

00001

FINANCING LONG-TERM CARE

00002

00003

POSITION PAPER

00004

00005

The American College of Physicians

00006

00007

April 10, 1989

00008

00009

00010 INTRODUCTION

00011

00012 This paper sets forth policy positions of the American College of Physi-
00013 cians concerning methods for financing long-term health care. It
00014 builds upon a previous information paper and public policy position
00015 statements of the College, and presents ACP recommendations for the
00016 profession and for national policy.

00017

00018 BACKGROUND

00019

00020 On November 14, 1987, the Board of Regents of the American College of
00021 Physicians adopted an information paper on Financing Long-Term Care
00022 /1. The paper recounted activities undertaken by the College to
00023 highlight some of the problems hindering attainment in the United
00024 States of a comprehensive, coordinated and continuous system of long-
00025 term health care. It also noted that the College had previously taken
00026 the position that the costs of major illness, including long-term care,
00027 should not prevent Medicare beneficiaries from receiving needed health
00028 care services /2. Next, it provided pertinent facts about the need
00029 for and financial costs of long-term health care. Finally, the informa-
00030 tion paper analyzed current methods of financing (e.g., personal re-
00031 sources, Medicare, supplemental insurance, Medicaid, as well as the
00032 Canadian national health care system), and considered alternative fi-
00033 nancing mechanisms. The advantages and disadvantages of each of the
00034 following financing methods were presented: private insurance (beyond
00035 Medigap), employment-based long-term care insurance, self-insurance,

00036 vouchers, financing through Medicare, home equity conversions, and
00037 capitated case management plans.

00038

00039 SUMMARY OF POSITIONS

00040

00041 This paper consists of three positions. Position 1 is a reaffirmation
00042 of our principle that everyone should receive the long-term health care
00043 services that they need. Position 2 declares that a national financing
00044 program is required. Position 3 presents the College's recommendations
00045 for the financing mechanism that will be needed.

00046

00047 POSITION 1:

00048

00049 All Americans should be able to receive long-term health care
00050 services of good quality in accord with their individual medical
00051 and functional needs.

00052

00053 RATIONALE

00054

00055 Long-term care involves personal care and supervision on a continuing
00056 basis for an extended period of time for persons who are frail and
00057 dependent due to chronic physical or mental impairments. It includes
00058 medical support services to allow maximum possible independence, treat
00059 acute exacerbations of chronic illness, maintain and restore the indi-
00060 vidual to the optimal level of functioning that can be sustained, pre-
00061 vent avoidable deterioration of health when possible, as well as to
00062 sustain a person when further deterioration is unavoidable. Long-term
00063 care includes diagnostic, preventive, therapeutic, rehabilitative,
00064 supportive, and maintenance services in both institutional and non-in-
00065 stitutional settings. Individuals of all ages may require long-term
00066 care for assistance with basic activities of daily living; however,
00067 because the need for such assistance increases dramatically with age,
00068 most people in need of long-term care are very elderly (over age 80)
00069 /1,2. Long-term health care is a necessity for frail and functional-
00070 ly dependent persons; it is not a luxury. In economic terms, long-term
00071 care can be seen as a trade-off against the large, but not easily mea-

00072 sured, costs of avoidable acute illnesses or accidents; avoidable or
00073 postponable declines in functional status that result in institutional
00074 care or more intensive home care; and the loss of income tax revenues
00075 which would otherwise be paid by functionally rehabilitated patients
00076 and by fully employed family care-givers.

00077

00078 The ACP has long maintained that there should be a comprehensive, coor-
00079 dinated, and continuous system of long-term care, and that access to
00080 needed care should not be denied because of costs /3. Yet, the avail-
00081 ability of appropriate long-term care services and the means to finance
00082 them remain outside the grasp of many frail and dependent Americans.
00083 Long-term care is the most catastrophic out-of-pocket health care ex-
00084 pense for older Americans, and nursing home care is the largest compo-
00085 nent of paid long-term care, accounting for 60% of non-hospital and
00086 non-physician costs /4. For those 18% of nursing home residents who
00087 stay for two years or more, the average cost is in excess of \$40,000
00088 /5. About half the costs of nursing home care are paid directly by
00089 the elderly and/or their families. Individuals and families can also
00090 face non-institutional costs that are equally or more expensive. These
00091 high costs, coupled with the limitations and inadequacies of Medicare
00092 and private insurance, force many of those in need of long-term care to
00093 resort to public assistance.

00094

00095 In 1986, it was estimated that half of all nursing home residents cov-
00096 ered by Medicaid were not initially poor, but "spent down" their sav-
00097 ings and liquidated their assets before attaining Medicaid eligibility
00098 /6. Prior to passage of the Catastrophic Health Insurance law of
00099 1988 (P.L. 100-360), once a nursing home resident became eligible for
00100 Medicaid, practically all of the recipient's income and resources had
00101 to be devoted to the costs of his or her care. All of a married cou-
00102 ple's income, except for a small monthly maintenance allowance for a
00103 spouse residing at home, was considered to be available to the Medicaid
00104 recipient. Consequently, non-institutionalized spouses of Medicaid-cov-
00105 ered nursing home residents typically were also impoverished and often
00106 required public assistance. The catastrophic legislation now provides
00107 greater protection of the income and resources of the community spouse

00108 of an institutionalized individual who establishes eligibility for
00109 Medicaid.

