Workable Solutions for Long-Term Care:
State-based Solutions

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I want to thank the Heritage Foundation and especially Dennis Smith for organizing this discussion and for inviting me to participate in it. I think the conversation today is especially important because it is focused on two subjects that get precious little attention in Washington: the role of the states and the problem of what to do about long-term care.

This is a very big topic, so I won't attempt to cover every possible issue needing discussion. Instead, I want to emphasize just four points:

- First, states must take the lead on long-term care reform because the federal government is in no position to relieve them of any current law commitments.

- Second, today's Medicaid financing system, built on federal matching rates, impedes innovation and real reform and has to change.

- Third, Medicaid provides powerful incentives for most Americans to go without private long-term care insurance.

- Fourth, one area that deserves more careful attention is how to maximize the financial savings for both Medicare and Medicaid with better care management of the sickest patients.

The Federal Government's Fiscal Position

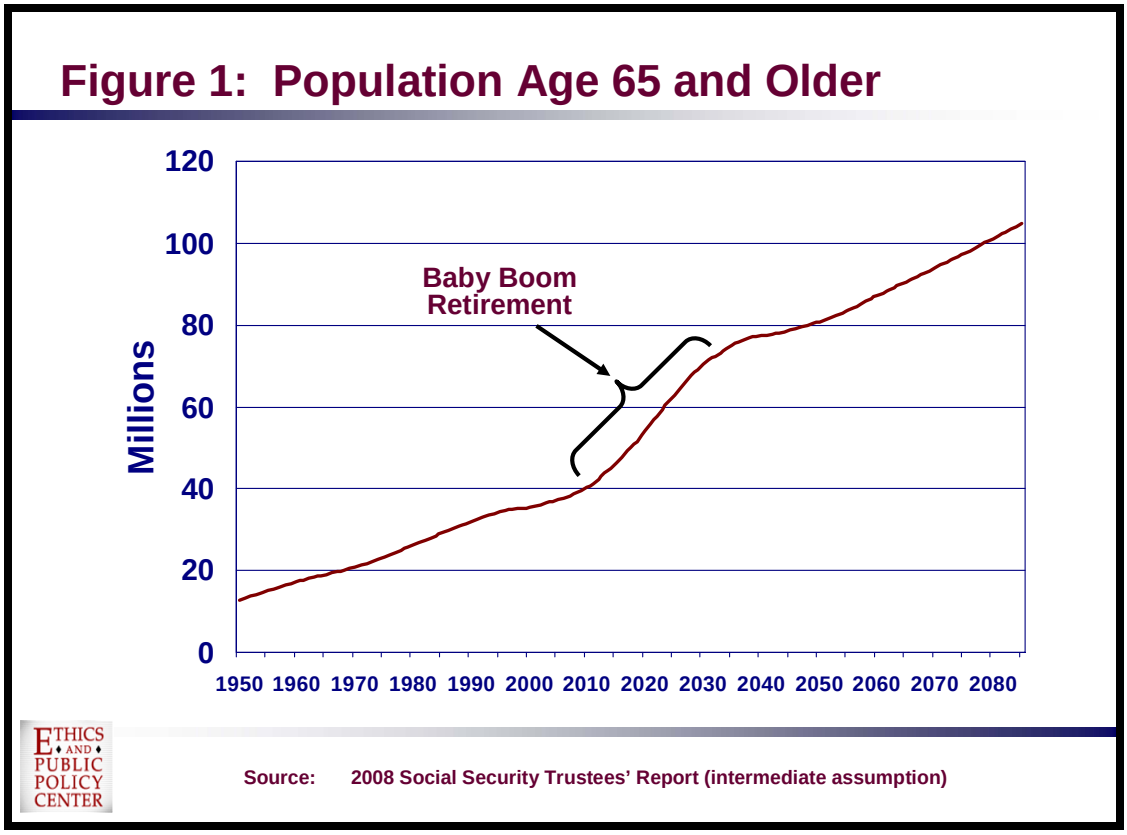
Some health care analysts have suggested that the solution for long-term care is to give place full financial responsibility for it at one level of government. Usually, this suggestion is made by those who would like the federal government to add long-term care to the Medicare entitlement.

But recent news regarding financial turmoil in credit markets should underscore the obvious: the federal government has already over-committed itself many times over and is in no position to take on responsibility for another elderly entitlement.

It's worth spending just a minute on the long-term budget outlook for federal health care spending to drive this point home.

Entitlement spending can be boiled down to fairly simple math: how many people are eligible for an entitlement multiplied by the average per capita cost of making good on the promise made to them ("per capita" costs).

Figure 1 shows the population in the United States age 65 and older from 1950 to 2080. This kind of long-term perspective helps us see the demographic revolution underway here and around the globe. We have been talking for many years about the coming retirement of the baby boom generation. Well, now it is upon us. Between 2008 and 2030, the number of persons age 65 and older will increase from about 39 million to over 70 million.



