



A not-for-profit health and tax policy research organization

The future of long-term care and Medicaid

Testimony presented to the
House Committee on Small Business
The Honorable Donald Manzullo, Chairman
The Honorable Roscoe Bartlett, Vice Chairman

Small Business Roundtable hearing
Hagerstown, MD

by
Grace-Marie Turner
President, Galen Institute

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Thank you for inviting me to offer testimony today before your hearing on “The Future of Long-Term Care and Medicaid.” To introduce myself, I am Grace-Marie Turner, president and founder of the Galen Institute. We are a non-profit research organization devoted to developing and furthering public understanding of free-market solutions to problems in our health sector. I am a member of the Advisory Council to the Agency for Healthcare Research and Quality in the Department of Health and Human Services, I have spoken at a number of White House events on health care issues, and I was honored last year to have been asked to serve on the Medicaid Commission.

Health and Human Services Secretary Mike Leavitt established the Medicaid Commission in July of 2005 to advise him “on ways to modernize the Medicaid program so that it can provide high-quality health care to its beneficiaries in a financially sustainable way.”

There are 15 voting and 15 non-voting members of the commission, drawn from a broad cross section of patient, business, government, research, and provider groups. Two former and two current governors serve on the commission as voting members: Former Tennessee Governor Don Sundquist is the chair of the commission, and former Maine Governor Angus King is co-chair; Florida Governor Jeb Bush and West Virginia Governor Joe Manchin also are bringing their real-world experience in managing Medicaid to enlighten our work. I am a voting member of the commission but am speaking today only for myself and not for the commission.

The commission was charged with submitting two separate reports to the Secretary for his consideration and submission to Congress. On September

1, 2005, the commission presented recommendations to the secretary on policy initiatives to save at least \$10 billion over five years in Medicaid. On December 31 of this year, our final report is due to make longer-term recommendations to modernize Medicaid and ensure its long-term sustainability.

The commission has held hearings around the country to gather testimony from experts and citizens about the program. Our first meetings focused on our initial recommendations for Congress for savings through Medicaid, and we have since been studying core aspects of the program, such as eligibility and long-term care, and we will examine in future hearings information technologies, program governance, quality, and other key issues.

Since the commission began its work, the Congress passed and President Bush signed the Deficit Reduction Act, which contained many of the recommendations that we had offered in our September 1 report. For example, the DRA allowed governors more flexibility in structuring Medicaid to gain some of the efficiencies that we have seen in private health coverage. And the new law put restrictions on the ability of affluent seniors to hide assets in order to qualify for taxpayer-financed Medicaid long-term care benefits.

In addition, there were a number of provisions in the DRA designed to help governors modernize the program so that they can better meet the needs of patients and give them new tools to manage spending. The new law gave governors the added flexibility that they had been requesting to allow them to tailor Medicaid benefit packages to the needs of specific patient populations. The DRA also allowed states to apply limited premiums and cost sharing for certain populations and to enforce those cost-sharing requirements.

As work on the DRA was being completed in January, Secretary Leavitt came before the Commission to ask that we pay particular attention to long-term care.

Governors and state legislators see Medicaid costs as threatening their ability to meet the other needs of citizens, such as education, transportation, and public safety. And the needs of adults with long-term care needs will continue to drive Medicaid's spending growth, especially as the number of retired baby boomers nearly doubles over the next several decades.

Medicaid enrollment overall is expected to increase from about 54 million enrollees today to 65 million by 2015, a 21 percent increase. In 2015, the program will be spending \$685 billion a year, a 145 percent increase over today.

Long-term care coverage is expected to continue to represent the biggest share of Medicaid spending. Medicaid is the largest payor for long-term care services nationally, funding care for more than half of all elderly nursing home residents. The Congressional Budget Office estimates that long-term care payments account for about 40 percent of total Medicaid spending.

