1970, state Medicaid spending as a share of Gross Domestic Product has tripled and is projected to double again by 2040.[11] Although the federal government will absorb almost all of the growth in Medicaid spending under the Affordable Care Act (ACA), there is no additional federal funding for projected LTSS expenditures. Federal matching payments for Medicaid LTSS remain unchanged, so the financial burden of an aging population will fall heavily on the states. Reducing the current reliance on Medicaid as the primary funder of LTSS is a political and a policy imperative.

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Aging is a certainty, but there are large variations in LTSS expenditures among individuals.[12] While most people have reasonably modest LTSS needs, a relatively small percentage of the population will have LTSS costs over $250,000. A sensible way to prepare for such an unpredictable and financially difficult event is through the pooling of risk.[13] Spreading the financial risk of disability across a large population reduces the amount any one person must set aside to try to cover his or her expenses. Spreading the financial risk also increases resources in the aggregate since individuals tend to underestimate their future need.[14]

Insuring an individual against the risk of needing LTSS continues to be a challenge for the private sector. The dimensions of LTSS risk (the probability and the cost of a claim) and the voluntary nature of private coverage require private insurers to either limit their exposure (by limiting services or excluding the highest risk individuals through medical underwriting) or to pass potential losses on to the consumer in the form of higher premiums. In fact, cost is most often cited as the primary reason for foregoing LTSS insurance, although medical underwriting also eliminates a significant share of the market.

half the value of the in-kind option. The other major disadvantage of a monetary benefit, however, is the difficulty of monitoring how funds are spent – for example, ensuring the quality of care provided and guarding against situations where the monetary payment is spent inappropriately or squandered on other than the beneficiary. A monetary payment also requires an administrative structure that includes uniform and fairly strict eligibility determinations, counseling, periodic reassessments and other forms of oversight to address concerns of fraud and abuse.

Expanding Medicare to Include LTSS

Medicare has long been seen as a natural platform for creation of an LTSS benefit.[21] Certainly, expanding Medicare makes demographic and administrative sense. The concentration of Medicare beneficiaries with chronic conditions and functional limitations account for one-third of Medicare spending.[22] Medicare's near universal reach addresses concerns about adverse selection while also eliminating the incentive to transfer assets that may be created by a means-tested program like Medicaid.[23] Expanding Medicare would also take advantage of current efforts under the ACA to increase the coordination and integration of acute care and LTSS across a range of providers.

Such an approach would require a reworking of Medicare's eligibility rules. Individuals are eligible for Medicare based either on a combination of work history and age, or on a determination of disability. Medicare relies on the definition of disability used by the Social Security Disability Insurance (SSDI) program: the inability to perform one's current work due to a medical condition that is expected to last at least one year or result in death. This is an appropriate disability standard for the provision of health insurance in a system

L V D F K L H Y H G W K U R X J K D Q D Y H U D J H G L I I H U H Q W R Q of services, not eligibility.

3. Catastrophic Coverage. This option Z R X O G F U H D W H D 0 H G L F D U H that covers out-of-pocket expenses after D O H Q J W K \ Z D L W L Q J S H U L R G (a waiting period of home care services) or expenditures E H Q H ¿ F L D U \ K D V S D L G I R U care services).[33] Expressing the waiting period in service hours would create an incentive for individuals to manage their needs in the most economic manner possible. State Medicaid programs would see savings since they would transfer to Medicare expenses above threshold. 3 U R Y L G H U V Z R X O G D O V R E H Q H ¿ W V L Q F H S U L Y D W H insurance and Medicare reimburses at a higher level than Medicaid, as do uninsured private pay consumers.[34]

This option would offer risk-averse individuals some certainty about the upper limit of their LTSS costs; it would create an insurable zone – a front-end V S D F H ± W K D W F R X O G E H ¿ O O H G E \ S H U V R Q D O savings or private insurance. Having the federal government provide reinsurance Z R X O G U H G X F H S O D Q O L D E L O L W L H V V L J Q L ¿ F D Q W O \ and lower LTSS insurance premiums. For individuals with chronic functional L P S D L U P H Q W D E H Q H ¿ W W K D W F R Y H U V W K H L U catastrophic care may enable them to avoid impoverishment if they can afford insurance or can pay for the initial services.

7 K H E H Q H ¿ W K R Z H Y H U Z R X O G E H D Y D L O D E O H W R D Q \ R Q H Z L W K V X I ¿ F L H Q W I X Q F W L R Q D O impairment, regardless of whether they could actually pay the out-of-pocket cost of care during the waiting period or had to rely on Medicaid. Most people with chronic functional impairment who rely on Medicaid would continue to rely on Medicaid for services below the threshold.[35] If the waiting period is very long – such as three years – then catastrophic coverage may not assist individuals with average out-of-pocket costs that are unlikely to exceed the threshold. $ E H Q H ¿ W

4. Expanding Medicaid Managed Care. Incorporating LTSS coverage into Medicare Advantage (MA) plans would highlight new methods of organizing F D U H D Q G H P S K D V L] H W K H of care integration. Plans could include case management, personal care services, transportation, daycare, prepared meals, respite care and social services. This appEMC has ld conbuiconMed wais ofon0( )]TJ

