

GEORGETOWN UNIVERSITY  
Long-Term Care Financing Project  
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## **Linking Medicare and Private Health Insurance for Long-Term Care**

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## Preface

At the same time we invest over \$200 billion in public and private resources in long-term care, dissatisfaction with our current public-private financing partnership is widespread. To promote a better partnership for the future, the Georgetown University Long-Term Care Financing Project examined options to move us from a partnership that consists primarily of out-of-pocket financing and last-resort public financing toward a partnership that spreads risk, supports access to quality care, and shares financial responsibility fairly among taxpayers and affected individuals and families.

To identify options, we invited experts to develop their own proposals for new ways to finance long-term care. We sought innovative ideas that varied in the nature of the partnership between the public and private sectors. This working paper is one of a set of eight proposals written for the project. These eight, plus an additional four proposals from other sources, are summarized and assessed in an overview paper, *Long-Term Care Financing: Options for the Future*, written by Judith Feder, Harriet L. Komisar, and Robert B. Friedland. The working papers and the overview can be found at: [ltc.georgetown.edu](http://ltc.georgetown.edu). The Georgetown University Long-Term Care Financing Project is funded by a grant from the Robert Wood Johnson Foundation.

Judith Feder and Sheila Burke

Project Directors

Georgetown University Long-Term Care Project

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# Linking Medicare and Private Health Insurance for Long-Term Care

Anne Tumlinson and Jeanne Lambrew

## Background

The retirement of the baby boom generation will place great demands on the nation's long-term care system. Even after accounting for general inflation, long-term care costs are projected to increase by two-thirds between 2000 and 2020.<sup>1</sup> However, the problem is more than just the magnitude of long-term care costs; it is also who pays. Medicare, the primary insurer of medical costs for the elderly, has very limited long-term care coverage. Private insurance coverage is even more constrained. As a consequence, the elderly typically pay for long-term care costs out of their savings until they are impoverished to the point of qualifying for Medicaid. These diminished savings not only affect the quality of life of these seniors but strain public programs. Most experts agree that affordable, accessible, good-quality long-term care insurance could relieve some of this strain and prevent depletion of already-inadequate retirement savings.

Although it has been growing rapidly in recent years, the private long-term care insurance market is small. In 2000, about 7 million Americans owned long-term care insurance, and an even smaller number — 15,000 people in

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<sup>1</sup> U.S. Congressional Budget Office. (1999). *Projections of Expenditures for Long-Term Care Services for the Elderly*.

1995<sup>2</sup> — were actually receiving long-term care insurance benefits. Although premiums in the group market average less than half as much as policies in the individual market, the vast majority of people with long-term care insurance purchase it individually.<sup>3</sup> Some of the suggested reasons for why so few people purchase long-term care insurance include: a mistaken belief that Medicare will fully cover long-term care; personal denial of the potential risk of ending up in a nursing home; competing, more immediate demands (e.g., cost of children's education, mortgage payments); and lack of knowledge or ease in taking advantage of existing options.<sup>4</sup> The state of the current long-term care insurance market also contributes to the problem. The cost of quality products is high, consumer protections are weak, and insurers sell primarily through the more expensive, individual rather than group market.

Recently, policy has begun to address some of these issues. Federal and state policy changes in the 1990s provided tax credits or deductions for qualified long-term care insurance premiums.<sup>5</sup> In 2000, the Federal government was authorized to offer long-term care insurance to its 20 million employees and dependents. And, education efforts were initiated by the Federal government about the limits of Medicare long-term care benefits. Yet these policies affect only a small number of people and do little to make insurance affordable to middle-income Americans who are most likely to need insurance but least likely to buy it.

While few people are covered under private long-term care insurance policies, almost everyone has access to home health benefits when they become

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<sup>2</sup> Background Information: Industry-Wide Long-Term Care Insurance Claimant Study, Conducted by LifePlans, Inc. for Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, May 1998.

<sup>3</sup> Health Insurance Association of America. *Who Buys Long-Term Care Insurance in the Workplace? A Study of Employer Long-Term Care Insurance Plans, 2000-2001*.

<sup>4</sup> Wiener JM, Tilly J, and Goldenson SM. "Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance." *The Elder Law Journal*, 8(1): 57-102.

<sup>5</sup> Wiener JM, Tilly J, and Goldenson SM. "Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance." *The Elder Law Journal*, 8(1): 57-102.

eligible for Medicare. Spending on Medicare home health has grown quickly over the past decade but the benefit has significant limitations that prevent it from serving as comprehensive community-based long-term care coverage. The Medicare home health benefit is restricted to a narrow set of benefits that require a person to be homebound and to have some need for skilled care. As a result, the benefits are often provided expensively and inefficiently relative to the needs of the people receiving care. Many experts agree that some of the spending for Medicare home health benefits could be redirected to provide more effective and efficient home and community-based services.