Most people don't realize that Medicare does not cover long-term care expenses until it is too late and they need nursing home care. And lawyers specialize in helping seniors, once they do need institutional care, in devising ways to give away their assets in order to meet the low income and asset tests of Medicaid to qualify for taxpayer funded care.

Governors know that these costs will swallow their budgets, and they know they must take action now to get control over the costs of Medicaid.

I will have some suggestions for innovative ideas and recommendations that we have heard and offered, but first, it seems appropriate to take a broader look at Medicaid.

❖ **First, the strengths of Medicaid:**

- Medicaid began as an afterthought to the legislation creating Medicare in 1965 but has since grown to be the largest health care financing program in the United States. Medicaid served an estimated 53 million people in 2005, and state and federal governments spent \$330 billion on the program last year.
- Medicaid truly is the safety net for our health care system and can be a lifeline for millions of people with low incomes and disabilities.
- Medicaid fills gaps in our private health sector that is dominated by employment-based health insurance, picking up millions of people who do not qualify for or cannot afford job-based coverage.
- Because Medicaid is a joint federal-state program, it benefits to some extent from the principles of federalism, allowing Medicaid to

be more flexible than Medicare. States have used this flexibility to experiment with programs to better meet the needs of their citizens.

❖ **But Medicaid is not without its problems:**

- Medicaid is a program primarily intended to cover the poor and medically needy, but over time it has evolved into a program that covers many people with lower-middle and middle incomes while denying coverage to many of those who are the poorest.
- Medicaid offers a rich benefits package, but recipients often have trouble finding private physicians who will see them. Patients are often relegated to Medicaid factories, sub-standard nursing homes, or to crowded hospital emergency rooms to receive medical care.
- This program designed for the poor winds up paying nursing home care bills for many middle- and upper-income elderly.
- The care of Medicaid recipients is often uncoordinated among the physicians, clinics, and hospitals where they receive treatment.
- The program pays for acute care but not for keeping people well.
- Medicaid is a rule-driven, price controlled program that is unresponsive to changes in market conditions, patient preferences, medical technology, and the relative supply of providers.
- Political leaders too often focus on how much Medicaid is spending and not on whether the money is being spent wisely to produce the best outcomes.
- While the federal-state partnership provides Medicaid with some limited benefits of federalism, states' flexibility is constrained by extensive rules and regulations which force them to go through long, complex, and time-consuming appeals to request program changes to better meet the needs of their citizens.

❖ **The key question:**

What is the role of the current Medicaid program in a future health system?

Solutions must respect the value of federalism, move toward simplification, and put the program on a path toward financial sustainability. Medicaid's historic and most important job is to take care of the most vulnerable and truly needy. Changes are needed so the program has the resources to meet that mission in the future.

Long term care recommendations

It seems appropriate to explain the challenges faced by one state, which are reflective of the problems in many others.

Kentucky was the first state in the nation to develop a major Medicaid reform plan based upon the new provisions in the Deficit Reduction Act. Governor Ernie Fletcher says Kentucky expects to cover the same number of its citizens on Medicaid, but the state expects to save \$1 billion over 7 years on the program.

But Gov. Fletcher told us in a briefing in Washington in June that, while the DRA gives him flexibility with some patient populations, he could do much more to provide better, more efficient, and more cost-effective solutions to seniors and patients with disabilities if he had more flexibility in providing long-term care services.

He said that states need the flexibility to match provider reimbursement to levels of care and in providing community-based alternatives to institutional care. Additionally, he said that patients need to be able to transition between different levels of care based on changes in their care needs without concern for waiting lists, etc. Even with passage of the DRA, multiple waivers are still required to allow this flexibility in "right sizing" long-term care.

Gov. Fletcher told us that he believes Medicaid's financial viability depends upon the flexibility given to states in setting variable reimbursement rates for different levels of care. The ability to design variable levels of care with corresponding variable rates would provide states a cost efficient means of tailoring services to an individual's needs, using market forces and reimbursement incentives.