Alternatively, MA plans could be required to include LTSS as part of the basic E H Q H ¿ W V H W E \ W K H I H G H U D O J R Y H U Q P H Q W Z L W K capitation amounts adjusted accordingly. Requiring all MA plans to include some minimum LTSS would reduce the potential for adverse selection among plans. Without LTSS as a component of traditional Medicare, however, it is not clear if federal payments could be risk-adjusted adequately to compensate plans for both the cost of /7 6 6 D Q G W K H P R U H V L J Q L ¿ F D Q W K H D O W K U L V N R I E H Q H ¿ F L D U L H V W K D W Z R X O G E H D W W U D F W H G W R MA plans. This option also raises a number of questions about the phase-in needed for plans to develop the capacity to provide and P D Q D J H V X F K E H Q H ¿ W V

5. Comprehensive Public Insurance.

Expanding Medicare to cover LTSS more fully can be accomplished in number of ways. One option is to create a new voluntary part of Medicare (such D V D 0 H G L F D U H 3 D U W (Z L W K E H Q H ¿ W V comparable to private insurance.[36] As Z L W K 3 D U W V % D Q G ' W K L V Q H Z E H Q H ¿ W Z R X O G E H Y R O X Q W +Jf0 @ p p P • 'u º E H Q H ¿ W Žì¬Ö ËD V qp p 'uT"9p •

existing Medicare program to provide seamless access to the continuum of LTSS and acute care medical services and was structured to be ¿QDQFLDOO\ VROYHQW to improve models of capitated, risk-based managed care for the dually eligible with LTSS needs. At least 25 states are actively working with the federal government to integrate Medicaid and Medicare services.[39] The next few years may be a time to focus on a PRQHWDU\ EHQH¿W WKDW LQFU individuals with disabilities – complementing rather than competing with or complicating changes currently ongoing in the health care delivery system.

7KH GXUDWLRQ RI WKH EHQH¿W LVVXH $OLIHWLPH EHQH¿W LV feature of existing social insurance programs like Medicare and Social Security, but it would in the case of LTSS drive up program FRVWV VLJQL¿FDQWO\ $ EHQH duration would offer some assistance to all who are functionally eligible; that would in PDQ\ FDVHV EH VXI¿FLHQW WR RI EHQH¿W[40] HQ Fourse, the shorter WKH GXUDWLRQ RI WKH EHQH¿ opportunity for private plans to offer a wrap-DURXQG EHQH¿W

One could also cap coverage by limiting WKH EHQH¿W WR WKH FRVW RI services. For example, one proposal developed by stakeholders in Washington State would RIIHU D PRQHWDU\ EHQH¿W SH cost of the nursing care provided in a skilled nursing facility.[41] This was done not simply forin a ski

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Conclusion

7KH FXUUHQW V\VWHP RI /766 ¿QDQFLQJ LV problematic at best. The lack of coverage leads WR VLJQL¿FDQW XQPHW QHHG ZKLOH JRYHUQPHQWDO payers strain under the cost of providing LTSS through vital programs such as Medicaid. Since PLGGOH LQFRPH $PHULFDQV KDYH IHZ ¿QDQFLDOO\ viable options to plan ahead for their potential LTSS needs, one's income security often depends on medical luck. Medicare covers surgery for congestive heart failure, but it often does not cover the daily care needs of someone with symptoms of late-stage Alzheimer's disease. Someone who needs the latter care is on his or her own. As a country, we have a program to help with LTSS when someone becomes impoverished, but nothing to prevent it.

It is time to change the paradigm for LTSS ¿QDQFLQJ PRYLQJ DZD\ IURP D ZHOIDUH program in which assistance is provided on a means-tested basis and toward an insurance-based model that allows people to spread risk and plan ahead for their LTSS needs. While a means-tested program like Medicaid has a critical role in ensuring millions of low-income individuals and individuals overwhelmed by the cost of care have access to LTSS, social

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1. LTSS includes services or devices provided over an extended period of time and designed to meet the medical, personal and social needs of a person in a variety of settings that enable him or her to live as independently as possible. See Family Caregiver Alliance. Selected Long-Term Care Statistics. http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=440 Accessed)HEUXDU\ /766 LV RIWHQ GH¿QHG LQ WHUPV RI KHO performing activities of daily living (ADLs) such as eating, bathing, dressing, toileting and transferring or instrumental activities of daily living or IADLs (light housework, managing medications, managing money, preparing meals and using the telephone). See Reinard S, Kassne E, Houser A. How the Affordable Care Act Can Help Move States Toward A High-Performing System of Long-Term Services and Supports. Health Affairs

11. Burman LE. The Perverse Public and Private Finances of Long-Term Care. In: Folbre N and Wolf DA eds. Universal Coverage of Long-Term Care In the United States: Can We Get There From Here? Russell Sage; 2012. See also Keckley P. Medicaid Long-term Care: The ticking time bomb. Deloitte, LLP. 2010; http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_2010LTCinMedicaid_062110.pdf. Accessed February 5, 2013.

12. 7KH DYHUDJH ROGHU DGXOW ZLOO QHHG WKUHH \HDUV RI WKLUG RI VHQLRUV ZRQ¶W QHHG DQ\ /766 ZKLOH RQH ¿IV in costs is even greater given the use of informal care by most people. The average older adult needs to set aside $47,000 to meet his or her LTSS needs, but 42 percent – almost half of older adults – won't have any LTSS costs while 16 percent will have expenditures of at least $100,000.

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