00110

00111 The American College of Physicians believes that frail and dependent
00112 individuals and their families should not have to forgo needed long-
00113 term care services, nor should they have to become financially desti-
00114 tute in order to receive needed care. Although improvements have been
00115 made in the Medicaid program to provide some financial protection for
00116 non-institutionalized spouses of nursing home residents, such couples
00117 still must exhaust much of their income and resources before becoming
00118 eligible for any assistance.

00119

00120 A substantial responsibility for the care of sick and dependent people
00121 must remain with the family, but support services, including home,
00122 community, and respite care services, should be available to assist
00123 those who are frail and dependent and to ease the burden on family
00124 care-givers. All Americans should be able to receive comprehensive,
00125 coordinated, and continuous long-term care services in accord with
00126 their individual medical and functional needs.

00127

00128

00129 POSITION 2:

00130

00131 A national financing program is necessary to enable all Americans
00132 to obtain appropriate long-term health care services of good quali-
00133 ty. Beyond a basic level of protection provided through a nation-
00134 al financing mechanism, individuals should remain free to purchase
00135 additional services and to buy private insurance.

00136

00137 RATIONALE

00138

00139 The American College of Physicians believes that a national program is
00140 needed to provide a financing mechanism to assure that all Americans,
00141 regardless of age or socio-economic status, can obtain requisite long-
00142 term care services. Existing Medicare coverage for long-term care is
00143 inadequate. Requiring sick and dependent elderly persons to impoverish

00144 themselves to obtain Medicaid coverage is inappropriate. Other financ-
00145 ing mechanisms such as private long-term care insurance, self-insur-
00146 ance, home equity conversions and life care communities are not viable
00147 options for national policy, as they are not generally available to
00148 most people (see Appendix). A national program would assure that those
00149 in need of long term care would have financial access to appropriate
00150 services.

00151

00152 Long-term care services could be provided under the existing pluralis-
00153 tic system of health care delivery involving public and private, for-
00154 profit and not-for-profit health care providers. A publicly financed
00155 program could pay or reimburse covered long-term care expenses by using
00156 private insurance companies, non-profit organizations, quasi-public
00157 authorities, or government agencies. The program should be structured
00158 to support, rather than supplant, the role of the family. A national
00159 financing mechanism could be expected to induce an expansion of both
00160 public and private long-term care programs and facilities, so that
00161 needed services would increasingly become available.

00162

00163 Persons with the means and the desire to purchase services beyond those
00164 provided in a package of covered services could do so by utilizing
00165 their personal financial resources or private insurance. Increased
00166 consumer awareness of the need for long-term care insurance could in-
00167 crease the demand for private insurance.

00168

00169 Importantly, a national financing program for long-term care would
00170 relieve other public programs of a substantial financial burden. Medi-
00171 caid -- a program designed to provide comprehensive primary and acute
00172 care for needy families with children and to supplement the Medicare
00173 program for the elderly poor -- has become the largest source of funds,
00174 other than those paid directly by the elderly themselves, for nursing
00175 home care. In 1987, although the aged, blind and disabled comprised
00176 only 28% of Medicaid recipients, they accounted for 73% of Medicaid
00177 expenditures. Of the remaining approximately 27% of Medicaid payments,
00178 only 12.3% went for care of dependent children (down from 18.1% in
00179 1972), another 13% was spent for care of adults in families with depen-

00180 dent children, and about 2% was spent for "others". Medicaid now pays
00181 approximately 42% of the nation's total nursing home bill /7.

00182

00183 With the development of a national program of financing long-term care,
00184 resources could be refocused to better achieve Medicaid's mission of
00185 assuring that medical services are provided for the poor. Medicare
00186 could retain its focus on payment for hospital care and other acute
00187 health care services.

00188

00189 The American College of Physicians recommends that a national long-
00190 term health care financing program contain the following basic ele-
00191 ments:

00192

00193 a. Coverage should be universal, but provision of services
00194 should be based on individual medical and functional needs.

00195

00196 Eligibility for coverage under a national long-term care insurance
00197 program should not be income nor age related, but should be based sole-
00198 ly on medical and functional needs. Frail and dependent people in need
00199 of long-term care should be covered regardless of age. Consequently,
00200 attaining age 65 should not be a prerequisite for receiving coverage
00201 for long-term care services.

00202

00203 Universal coverage would achieve the greatest spreading of insurance
00204 risks among the entire population. Such a system of financing would be
00205 consistent with established insurance principles. It would reduce the
00206 risk of "adverse selection", that is insurance being bought by those
00207 most at risk, since all citizens would be enrolled. Basing benefits on
00208 medical and functional needs and requiring periodic functional status
00209 assessments would also reduce the risk faced of "moral hazard", that is
00210 the danger that people will use more services because they have insur-
00211 ance coverage. By covering basic services in a uniform and predictable
00212 manner with effective care management to achieve appropriate utiliza-
00213 tion of services, a publicly financed long-term care insurance program
00214 might further enhance the newly developing market for private long-term
00215 care insurance.

00216

00217 b. A package of covered benefits would need to be clearly de-
00218 fined.