Of course, even as more and more retirees become eligible for Medicare and Medicaid services, the costs of those services are expected to increase rapidly. Between 1975 and 2005, the Congressional Budget Office (CBO) estimates that per capita Medicaid spending increased an average of 2.2 percentage points faster than per capita GDP growth (see Figure 2). Quite reasonably, unless there is a major shift in policy, CBO expects this basic trend to continue into the indefinite future.

Figure 2: Health Care "Per Capitas"

Per Capita Spending Growth, 1975 to 2005

	Real Per Capita Cost Growth	Excess Cost Growth*
Medicare	4.6%	2.4%
Medicaid	4.4%	2.2%
Other Health Care	4.1%	2.0%

*Excess Cost Growth is per capita spending growth rate in excess of per capita GDP growth.

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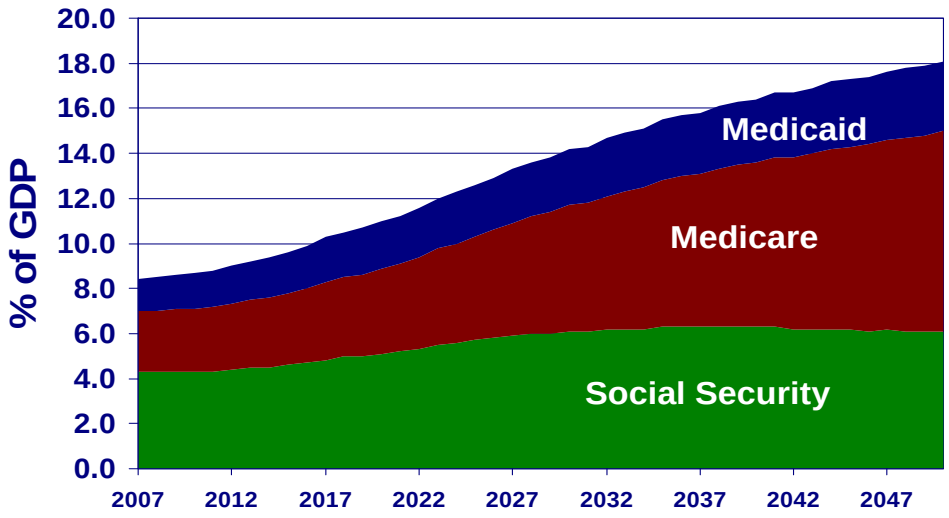
Source: The Long-Term Outlook for Health Spending, CBO, November 2007.

The result is that projected spending on Medicare and Medicaid, as well as on Social Security, is expected to increase rapidly, as shown in Figure 3. CBO projects spending on these three programs will increase from 8.5 percent of GDP in 2008 to 14.2 percent in 2030.

Figure 3: Long-Term Budget Pressure



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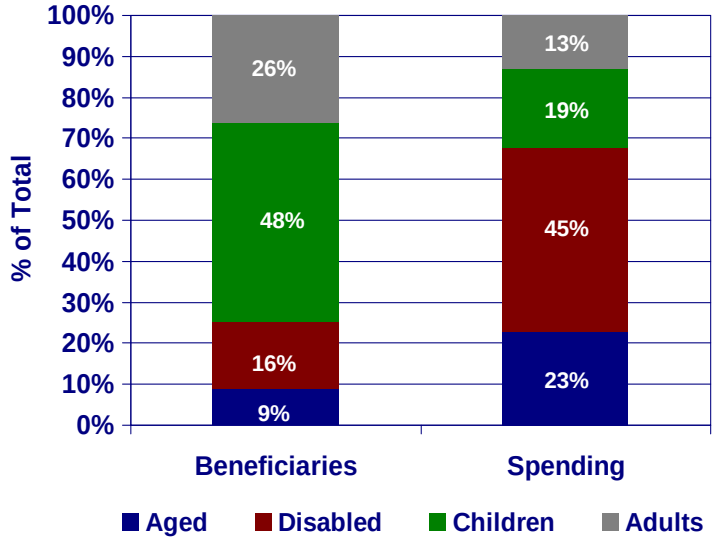
Source: The Long-Term Budget Outlook, CBO, December 2007 (extended baseline scenario).

It is also worth noting that Medicaid spending per capita is heavily weighted to the elderly and disabled. As shown in Figure 4, the elderly and disabled comprise only 25 percent of all Medicaid beneficiaries but nearly 70 percent of the Medicaid spending is for services provided to them.

Figure 4: Medicaid Spending by Enrollee Type



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Source: The Long-Term Outlook for Health Spending, CBO, November 2007.

Medicaid's Matching Rates

Medicaid's system of federal matching rates is a hindrance to innovative reform. To see this, it is useful to review again the experience of welfare changes set in motion in 1996.

The old Aid to Families with Dependent Children (AFDC) was supposed to help poor single mothers and their children who had been abandoned by their fathers without a steady source of earned income. The program was structured much like Medicaid is today, with the federal government paying for a portion of the entitlement for each eligible recipient.

The tragedy of AFDC was that the indefinite cash entitlement discouraged work and encouraged dependency. But with a matching rate funding system, states had little incentive to aggressively move citizens out of the program because much of the savings from such an unpopular effort would have gone to the federal government, not the states.

