderly population. Most of the spending (55%) is for services, such as prescription drugs and hospice care, that are provided at the state’s option. In addition, 36 states have “medically

needy” programs that extend coverage to individuals impoverished by very high health care costs.

There are five requirements for Medicaid eligibility:

- Categorical (disabled, aged, children, pregnant women)
- Income (under a specified threshold)
- Resources (assets, from bank accounts to homes)
- Immigration status
- Residency

The program has strict methodologies and standards to establish income and resource levels and determine an individual’s eligibility for services.

While four population groups receive benefits, each group receives a disproportionate level of funding per person:

Population Group	% of Pop.	% of Funding
Low-income families	73%	41%
Disabled individuals	15%	31%
Elderly	12%	28%

Virtually all senior recipients are also covered by Medicare.

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Eligibility



- Categorically Qualified (SSI)
 - 75% of Poverty Level (\$7,990 in 1999)
 - 2.1 Million Eligibles
- Medically Needy
 - Offered in 36 States
 - .8 Million Eligibles
- Low Income Medicare (QMBs)/Others
 - 1 Million Eligibles

9

To qualify for Medicaid, the recipient must have an income that is no more than 75% of the poverty level. As previously noted, the 1999 poverty level was \$7,990 for a senior living alone, \$10,075 for two. By this standard, just over 2 million seniors are qualified.

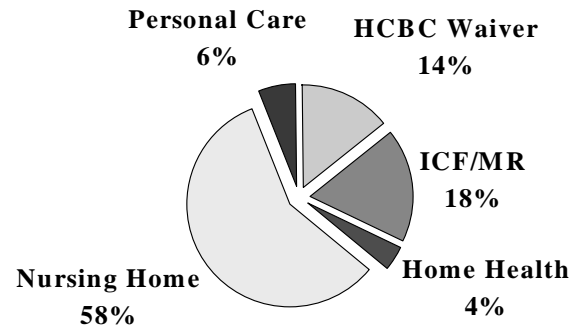
Medically needy programs offered in 36 states provide coverage for 800,000 million individuals.

Low income Medicare and other programs for low-income seniors cover another one million people.

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Medicaid LTC Spending: 1997



10

About 75% of Medicare’s spending for the elderly is for hospitals and managed care. Typically, almost all of the funding is for acute, rather than long-term care.

Conversely, Medicaid is the primary public funding mechanism for long-term care. The “spend-down” aspect of Medicaid (i.e., becoming poor because of large health care expenses) is the primary reason for this.

Within the Medicaid program, the bulk of expenditures are oriented toward institutional care, primarily nursing facilities.

Very few Medicaid dollars go into assisted living. No funding is available for independent living or congregate care.

NOTES:

Medicaid Pluses



- Enhances Medicare for Low Income Elderly (and Their Greater Needs)
 - 5.4 Million Dual Eligibles
 - 16% of Medicare Recipients, 30% of Costs
 - 17% of Medicaid Recipients, 35% of Spending
- Only Real Source of LTC and Prescription Drug Coverage

11

Like Medicare, Medicaid has clearly met its objective of providing health care services to the country’s poorest seniors. While the elderly are a small percentage of Medicaid recipients (17%), the program is the largest insurer of long-term care for all Americans, including the middle class. Medicaid covers 66% of nursing home residents and over 50% of nursing home costs.

Spending levels are disproportionate, however. The increase in spending for the elderly recipient has grown much more rapidly than the population to its current level of 35% of

all Medicaid payments—nearly double the percentage of seniors receiving benefits. (A similar discrepancy exists for Medicare: 16% of recipients receive 30% of the benefits.)

Although such services as long-term care and prescription coverage are optional, most states provide these and/or other services that are virtually unattainable except through Medicaid.