00219

00220 Defining an appropriate minimum benefits package will require a substan-
00221 tial national effort requiring input from professionals in many differ-
00222 ent fields, including medicine, nursing, ethics, social work,
00223 geriatrics and gerontology, to name a few. This task will require
00224 consideration of the efficacy, appropriateness, value, and cost-effec-
00225 tiveness of various approaches in delivering long-term care services.
00226 Any national benefits package will have to be flexible enough to meet
00227 individual needs, but benefits will also need to be constrained within
00228 some set of nationally determined priorities.

00229

00230 Previous efforts to define a national long-term care benefits package
00231 have revealed that the task is much more complex than one would ex-
00232 pect. There are many grey areas where not enough is known about the
00233 effectiveness, value, or appropriateness of alternative types of servic-
00234 es and means of providing care. Consensus is also lacking on what
00235 services should be considered absolutely essential and which should be
00236 considered as optional, marginal or non-essential.

00237

00238 The American College of Physicians believes that these are critical
00239 issues which the medical profession must address. Our initial reaction
00240 is that a national long-term care insurance program should cover a full
00241 array of long-term health care services including home health, skilled
00242 nursing, custodial, ambulatory, mental health, hospice, respite, and
00243 adult day care at levels that enable the beneficiary to obtain needed
00244 services that are of good quality. We further tentatively conclude
00245 that benefits should include services in institutional, community, and
00246 home settings, depending upon the changing needs of the individual and
00247 the availability of appropriate services. The College will further
00248 address these issues and seek to develop its own priorities for long-
00249 term care services.

00250

00251. However, we suggest that a national commission, perhaps under the aegis
00252 of a body such as the National Academy of Science's Institute of Medi-
00253 cine, should also undertake such a study. The College would welcome an
00254 opportunity to contribute its expertise in helping to define the bene-
00255 fits that should be covered under a national long-term care financing
00256 program.

00257

00258 c. Medical and functional assessments are critical to assure
00259 appropriate use of long-term care services, including admis-
00260 sions to nursing homes, and should form the basis for eligi-
00261 bility standards.

00262

00263 Periodic, comprehensive, reproducible, and reliable functional assess-
00264 ments should be required to assure that patients receive appropriate
00265 levels of care in conformance with changes in their physical, cogni-
00266 tive, behavioral, and social needs /8. Eligibility standards will
00267 need to be developed to avoid excessive or inappropriate provision of
00268 services. Although coverage will be universal and benefits will be
00269 defined, it will also be necessary to determine at what level the indi-
00270 vidual qualifies to receive covered services. The program will require
00271 consistent standards for determinations of medical need and functional
00272 impairment, as well as objective criteria for determining the capabili-
00273 ties of the family and the home to provide certain services.

00274

00275 Case management or as we prefer, "care coordination" will also be neces-
00276 sary to assure that services are utilized appropriately and that Medi-
00277 care beneficiaries receive the services that they require. Care coordi-
00278 nation, implies that a health professional take responsibility for
00279 assessing a person's needs in an ongoing fashion, coordinating the
00280 provision of needed services, and simultaneously monitoring the quality
00281 of services provided. This may sometimes involve conflicts between
00282 pressures for cost containment and patient needs. However, the care
00283 coordinator should serve foremost as the patient's advocate. The care
00284 coordinator should not be responsible for determining the patient's
00285 financial resources or the financial obligations of the patient's fami-
00286 ly. These functions belong more appropriately within the scope of

00287 social agencies. Care coordination can be performed by non-physicians,
00288 but it should be noted that internists, by their training and experi-
00289 ence, are among the best qualified professionals to determine, provide,
00290 and coordinate needed long-term care services for elderly patients /3.

00291

00292 Utilization review, peer review and other quality assurance mechanisms
00293 will also be necessary to further assure that all services rendered are
00294 necessary and are provided cost-effectively.

00295

00296 d. The program should not rely upon copayments or deductibles
00297 as means of controlling the utilization of services.

00298

00299 The College favors evaluations of individual functional needs linked to
00300 case coordination and utilization review as appropriate means for con-
00301 trolling utilization. This is a critical feature of the program we
00302 envision. We do not favor imposing copayments or deductibles as a
00303 means of reducing inappropriate utilization. Research by the Rand
00304 corporation indicates that copayments and deductibles can reduce the
00305 use of services by poor persons under age 65, but both appropriate and
00306 inappropriate services are reduced /9. There have been no comparable
00307 studies for non-poor persons or for people age 65 and older. There-
00308 fore, the College would prefer that a national long-term care insurance
00309 program not contain copayment or deductible requirements, because of
00310 the documented risk of creating financial barriers to access to needed
00311 services.

00312

00313 Despite available evidence indicating that copayments reduce both appro-
00314 priate and inappropriate utilization without distinction, some believe
00315 that the cost savings of reducing that portion that may be inappropri-
00316 ate and enhancing consumer cost awareness necessitates use of
00317 copayments. In addition, as a political reality, introduction of
00318 copayments into a system gives the appearance of fiscal prudence.
00319 Therefore, if cost sharing is deemed necessary as a practical means of
00320 containing costs, we recommend that any co-insurance requirements be
00321 levied based on ability to pay with no requirements for those below
00322 some agreed upon income threshold. Evaluations of functional need and

00323 care coordination in the use of services would then act as deterrents
00324 to inappropriate utilization. Any cost sharing requirements should
00325 also be structured so that they do not create financial incentives for
00326 receiving care in particular types of setting. Thus, financial contri-
00327 butions for nursing home care might include an amount equivalent to
00328 costs for food and basic housing that the individual would otherwise
00329 bear if needed services were provided in the home or in a community
00330 setting. The financing mechanism could thus be neutral regarding the
00331 site of care, allowing the individual and family in conjunction with
00332 the care coordinator to make decisions based on where services can be
00333 obtained that best meet the person's overall needs.