## **Proposed Policy**

The proposed policy would give Medicare beneficiaries the option when they sign up for Medicare or Social Security retirement benefits of trading the current Medicare Part B home health benefit for an income-related Medicare long-term care catastrophic benefit if they simultaneously purchase a pre-approved private long-term care insurance policy. The Medicare catastrophic benefit would be available once private coverage is exhausted. The goal would be to refocus and add flexibility to Medicare's limited long-term care investment to both encourage a better relationship between private and public coverage and protect beneficiaries from the catastrophic costs of chronic illness. In so doing, private long-term care insurance should become more affordable since Medicare would act as a reinsurer, limiting the liability of private insurers — to a greater extent for lower-income people — and allowing them to offer better coverage (longer and higher quality) compared to existing products, but for a comparable price.

## **Background and Illustration of Proposed Policy**

Before the Balanced Budget Act (BBA) of 1997, all Medicare home health and skilled nursing facility benefits were paid out of Medicare Part A, the fund originally established to pay hospital benefits. The rationale for paying home health and skilled nursing care out of Part A was that the benefits represented a

continuation of hospital care — post-acute care. However, unlike skilled nursing facility care, the pre-BBA Part A home health benefit was not constrained solely to care provided after a hospitalization, nor was it constrained by number of visits or days of care. In fact, Medicare beneficiaries having a skilled need were eligible for home health even if they had not been hospitalized and could receive this care as long as their practitioner could document the need for skilled care. Therefore, some Medicare beneficiaries received home health following a hospitalization and some did not. Some received over 100 visits a year while others received only a handful.

The BBA essentially rationalized Medicare Part A to pay only for care that is associated with a hospitalization and therefore moved payment for certain non-hospital related care to Medicare Part B. This care included any home health visit that is not preceded by a hospitalization and all visits past 100 in a year. Therefore, a Medicare beneficiary could be hospitalized and discharged to home health. This beneficiary's home health benefit would be paid by Medicare Part A until the 101<sup>st</sup> visit of the year, at which time it would switch to Part B. On the other hand, a person could be authorized to receive home health without a prior hospitalization. All of this person's home health visits would be paid under Part B.

Under the proposed policy, a person could choose to drop the “long-term care” portion of their Medicare benefit (that is, the non-hospital-related Medicare Part B home health benefit) in exchange for a new Medicare long-term care benefit as long as that person also purchased a private long-term care insurance policy. The details of benefit design under the private long-term care insurance policies are discussed in detail below. However, as a preview, the following are a few scenarios that illustrate how this coverage might work:

- The Medicare beneficiary is hospitalized and discharged to home health. Medicare Part A pays for 100 visits of home health care. At this time, the Medicare Part A benefit expires. The beneficiary's needs

meet the trigger for his or her private long-term care insurance policy. Thus, the private long-term care insurance policy begins to pay for home health care. Because this care costs less than the daily coverage amount (for example \$100/day), the difference is carried over to cover future care. This person is eventually admitted directly to a nursing home where the private insurance policy continues to pay until the benefits are exhausted. The person is entitled to payment for his or her nursing home care under the Medicare long-term care benefit until death.

- The Medicare beneficiary is discharged from a hospital to a skilled nursing facility (SNF) to rehabilitate a hip replacement. After 10 days in intensive rehabilitation at the SNF, the beneficiary returns home, does not meet the trigger for long-term care insurance (i.e., is fully functioning). Neither the private long-term care insurance nor the Medicare long-term care benefit are used.
- Another Medicare beneficiary breaks her hip, is discharged to a skilled nursing facility but also has dementia and other complications. She stays in the skilled nursing facility because her family decides they can no longer care for her at home. Medicare Part A pays for the first 100 days, the private long-term care insurance policy pays starting with day 101 and continues to pay until the benefit is exhausted. Then, Medicare long-term care begins paying for the nursing home and continues to do so until her death.
- Finally, a Medicare beneficiary has a need for skilled home health care but is not hospitalized. The Medicare beneficiary meets the trigger for his private long-term care insurance policy and the policy begins paying. The policy continues paying until it is exhausted and the beneficiary remains at home. At this point, the Medicare long-term

care benefit begins paying and continues until the person no longer needs home health or dies.

## **Eligibility and enrollment**

### ***Eligibility***

Individuals eligible for Medicare Parts A and B would be eligible for the new Long-Term Care Program (LTCP). The eligibility period would last for six months from the enrollment in Medicare (like Medigap). Upon enactment, there would be a one-time, open enrollment period for individuals ages 65 to 70 who are already enrolled in Medicare. During this eligibility period, individuals who are not receiving or imminently eligible for long-term care benefits would be guaranteed enrollment in LTCP. The assessment for eligibility would be determined by using the short-form version of the screen used for the Federal Long-Term Care Insurance Program.