NOTES:

Medicaid Minuses



- Impoverishment (Medicaid Is A “Welfare Program”)
- Subject Solely to State Political/Financial Vagaries
- Limited Public Support
- Access Problems for Many Services and Beneficiaries
- Institutional Bias

12

Impoverishment: Unlike Social Security and Medicare, Medicaid is largely seen as being strictly for the poor and therefore a “welfare program.” It thus tends to have less popular support than those programs.

Variations: Although Medicare costs vary by state, its benefits are standardized. In Medicaid, both costs *and* benefits vary. States’ benefit costs vary by as much as 2.5:1. The wide range of states’ options plus changes in policy can make benefits unpredictable and inconsistent among states.

Further, states have unlimited authority to set rates to providers at whatever level they choose.

Limited public support: In addition to the “welfare program” perception, the wide range of people receiving benefits can create animosity that becomes generalized to all recipients.

Access problems: Given chronic low payments to providers (and their disinclination to participate in the program), access to health care services can be limited in some states.

Institutional Bias: Like Medicare, Medicaid is more likely to pay for institutional long-term care than home and community-based services.

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Proposals for Reform



- Bloc Grants
- Managed Care
- Reduced Coverage
- Limit Eligibility
- Provider Payment Reform
- Cost Shifting
- Eliminate QMB Coverage

13

These and other proposals all have their advantages. Each proposal also has a constituency that strongly advocates it and another that is equally strong in its opposition. Proposals for reform of Medicaid are compounded by the fact that it has, in the states, clearly interested participants in the process. And for Medicare, add the fact that seniors are a powerful voting block (if only because of the high percentage who vote regularly), and reform becomes a very touchy political issue.

There is increasing agreement that Medicare and Medicaid must be modified in some way to continue being financially

viable. What is less certain is how and when the political process will achieve this objective.

NOTES:

Managed Care Essentials



- Designed to Better Coordinate the Delivery of Services As Well As Finance Coverage in a Cost-effective Manner
 - Primarily Through Risk-sharing
 - And/or Care Management
- 12.7 Percent Medicare Enrollment (Twenty Percent for Total Population)
- But Rate of Growth Twice That of U.S (until recently).

14

Managed care was a major controversy in the last election and is likely to continue as such. Such programs have several advantages and disadvantages; their future form will probably be determined by the marketplace, political decisions, and other developments within the health care system.

Several issues must be addressed as managed care continues to expand, including:

- An argument can be made that managed care is not well-designed to handle chronic conditions or require

ments, such as long-term care. Can managed care respond to this environment?

- Can managed care respect and work with the very personal and broad-ranging choice of where seniors may live the rest of their lives?
- Managed care organizations rely largely on their ability to coordinate care; what kind of role will they play in states and localities that have already established such networks through local providers?
- Can long-term care providers adapt to the managed-care environment? Or would it be more effective for providers to adapt services to respond to the new guidelines?
- How can the quality of long-term care be monitored? Who will be responsible for quality control?

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Managed Care Pluses

- Better Coordinates Services
- Potential to Manage High Cost Cases
 - Care Delivered More Efficiently than FFS
- Does Away with Need for Medigap Policies
- Provides Comparable Quality/More Prevention/High Satisfaction
- Controls “Bad” Providers
- Allows Supplementation

15

Additional advantages of managed care for seniors:

- Managed care organizations are better situated than others to identify and promote preventive/maintenance care rather than respond to single acute incidents. Such care might include:
 - Routine physicals and dental care
 - Immunizations
 - Outpatient drugs
 - Eye and ear examinations

- Health education

- Podiatry

- Lenses and hearing aids

- Their information systems can track patients over time and provide information to service providers regarding patients’ status and any unusual circumstances.
- Managed care can effectively coordinate patient care.
- Managed care has more flexibility than traditional organizations to identify approaches to patient care that may be more effective and less expensive.
- Managed care’s aggressive monitoring of high-risk patients can reduce the need for hospital care.
- Seniors and, possibly, the government can save money through managed care. In fact, there has even been some reduction in fee-for-service costs where managed care has a high level of penetration.