00334

00335 e. Payments through the national program should be adequate to
00336 obtain covered services that are of good quality.

00337

00338 The American College of Physicians believes that payment levels in a
00339 national program of long-term care should be sufficient so that benefi-
00340 ciaries can obtain covered services that are of good quality. Payments
00341 could be made on an indemnity basis in which the national program would
00342 pay certain amounts for specific professional services. Beneficiaries
00343 and their families might then retain incentives to shop for cost-effec-
00344 tive care, but could choose to purchase additional amenities costing
00345 more than the indemnified amount. Other methods of payment are also
00346 possible. Regardless of the method used, the level of payment should
00347 be sufficient to enable those without other insurance or additional
00348 financial means to obtain access to services of good quality.

00349

00350 f. A mechanism will be needed to implement and administer the
00351 program.

00352

00353 Implementing and administering a new national program for financing
00354 long-term health care will not be easy. Many difficult public policy
00355 issues must first be resolved. Aside from the issue of how the program
00356 will be financed, which we address in Position 3, decisions will need
00357 to be made as to how the program is structured and administered. There
00358 must be a process for defining benefits, determining eligibility, set-

00359 ting standards, monitoring and assuring quality and appropriateness of
00360 care, and paying for services.

00361

00362 Should the program be administered through Medicare, which already
00363 covers 98% of the elderly for hospital insurance, or through some other
00364 mechanism? What would be the role of private insurers? What would be
00365 the role of case managers or care coordinators; what qualifications
00366 would they require; and who would they work for? Would payments and
00367 benefits be equal throughout the country or would there be some adjust-
00368 ments for regional, state or local differences in costs? At what level
00369 and through what mechanism would payments be made? How would persons
00370 obtain coverage and where would they obtain services? What standards
00371 would be required for institutional, community and home health care
00372 agencies; how would these standards be set; and what monitoring and
00373 review mechanisms would be required? What planning mechanisms would be
00374 necessary, if any, to assure availability and proper distribution of
00375 services? Obviously, there are many other administrative issues that
00376 would need to be worked out.

00377

00378 We have highlighted only a few of the many questions that need to be
00379 considered relating to the implementation and administration of a na-
00380 tional long-term care financing program. We suggest that these and
00381 other related questions should be addressed on an ongoing basis by a
00382 national, semi-independent governmental body of representative experts
00383 from the full spectrum of diverse fields involved in long-term care.
00384 We suggest that a national commission be established that would be
00385 similar to the Physician Payment Review Commission (PPRC) or the Pro-
00386 spective Payment Assessment Commission (ProPAC) to make recommendations
00387 concerning the development and implementation of a long-term care fi-
00388 nancing program. This commission would also have on-going monitoring
00389 and review responsibilities.

00390

00391 g. Funding should be provided to encourage and sustain health
00392 services research, education, and training in long-term care.

00393

00394 A national program to finance long-term health care must encompass the
00395 means to assure that services are provided as efficiently and effective-
00396 ly as possible. It should also promote education and training in long-
00397 term health care for both physician and non-physician health care pro-
00398 fessionals. Adequate investments must be made in both basic and ap-
00399 plied research to expand knowledge concerning care of those who are
00400 chronically ill or functionally dependent and to improve the quality
00401 and delivery of long-term care services. Funding will be needed for
00402 studies to better refine functional assessment capability, to improve
00403 understanding of the appropriate use of services, to increase knowledge
00404 on expected outcomes of various courses of treatment, as well as to
00405 identify cost-effective means of delivering care.

00406

00407 Likewise, it is critically important that the nation have an adequate
00408 supply of medical educators and financially viable academic institu-
00409 tions with appropriate training facilities to provide education and
00410 training for the health care professionals that will be needed to pro-
00411 vide long-term care services. Financial assistance in the form of
00412 grants and loans will also be required so that sufficient numbers of
00413 health care professionals are prepared to meet the nation's future
00414 health care needs.

00415

00416 In addition, the program should provide funds for educating the public
00417 about all aspects of long-term care, including information on the vari-
00418 ous options that are available.

00419

00420

00421 POSITION 3:

00422

00423 Numerous options exist for financing a long-term care insurance
00424 program. The American College of Physicians recommends that a
00425 financing mechanism be implemented that spreads the costs both
00426 broadly and equitably.

00427

00428 The Congressional Budget Office estimated that total spending for long-
00429 term care was \$4.5 billion in 1985. Nursing home care accounted for

00430 80% (\$35.8 billion) of this total. The Federal government paid \$14.4
00431 billion (32%) of these costs through Medicare, Medicaid, VA and other
00432 programs. State and local governments paid \$9.1 billion or 20% of the
00433 total, (\$8.2 billion of which was Medicaid). Private sources accounted
00434 for the remaining \$21.3 billion (48%). Of the private share, some
00435 \$19.8 billion or 44% of the total was paid out-of-pocket, and only \$1.5
00436 billion or 3% was paid by other sources including private insurance.
00437 Demographic projections of the elderly population indicate that the
00438 need for long-term care and the resulting costs will continue to rise
00439 /10.