### ***Enrollment and disenrollment***

Information about LTCP would be presented at the time beneficiaries receive information about Medicare Part B and Medigap plans (see marketing section below for further details). Individuals would have to enroll in LTCP in person, at Social Security Administration offices, to ensure that the decision is well-informed. The change in the Medicare benefit for individuals enrolling in this program would occur simultaneously with purchase of a qualified policy that provides the standard benefit and the lifetime maximum that links to the individual's income-related Medicare catastrophic benefit. An administrative system to coordinate the private long-term care insurance policies and Medicare LTCP would be developed. Default enrollment would be into traditional Medicare with its current home health benefit.

Individuals enrolled in the LTCP could disenroll but could not subsequently reenroll in the program. Beneficiaries who voluntarily disenroll or cease paying private long-term care insurance premiums would receive a

shortened benefit period or a cash payout based on the amount of premiums paid (discounted for administrative costs and interest). These individuals would also become eligible for the traditional Medicare home health benefit (although Medicare secondary payer rules would apply with regard to the shortened benefit period). As long as the individual pays premiums, the long-term care insurance policies are guaranteed renewable. If the private insurer moves out of the area, closes, or its reserves fall below state-required levels (requiring a premium increase), its enrollees would have the option to disenroll (as described above) or join another insurance plan with guarantee issue and premiums comparable to those of enrollees in the new plan, (as determined by the Centers for Medicare and Medicaid Services, CMS, through regulation). The insurance companies would be responsible for transfer of these vested benefits with oversight by the state insurance commissioner. A condition of participation in the LTCP is that private insurers immediately submit information on disenrollment to CMS, and give notice of any reduction in service so that individuals can be offered a different plan option (as is done in the MedicareAdvantage system).

## **Private insurance**

### ***Benefit design***

Medicare, working with the National Association of Insurance Commissioners (NAIC), would set standards for a pre-approved, state-licensed group private long-term care insurance policy options. Carriers that agree to the terms of the option could offer these standard policies through Medicare. If no carriers choose to participate (nationwide or in an area), Medicare would offer a standard policy at an unsubsidized premium. (It would pay for home health, SNF and hospice using existing payment methodologies and would competitively bid out for coverage for other services like personal care and adult day care services. States could be a bidder for these services as well.)

The covered services would be patterned on those in the Federal Long Term Care Insurance Program for Federal employees. They would include the following (reimbursed at 100 percent of the daily benefit amount unless otherwise stated):

- Nursing home, hospice facility or assisted living facility
- Hospice care at home
- Home care provided by a formal caregiver (75 percent of daily benefit amount)
- Informal caregiver services (75 percent of daily benefit amount)
- Adult day care center (75 percent of daily benefit amount)
- Respite services
- Caregiver training
- Bed reservations

Benefit maximums apply to informal caregiver services, respite services, caregiver training, and bed reservations, following the Federal Long-Term Care Insurance Program. Informal caregiver services provided by family members cannot exceed 365 days in beneficiary lifetime. Caregiver training is limited to 7 days multiplied by the daily benefit amount in beneficiary lifetime. Respite services are limited to 30 days multiplied by the daily benefit per calendar year. Bed reservations are limited to 30 days per calendar year.

Participants would be required to purchase a daily benefit amount of \$100 at a minimum (meaning plans could not offer daily benefit amounts that would be less than \$100) but would have the option of purchasing higher daily benefit amounts if they choose. Evidence from Medigap suggests that some seniors may choose additional coverage if they can afford it, given seniors'

general risk aversion, although this would delay the onset of the Medicare catastrophic benefit. To the extent that providers charge less than the daily benefit amount for covered services, the unused portion of the daily benefit amount would be carried forward, saved in the lifetime maximum amount and used to extend the duration of private insurance coverage (requirements for duration of coverage and lifetime maximums are discussed below). In other words, only the amount of benefits that the policy pays would count toward the maximum lifetime benefit. Participants would be required to purchase automatic compound inflation protection so that the day limits would increase by a long-term care price index (a composite of the CMS nursing home and home health Producer Price Indexes) developed by the CMS Office of the Actuary after the first year.

In order to create seamless coverage through a public and private partnership, the private long-term care insurance would be designed to wrap-around existing Medicare benefits. Specifically, the insurance would have a zero day waiting period for all long-term care benefits that are not covered by Medicare (i.e., home health without prior hospital stay, adult day care center) but would not pay for the first 100 home health visits following a hospital stay or for the first 100 days of SNF benefits. In other words, the insurance would coordinate with Medicare Part A post-acute care benefits rather than pay regardless of this coverage. Similarly, the insurance would not pay hospice benefits until the first day following exhaustion of the Medicare benefit.