NOTES:

Managed Care Minuses



- Loss of Choice
- Incentive to Undertreat (Ethical Issues)
- Incredible Geographic Variations
- Cost Savings May Be Ephemeral
 - Most Enrollees Healthier
- No Real Emphasis on Geriatric or Long Term Care
 - Exceptions: S/HMOs/PACE

16

Managed care has both explicit and implicit barriers to health care:

- Explicit requirements are written into policy or otherwise directly stated. For example, the company probably will not cover elective cosmetic surgery.
- Implicit barriers relate to the structure of managed care and procedures for reimbursing providers. A physician might not recommend a type of procedure because it would reduce his or her bonus from the insurer.

Additional minuses of managed care for seniors:

- Changing providers: Managed care may require seniors to change doctors or facilities, which can be painful for someone who has developed a relationship with his or her physician.
- Access only to specified hospitals: Again, reduced choice could be difficult for some seniors, even if the new facility is as good or better than the one they’ve come attached to.
- Restricted access to specialty care and tests: The primary care physician’s controversial role as gatekeeper can be particularly significant for seniors, who often need a high level of specialty care.
- Limited coverage of medications: Some medications may not be covered under the plan, causing financial hardships or even inaccessibility to some drugs. In other cases, the seniors may be required to take less-than-ideal substitute medications.

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LTC Insurance Essentials

- Over Six Million Policies Sold To Date
- 119 Companies (in 1997) Selling Policies
- Average Age of Buyer
 - 66 (Individual/Group Association)
 - 45 (As Part of Life Insurance Policy)
 - 43 (Employer Sponsored)
- Seven Out of Ten Companies Over 9 Years in Market

17

Long-term care insurance’s significance is more potential than actual, since only 3% of potential policyholders are currently insured. The percentage may increase, however, particularly as more employers offer policies (often through “cafeteria-style” benefits). Further, policies may become more affordable as a larger number of people obtain policies and insurers obtain more actuarial experience.

A Health Insurance Association of America study of long-term care insurance found the following:

- About 80% of policies are sold in the individual and group association markets.
- Employer-sponsored and life insurance markets are increasing (2100 employers now offer long-term care insurance as a benefit.)
- Policy holders annually spend about \$700 million in premiums.
- Premiums vary dramatically according to age and provisions, although premiums have remained stable.

Overall, long-term care insurance continues to become more common, suggesting it may become a significant source of funding for seniors’ care. A key factor, however, is how many employers begin to offer this insurance as a benefit to their employees. Doing so reduces the cost of the premiums and encourages younger people to consider obtaining the insurance.

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Typical Services Covered

- Nursing Home Care
- Assisted Living Facility
- Home Health Care
- Alternate Care
- Hospice Care
- Respite Care

18

Long-term care policies may cover such services as:

- Care coordination or case management
- Homemaker or chore services
- Restoration of benefits
- Bed reservation reimbursements
- Medical equipment
- Home-delivered meals
- Spousal discounts
- Survivorship benefits

- Caregiver training

Typical factors in determining eligibility for benefits are deficiencies in performing ADLs and determination of cognitive impairment. The policies themselves also offer flexibility and protections for the policyholder:

- Typically, waiver of pre-existing condition limitations under specified conditions
- Broadened age limits for purchasing policies, in some cases from 18 to 99 years old (although the latter is unusual)
- Inflation protection for benefits
- Nonforfeiture benefit

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Premiums



Age	Base	Inflation	Forfeit	Both
40	\$274	\$595	\$357	\$770
50	\$385	\$888	\$485	\$1,110
65	\$1,007	\$1,850	\$1,232	\$2,305
79	\$4,100	\$5,880	\$4,779	\$7,022

19

These average levels are representative, but actual premiums vary dramatically, even for identical coverage. Perhaps more than any other type of insurance, some “shopping around” is truly warranted.