00440

00441 The cost of a national program to finance long-term care would depend
00442 upon the benefits provided and the structure and administration of the
00443 program. Long-term care legislation introduced in 1987 by Congressman
00444 Claude Pepper, which would have expanded coverage primarily for home
00445 health care, was projected to cost \$4.5 billion in 1989 and was estimat-
00446 ed to total \$24.8 billion over a five-year period through 1992. Reve-
00447 nue for the program, primarily from eliminating the cap on income sub-
00448 ject to the Medicare payroll tax of 1.45%, was projected to be \$6.3
00449 billion in 1989 and \$30.6 billion over the five-year period /11.

00450 Another plan proposed by Senator George Mitchell would have covered 70%
00451 of skilled nursing home expenses for Medicare beneficiaries who quali-
00452 fied upon completion of a two-year waiting period. This plan was esti-
00453 mated to cost \$16-18 billion when fully implemented.

00454

00455 There is no doubt that additional costs would be incurred in implement-
00456 ing a national program that would assure access to long-term care ser-
00457 vices for all citizens in need of such care. Certainly, additional
00458 costs would be incurred in providing services to persons who otherwise
00459 would not receive needed professional care. However, benefits could be
00460 expected to include greater provision of services, reduction of unmet
00461 needs, better health, increased patient satisfaction with services
00462 received, reduced emotional and financial burdens on family care-giv-
00463 ers, increased satisfaction with life, and assurance that care will be
00464 available when needed.

00465

00466 The development and refinement of a financing mechanism is not within
00467 the expertise of the American College of Physicians. However, we would
00468 like to offer some suggestions that reflect our position in favor of a
00469 broad and equitable revenue base. The American College of Physicians
00470 favors careful consideration of several public financing options includ-
00471 ing raising revenues from general taxes, increasing excise taxes on
00472 targeted products, and raising estate taxes.

00473

00474 We believe that the broadest means of financing long-term care would be
00475 through general tax revenues. This would spread the costs over the
00476 entire tax-paying population. To the extent that the tax system is
00477 progressive, this would more equitably distribute the burden of financ-
00478 ing long-term care. This approach recognizes that the need for long-
00479 term care is not restricted to the elderly and that all of society
00480 benefits from having a mechanism that assures that everyone will have
00481 access to long-term care when they or their family require it.

00482

00483 Revenue raising options that might be considered include raising indi-
00484 vidual and corporate tax rates. Under current law, there are only two
00485 individual tax brackets. Individuals pay either at the 15% or 28%
00486 rate. Raising these rates to 16% and 30% respectively would yield 32.9
00487 billion in 1991. The cumulative revenue generated by this increase
00488 over the five-year period 1990-94 would amount to \$166.7 billion.
00489 Another option would be to place a flat 5% surtax on all individual
00490 taxpayers. This would yield \$24.0 billion in 1991 and \$121.4 billion
00491 over the same five-year period. Raising the maximum tax rate on corpo-
00492 rate income from the current level of 34% to 35% would increase Federal
00493 revenues by \$2.3 billion in 1991 and \$11.6 billion over five years.
00494 Similarly, a 5% surtax on corporate income would yield an additional
00495 \$6.0 billion in 1991 and a total of \$29.1 billion by 1994 /12.

00496

00497 Increasing excise taxes on products such as cigarettes, alcohol, and
00498 chewing tobacco, which have demonstrable adverse effects on health,
00499 would serve both as a means of raising revenue as well as a means of
00500 health promotion and disease prevention. Cigarette smoking is responsi-
00501 ble for more than 320,000 avoidable deaths in the United States per

00502 year /13. In 1984, approximately 3.6 million potential years of life
00503 were lost due to smoking. By contributing to heart and lung diseases,
00504 cancers, fires and other causes of mortality, cigarette smoking is
00505 responsible for almost 16% of all annual deaths in the United States.
00506 It is the single most preventable cause of death in this country. Yet,
00507 33% of men and 28% of women continue to smoke /14. Raising federal
00508 cigarette excise taxes from 16 cents to 32 cents per pack would in-
00509 crease federal revenues by approximately \$3 billion per year over the
00510 next five years /15. The current tax, which was last raised in Janu-
00511 ary 1983, represents less than 15% of the current average market price
00512 (it was 42% in 1951). Increased excise taxes paid by smokers would
00513 offset some of the smoking-related long-term medical costs borne by all
00514 taxpayers, and to the extent that smoking is discouraged, would help
00515 increase health.

00516

00517 Increasing excise taxes on alcoholic beverages could also be justified
00518 by the social costs of drinking (e.g., health related costs of disease
00519 and medical and social costs due to alcohol-related automobile acci-
00520 dents). The Congressional Budget Office (CBO) notes that the per-unit
00521 taxes on beer and wine have not changed since 1951. Increasing the
00522 taxes on these beverages to the alcohol-equivalent of the current tax
00523 on distilled spirits would raise \$21 billion in 1989 through 1993. The
00524 CBO further notes that although the tax on distilled spirits was in-
00525 creased to \$12.50 per proof gallon effective October 1, 1985, this was
00526 the first increase in that tax since 1951 when the rate was \$10.50 per
00527 gallon. Raising the tax to \$15.00 would yield an additional \$2 billion
00528 in revenues through 1993 /15.