He listed the benefits of having variable rates: beneficiaries would become secure in their belief that services will be available and adaptable to their changing needs; providers would have the financial support to diversify

their services to cover all levels of care; and beneficiaries would enjoy more service choices and greater personal freedoms by seeking institutional care only as a last resort.

The one theme we have heard from public officials and patients alike is the need to respect the continuum of care for seamless treatment, and patients don't face redundancy and gaps as they try to fit in various bureaucratic categories.

My colleague Bob Helms of the American Enterprise Institute and I have offered several recommendations to the commission on long-term care. For example:

1. Federal and state governments must begin now to encourage more working-age people to obtain long-term care insurance. Some recommendations:
 - a. Encourage states to participate in the recently-expanded Long-Term Care Partnership program. This builds on the expanded authorization for LTC Partnership programs provided in the Deficit Reduction Act.
 - b. Create new federal and state tax incentives or other subsidies to encourage working-age people to purchase private long-term care insurance.
 - c. Encourage the use of reverse mortgages that allow seniors to draw resources from their home equity to give them alternatives to institutional care.
 - d. Continue the spend-down restrictions of DRA to make sure that Medicaid funds are being spent on those with the greatest need and not on middle to high-income people who could pay for their own care. They may be depriving more needy recipients of benefits if they shelter assets to protect the inheritance of their children and seek nursing home care at taxpayer expense.
2. Medicaid must adopt a long-term view of the health care needs of current recipients and encourage wellness and prevention so the program isn't just paying for treatment after an illness is manifest.

3. States should be encouraged to develop incentive programs, such as those in Florida's reform model which reward recipients for enrolling in smoking-cessation or weight-loss programs, to encourage participants for being more actively engaged in their health management. States also should be encouraged to create Medical Assistance Accounts that give recipients more flexibility as to where they receive certain services and support.
4. States such as Vermont have had remarkable success in fine-tuning long-term care services for its residents, demonstrating that better care can be provided in appropriate settings, more cost-effectively, when solutions are tailored to individual needs. States are much more adept at tailoring benefits than the federal government because they are closer to the people being served, but the federal government must continue to financially support long-term care services.

Therefore we recommend for dual-eligibles: Medicaid should promote integrated care systems that offer low-income elderly and disabled recipients the opportunity to receive a seamless continuum of medical care and disease and care management under one program. We recommend coordinating the enrollment of dual-eligible recipients into one organizational entity that is responsible for providing integrated, coordinated care.

To achieve this continuity of care, and not have care split between Medicare and Medicaid program management, we recommend creating a new Medicaid Advantage program. The states and the federal government would continue to share the costs of providing long-term care for low-income seniors and the disabled, as they do today, but the care would be coordinated at the patient level. Funds would flow into the system from different sources, including the federal government, state governments, and recipients, where feasible. This could mean developing a system of capitated, risk-adjusted payments for certain long-term care populations.

5. Medicaid must adopt new incentives to implement more flexible and more effective disease management and chronic care programs for recipients with disabilities and chronic illnesses. Therefore, we should expand targeted case-management and capitated programs as a means to improve the quality of care and contain costs by increasing efficiency in care delivery.

6. A medical care program should provide health care, but it cannot also pay for housing and other social services needs. Therefore, payments for social services, income maintenance, and other welfare services should be made by the appropriate agencies while Medicaid pays for medical services.
7. States should be given flexibility to establish different criteria for institutional and community long-term care as well as medical, functional, and cognitive eligibility. States may be able to design benefit packages for certain populations receiving long-term care services that are not as comprehensive as those provided to others in order to target funds to those with the greatest need.
8. Build on the Independence Plus waiver to expand consumer-directed care to the broader Medicaid population.

We believe that these changes in long-term care policy would help preserve Medicaid's ability to serve seniors, the disabled, and other vulnerable populations while still working toward modernization of the program to better serve all of its recipients.

Thank you for the opportunity to make this presentation to you today, and I look forward to working with you on policy changes on long-term care and other aspects of the program to make Medicaid sustainable for the next generation and beyond.