A quality policy will offer the following features:

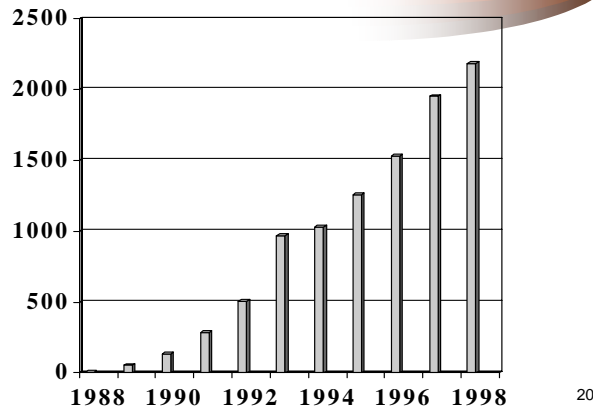
- An inflation rider, typically 5% per year. Otherwise, the value of the policy may not remotely cover costs once the insured person requires care.

- A non-forfeiture clause that enables the insured to receive some of the premiums back upon surrendering the policy.
- Premiums stay the same with no increase as the insured ages.

There is some question as to whether such provisions should be mandated by the government. The provisions are important, but should the government supplant customer choice in making such decisions?

NOTES:

Employer Sponsored Plans



As previously noted, employer-sponsored plans are becoming much more common and may significantly increase the percentage of adults obtaining long-term care insurance. In addition, the broader coverage may reduce insurance premiums for the general population, particularly since employer-sponsored and private plans are comparable.

Unfortunately, while employers offer the plans, most do not pay for them. And it is too early to judge whether the insured employee will continue the coverage once retired.

Recently enacted legislation providing long-term care coverage to federal employees might encourage more private-sector employers to offer coverage.

NOTES:

LTC Insurance Pluses



- Relieves Pressure on Public Funding
 - Enhances Safety Net for Those in Need
 - Improves Quality of Medicaid Providers
- Facilitates Customer Choice
 - Reduces Pressure for “Cookie Cutter” Models
 - Promotes Growth of Different Approaches to Care

21

Long-term care insurance can enhance the safety net for those in need, providing an independent source of funds that can supplement or even replace Medicaid funding and other programs without jeopardizing personal resources.

If insurance reduces Medicaid’s role as the primary payer for long-term care services, Medicaid might be able to more adequately fund participating providers. Such a step would enhance quality of care across the entire industry.

In fact, the availability of alternative funding sources can only increase the array of service modalities, provider types

and available settings. Hopefully, such a step would reduce the sameness of long-term care services, facilitating innovation and experimentation in long-term care delivery.

NOTES:

LTC Insurance Minuses



- Limited Penetration
- “Affordability”
- Slow Growth of Employer Sponsorship
- Competition from Medicaid
- Public Perception
- Lukewarm Government Support
- Geographic Concentration

22

Minuses occur on both the government and private levels.

Government issues:

- People may decide against long-term insurance. They assume that they will be eligible for Medicaid, so there’s no reason to pay the premiums. In fact, one guide recommends that people with assets of less than \$100,000 do not obtain long-term care insurance.

- Until recently, the government has not strongly supported this insurance, although qualified plans do receive a modest tax deduction.

Private issues:

- To date, only about 3% of eligible individuals have long-term care insurance. Unless this percentage increases, insurance will not be a significant funder of long-term care.
- Affordability is a real issue, since many people who could benefit from such insurance simply can’t afford it—and these are often the people most likely to need the funds as seniors.
- Although an increasing number of employers now offer long-term care insurance as a benefit, the percentage is still small.
- Public skepticism regarding the credibility of insurers may lead people to shy away from this relatively new product.
- Half of all policies have been sold in only nine states. If this pattern continues, the influence of insurance on

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housing for seniors will vary among states, with possible implications for investors.