00529

00530 An increase in Federal estate taxes might also be a reasonable means
00531 for funding some of the costs of a long-term health care financing
00532 program. Such taxes would yield Federal revenues without placing a
00533 burden on the users of long-term care services during their lifetimes.
00534 Inheritance taxes have been substantially reduced since enactment of
00535 the Economic Recovery Tax Act of 1981. That law provided a credit that
00536 exempted from taxation all estates valued at under \$325,000 in 1984 and
00537 gradually raised the exemption threshold to \$600,000 by 1987. The

00538 maximum tax rate on inheritances was also reduced from 70% to 50% over
00539 a four-year period. The CBO notes that the changes in the amounts
00540 exempted from estate taxes were intended to adjust for changes in
00541 property values due to inflation, but that some would argue that the
00542 adjustments had been too large since inflation rates were lower than
00543 anticipated in 1982. Lowering the credit to the 1982 level adjusted
00544 for inflation would exempt the first \$225,000 from taxation and raise
00545 nearly \$15 billion in 1990 through 1994. This would affect only about
00546 5% of all estates /12. Restoring estate taxes to their previous
00547 levels would provide a fair means of taxation based on wealth, allowing
00548 individuals to maintain their assets during their lifetimes and during
00549 that of their spouses.

00550

00551 We have identified only a few of the potential means of raising Federal
00552 revenues that could be used to finance a national system for assuring
00553 access to health care. Many other means of increasing Federal revenues
00554 or decreasing spending in other areas are possible.

00555

00556 Another approach would be to create a new Medicare Part C with separate
00557 funding; this could be financed by progressive payroll taxes, beneficia-
00558 ry premiums, or both. Eligibility to the new Part C could be extended
00559 to people in need of long-term care services regardless of age, in a
00560 manner similar to the current Social Security disability insurance
00561 program, but without the same requirements for a minimum contribution
00562 period.

00563

00564 Public policy should also permit creative financing arrangements such
00565 as those that enable the elderly to convert the value of their home
00566 equity for the purchase of long-term care services or insurance. Simi-
00567 larly, public policy should encourage self-insurance through savings,
00568 individual medical accounts, and by other means. Other financing mecha-
00569 nisms that should be considered include the delivery of long-term care
00570 services through prepaid case management plans, social health mainte-
00571 nance organizations, and continuous care communities. None of these
00572 options should be precluded; a multitude of long-term care delivery and
00573 financing mechanisms may be desirable.

00574 SUMMARY

00575

00576 The American College of Physicians believes that everyone should have
00577 access to the health care services that they need. Currently, this is
00578 not the case, and persons in need of long-term health care, particular-
00579 ly the frail and elderly, often cannot obtain the services they need
00580 because they do not have sufficient personal financial resources and
00581 lack adequate insurance protection.

00582

00583 The College recommends that the most effective means of achieving this
00584 goal would be to create a national financing mechanism that would build
00585 upon our existing pluralistic system to assure that those who are func-
00586 tionally impaired receive a basic level of long-term care services. A
00587 national financing mechanism should be created to assist individuals
00588 and families with the burden of caring for the functionally dependent.
00589 Such a financing system would help with the financial burden when pro-
00590 fessional long-term care services are required.

00591

00592 The system envisioned by the College would involve reproducible and
00593 reliable assessments of medical and functional needs, care coordination
00594 by competent health professionals, mechanisms such as utilization re-
00595 view to assure appropriateness of care, and a means of financing to
00596 guarantee that everyone in need of long-term care can obtain at least
00597 certain essential services. The financing mechanism would also provide
00598 funding for research, education, and training in long-term care. We
00599 believe that comprehensive functional assessments coupled with on-going
00600 case coordination and utilization review will serve as the best means
00601 of utilization control.

00602

00603 However, some cost-sharing may be necessary in light of the practical
00604 and political needs to restrain costs. We suggest that cost-sharing
00605 requirements might be linked to amounts an individual would otherwise
00606 pay for room and board, so that financial incentives would not be creat-
00607 ed for receiving care in one type of setting over another. Further-
00608 more, we recommend that there should not be copayment requirements for
00609 low-income individuals. Sources of revenue recommended for considera-

00610 tion by the College as possible means for funding a long-term care
00611 financing program include raising general taxes, such as individual and
00612 corporate income or payroll taxes; excise taxes on products that have
00613 harmful effects on health, such as alcohol and tobacco; and restoring
00614 estate taxes to previous levels.

00615

00616 We have raised just a few of the many questions that will need to be
00617 addressed in order to implement and administer a national program for
00618 financing long-term health care. We have also suggested that a nation-
00619 al advisory body be established to deal with these issues and to over-
00620 see implementation of the national program. Creation of such a commis-
00621 sion or panel should not, however, serve to delay further action, but
00622 should serve as a means of speeding its development. Steps must be
00623 initiated now to develop a national financing mechanism that will en-
00624 able all Americans to obtain the appropriate long-term care services
00625 they require.