Still, by the 1990's, welfare dependency had become such a problem that a broad consensus emerged that dramatic reform was needed. The 1996 welfare reform program took the controversial step of terminating the previous federal entitlement to cash benefits, providing states instead with a limited grant along with new requirements for work by recipients.

With a fixed budget, the financial incentives for states changed overnight. In 1996, there were more than 4.6 million Americans receiving cash benefits through AFDC. By 2002, state caseloads had been cut by more than half, to just 2.1 million people.

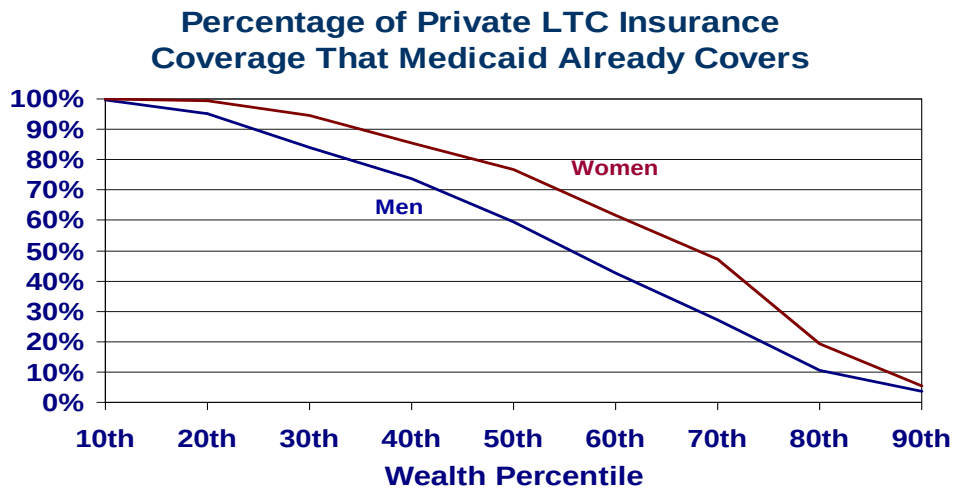
State efforts to reform Medicaid-financed long-term care face similar hurdles as welfare, pre-1996. For every dollar saved with reform, states only get to keep, at most, 50 percent of the savings. That's a tremendous disincentive to making difficult and politically unpopular changes. I believe the single most important long-term care reform we could make would be to move away from today's Medicaid matching rate structure to something which provides appropriate financial incentives to the states.

Medicaid and Crowd-Out

One would think protection against the costs of a long-term care episode would motivate more people to buy private insurance protection. But, historically at least, they haven't. Why?

The answer is Medicaid "crowd-out" effect. A study in 2004 by economists Jeffrey Brown and Amy Finkelstein quantified the redundancy of private LTC insurance and Medicaid's last-resort financial protection. As shown in Figure 5, for large portions of the wealth distribution, the amount of asset protection secured by purchasing a private policy is redundant of the protection provided through the Medicaid program. This is the case in large part because the assets protected by private insurance are not also, at least historically, protected by Medicaid. So even if someone had LTC insurance, they could lose all or some of their assets if they ran through their coverage and needed public assistance to pay their nursing home costs.

Figure 5: Medicaid "Crowd Out"



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Source: "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market, Jeffrey R. Brown and Amy Finkelstein, National Bureau of Economic Research, Working Paper 10989, December 2004

Some states are now removing this disincentive with the new authority to establish so-called partnership programs. Under these partnership arrangements, the assets protected by private LTC insurance can also be protected by Medicaid if a person runs through his or her private insurance coverage limits. States should look seriously at creative ways to leverage this authority to build a more vibrant private insurance marketplace.

Medicare and Medicaid Coordination

One area that deserves much more attention is how to manage care better for the dually eligible population.

It is apparent that careful care management for potentially high cost patients at risk of admission to nursing homes can improve quality and cut costs.

But this requires some coordination between the states and the Medicare program, which is a major challenge, especially given the split financial responsibilities between the programs. In a typical case, a Medicare beneficiary may get admitted to a nursing home through services financed entirely by Medicare (Medicare pays for short stays in nursing homes after an inpatient hospital stay). Once in the nursing home, however, it is possible the patient will become eligible for Medicaid coverage, at which point the state would bear much of the costs.

States, therefore, have a strong interest in managing care well for the elderly population to take the pressure off of expensive nursing home admissions. But the states don't control the acute care insurance.

The Medicare program and the states would both benefit financially from better management of care of those frail elderly patients at risk of needing expensive acute and long-term care services. What's needed is a new financing and governance option which would allow states, at their choosing, to take the lead in establishing better managed care arrangements for patients in this category. States would take on greater risks, but would also benefit from the expected savings from providing more coordinated and higher quality care across care settings. An appropriate portion of the savings from such an option would also need to be returned to the Medicare program.

Conclusion

The United States faces a number of challenges in health care. We hear and talk a great deal about the need for broader insurance coverage for acute care. But today's meeting is raising important issues about what needs to be done in long-term care as well. As in so many other areas, the best ideas are likely to come from the states. Federal reform should focus on making sure states have the proper financial incentives to find solutions. If that is done, I am sure they will.