APPENDIX

00626

00627

00628 The following is a summary of the College's conclusions following re-
00629 view of various options for financing long-term care.

00630

00631 Limitations of Medicare:

00632

00633 In 1988, Medicare coverage for care in a skilled nursing facility (SNF)
00634 was limited to 100 days. The first 20 days were covered by Medicare
00635 without cost to the beneficiary, but copayments equal to 1/8 of the
00636 Medicare hospital deductible were required for days 21-100. Coverage
00637 was restricted to only admissions that followed hospitalizations of at
00638 least three days. The copayment required was \$67.50 per day, an amount
00639 that exceeded both the average Medicare prospective payment limit
00640 (about \$61.45/day) and average approved daily charges (about \$55/day)
00641 for routine care in free-standing skilled nursing homes. Thus, the
00642 Medicare benefit was in effect limited to coverage for the first 20
00643 days, since thereafter beneficiaries were responsible for copayments
00644 that generally exceeded Medicare approved payment amounts.

00645

00646 With implementation of the catastrophic health care provisions on Janu-
00647 ary 1, 1989, SNF coverage was increased to 150 days per year and the
00648 prior hospitalization requirement was eliminated. Cost-sharing require-
00649 ments were restructured so that beneficiaries have to make copayments
00650 of approximately 20% for the first eight days of SNF care per calendar
00651 year, but nothing during the next 142 days. After 150 days of cover-
00652 age, the beneficiary is again fully responsible for SNF costs for the
00653 remainder of the calendar year.

00654

00655 A major limitation of Medicare coverage for long-term care is that home
00656 health care, like skilled nursing care, is linked to treatment for
00657 recovery from an acute illness. Payment is allowed only for care that
00658 would be considered a covered service if provided on an inpatient hospi-
00659 tal basis. There is a 20% copayment requirement for items that are
00660 considered to be durable medical equipment; otherwise there are no
00661 cost-sharing requirements. Medicare home health care does not include

00662 full-time nursing care, drugs or medicines, personal comfort items,
00663 general housekeeping services, food services such as "meals on wheels",
00664 blood transfusions, or transportation services.

00665

00666 Medicare will not cover care that is considered maintenance or custodi-
00667 al. Thus, once a patient no longer meets the requirements for skilled
00668 nursing care on an intermittent basis, coverage ceases for both skilled
00669 and non-skilled services, including those of a home health aide. Conse-
00670 quently, those in need of long-term care services typically find that
00671 they must rely primarily upon their personal resources, and soon discov-
00672 er that their savings and insurance are inadequate.

00673

00674

00675 Limitations of Other Financing Mechanisms:

00676

00677 To compensate for the gaps in coverage under Medicare, many elderly
00678 people buy private supplemental insurance. Most so called "Medigap"
00679 policies, however, are patterned after Medicare; they pay the copayment
00680 and deductible amounts, but provide little protection from the costs of
00681 non-covered services such as those required on a continuing basis for
00682 chronic illness and disability.

00683

00684 Other alternative financing mechanisms, besides resorting to Medicaid,
00685 also require personal resources and financial planning. Private insur-
00686 ance companies have only recently begun to market individual long-term
00687 care insurance. The problem of adverse selection (insurance being
00688 bought by those most at risk) and the potential for open-ended liabili-
00689 ties create incentives for insurers to screen applicants strictly and
00690 to deny coverage for pre-existing conditions. Another concern regard-
00691 ing long-term care insurance is that of "insurance-induced demand", or
00692 risk of "moral hazard", which refers to the possibility that people
00693 with insurance coverage might more readily avail themselves of covered
00694 services. Concerns among carriers about open-ended liability in indi-
00695 vidual long-term care insurance policies stem from recognition that
00696 people may require care for the remainder of their lives, and that life
00697 expectancy has been increasing.

00698 Group insurance can provide comparable insurance at reduced premiums,
00699 because insurance risks can be spread over a large, relatively healthy
00700 population and savings can be achieved in marketing and administrative
00701 costs. Long-term care insurance could be marketed to any large group;
00702 however, most group policies are provided through the employment set-
00703 ting, and protection often ceases upon termination of employment.
00704 Coverage could be extended after the cessation of employment and fi-
00705 nanced in a variety of ways. These include: voluntary individual pay-
00706 ment of premiums, mandatory employer payments, use of retirement or
00707 life insurance benefits to purchase paid-up long-term care insurance,
00708 granting of tax credits to either employers or individuals, or in other
00709 innovative ways.

00710

00711 Mandating that employers provide long-term care health insurance is
00712 another option for extending long-term care insurance protection.
00713 However, employment-based policies would not benefit the unemployed,
00714 and employers could be expected to resist any extensions of benefits
00715 that might raise health care costs. Mandatory employer-paid insurance
00716 could be particularly burdensome for small employers. A large segment
00717 of the population could be covered in this manner, and costs would be
00718 lower under employer group plans than under individually marketed poli-
00719 cies. However, it does not appear appropriate to impose obligations on
00720 employers for the cost of benefits that are most likely to be used
00721 after employees have left the work force, particularly when many employ-
00722 ers do not now provide health insurance benefits for current employees
00723 or their dependents.

00724

00725 A person with a large *endowment* or substantial cash reserves might rely
00726 upon these assets as a means of self-insurance. Individual Retire-
00727 ment Accounts (IRAs), savings accounts, investments or similar means of
00728 asset accumulation can also be used for self-insurance. Reliance on
00729 self-insurance would encourage people to assume personal responsibility
00730 for paying for their own long-term care. but would expose individuals
00731 to unlimited personal financial risk. Self-insurance is an option that
00732 would apply generally only to middle and upper-income families, and

00733 would be of little or no benefit to those without substantial financial
00734 means and those who experience inordinate or unanticipated expenses.

00735

00736 Home equity conversions have similar disadvantages. Although they
00737 would enable elderly homeowners to take advantage of the asset values
00738 of their homes to purchase either long-term care or long-term care
00739 insurance; individuals would bear the full financial risks and those
00740 without sufficient assets would not benefit. We consider this alterna-
00741 tive to be an option that should be available as a choice for those who
00742 can afford it, but it is not a viable mechanism for most people to
00743 finance the costs of long-term care.

00744

00745 Life care communities or continuing care retirement communities
00746 (CCRCs) offer another option for the financing and delivery of long-
00747 term care. Residents of these communities typically pay a lump-sum
00748 entrance fee in addition to monthly payments under a contract that
00749 guarantees provision of a continuum of housing accommodations and relat-
00750 ed services in a life care home. Services provided generally include
00751 medical and nursing care, other health related services, as well as
00752 social and recreational activities. In 1986 there were about 700 such
00753 communities in the United States /16. The average size was about 300
00754 residents. Some life care communities have been in existence since
00755 before 1900, but the average age of existing communities is 19 years.
00756 Most are run by religious or other not-for-profit organizations; but
00757 for-profit organizations have also entered the field. We consider this
00758 option to be a viable and promising alternative. However, life care
00759 communities may not appeal to everyone, and they are not always an
00760 easily affordable or available option for most people.

00761

00762

00763

REFERENCES

00764

00765 1. American College of Physicians. Financing long-term care. Ann
00766 of Intern Med 1988;108(2):279-88.

00767

00768 2. American College of Physicians. Medicare payment for physician
00769 services. Ann of Intern Med 1987;106;151-63.

00770

00771 3. American College of Physicians. Long-term care of the elderly.
00772 Ann of Intern Med 1984;100:760-3.

00773

00774 4. Waldo DR, Lazenby HC. Demographic characteristics and health care
00775 use and expenditures by the aged in the United States: 1977-1984;
00776 Health Care Financing Review 1984;6:1.

00777

00778 5. Bowen OT. Catastrophic Illness Expenses. Washington, DC:
00779 Department of Health and Human Services, 1986.

00780

00781 6. US Senate Special Committee on Aging, American Association of
00782 Retired Persons, the Federal Council on Aging, and the Administra-
00783 tion on Aging. Aging America: Trends and Projections, 1985-86.
00784 Washington, DC: Department of Health and Human Services (Publica-
00785 tion 498-116-814/42395),1986.

00786

00787 7. Office of the Actuary, Medicaid Statistics Branch, Health Care
00788 Financing Administration as cited by Cberg CN and Polich CL. "Medi-
00789 caid: Entering the Third Decade", Health Affairs 1988;7(4):
00790 83-96.

00791

00792 8. American College of Physicians. Comprehensive Functional Assess-
00793 ment for Elderly Patients. Philadelphia, PA: American College of
00794 Physicians, 1988.

00795

00796 9. Brook RH, et al. The Effect of Coinsurance on the Health of
00797 Adults. Santa Monica: The Rand Corporation, 1984.

- 00798 10. Gordon NM. Statement before the Health Task Force, Committee on
00799 the Budget, U.S. House of Representatives. Washington, DC: Con-
00800 gressional Budget Office, October 1, 1987.
00801
- 00802 11. Office of Congressman Claude Pepper. Fact Sheet on Pepper/Roybal
00803 Long-Term Home Care Proposal H.R. 3436, Washington, DC: 1987.
00804
- 00805 12. Congressional Budget Office. Reducing the Deficit: Spending and
00806 Revenue Options. A Report to the Senate and House Committees on
00807 the Budget, Part II. Washington DC: U.S. Government Printing
00808 Office, 1989.
00809
- 00810 13. Centers for Disease Control. Smoking-Attributable Mortality and
00811 Years of Life Lost -- United States, 1984, Leads from the Morbidi-
00812 ty and Mortality Weekly Report, JAMA 1987;258(19):2648,2652.
00813
- 00814 14. Cummings SR, Rubin SM and Oster G. The Cost-effectiveness of
00815 Counseling Smokers to Quit, JAMA 1989;261(1):75-79.
00816
- 00817 15. Congressional Budget Office. Reducing the Deficit: Spending and
00818 Revenue Options. A Report to the Senate and House Committees on
00819 the Budget, Part II. Washington DC: U.S. Government Printing
00820 Office, 1988.
00821
00822
- 00823 16. American Association of Homes for the Aging and Ernst and
00824 Whinney. Continuing Care Retirement Communities: An Industry in
00825 Action: Analysis and Developing Trends. Washington DC: AAHA,
00826 1987.
00827