The minimum daily benefit is designed to cover daily nursing home costs. However, as with current long-term care insurance, if the daily benefit is insufficient, the long-term care provider would bill the senior for the excess amount. This out-of-pocket spending would, without a change in law, count towards Medicaid “spend down” in most states (see “Medicaid” section below for additional discussion).

Private insurers would report to CMS when a LTCP participant has entered into a benefit period and when a person is at 90% of their maximum benefit amount. This will ensure that there is a seamless transition from the private to the Medicare coverage. Penalties would be imposed on insurers that falsify claims paid in order to start the Medicare catastrophic benefit earlier than it otherwise would have begun.

### ***Eligibility triggers***

A person would be eligible for benefits if he or she meets all of the following requirements:

- A licensed health care practitioner certifies that the covered individual is unable to perform without substantial assistance at least two Activities of Daily Living (ADLs, see definition below) for an expected period of at least 90 days; or needs substantial supervision due to Severe Cognitive Impairment (see definition below).
- A written plan of care has been established for the covered individual by a licensed health care practitioner.

ADLs are the following:

- Bathing: washing one's hair, washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower;
- Dressing: putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs;
- Transferring: moving into or out of a bed, chair, or wheelchair;
- Toileting: getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene;

- **Continence:** maintaining control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, performing associated personal hygiene (including caring for catheter or colostomy bag); and
- **Eating:** feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table or by a feeding tube or intravenously).

“Severe Cognitive Impairment” is a deterioration or loss in intellectual capacity, such as may occur with Alzheimer's disease, that places an individual in jeopardy of harming oneself or others.

Premiums would be suspended when an individual is claiming benefits, consistent with the current practice in most long-term care insurance policies.

### ***Premiums***

The amount of the premiums charged would be based on the daily benefit amount, the individual's duration of coverage (i.e., maximum lifetime coverage — see below), and age at enrollment. Because automatic compound inflation protection is required for all policies, the premiums, once set, would not increase over time. Insurers that could no longer sustain the premium would be required to offer nonforfeiture benefits to people who disenroll. Individuals could remain in these plans by paying a higher premium but would be guaranteed access to an alternative insurance plan (other private plan or Medicare plan) at roughly the same premium that they were promised upon enrollment.

### **Medicare catastrophic long-term care benefit**

#### ***Benefit design***

Individuals enrolling in the LTCP would be entitled to unlimited Medicare payment for qualified long-term care benefits (defined below) once private long-term care insurance is exhausted. Enrolled individuals would forgo Medicare's

current Part B home health benefit but must purchase pre-approved private long-term care insurance that provides seamless coverage beneath the Medicare catastrophic benefit.

The Medicare catastrophic coverage would be “triggered” by the exhaustion of private long-term care insurance coverage — once the fixed dollar amount of lifetime coverage has been spent. Enrolled individuals’ cumulative qualified long-term care expenditures — paid by the pre-approved long-term care insurance policy — would count towards this trigger. “Qualified long-term care expenditures” are defined as spending on benefits covered by the private long-term care insurance plan.

The lifetime maximum amount would vary by income. Therefore, the trigger for the Medicare catastrophic benefits would be income-related, meaning that its value would be greater for lower-income Medicare beneficiaries. This implicitly makes the private long-term care insurance less expensive for lower-income individuals. Each individual’s trigger (or required maximum lifetime coverage amount) would be determined as follows:

- The “base” trigger is defined as the point at which the catastrophic benefit for Medicare beneficiaries with income above \$50,000 (single) or \$75,000 (couple) begins or the amount of lifetime maximum coverage required for people who exceed these income thresholds;
- The “income-based” trigger threshold for individuals at or below \$50,000 (single) or \$75,000 (couple) is calculated so that an individual with no income would have a trigger (or lifetime maximum required coverage amount) that is 50% of the base trigger. These income amounts would increase over time by the rate of general inflation.

In subsequent years, the base trigger would be adjusted by the long-term care inflation index (described above). “Income” would be defined as adjusted gross income plus tax-exempt interest. Determinations of the trigger for an

individual would be determined once, by the Social Security Administration, at the time of enrollment in Part B. This would be done using the individual's most recent tax return. CMS Actuaries would provide SSA with and post an internet-based tool to determine, based on income and age, the individual's trigger. This trigger would be determined once, at the time of enrollment.

The base trigger could be set in at least two ways:

1. *Budget neutral*: The base trigger would be determined by: (1) estimating the cumulative lifetime cost of Medicare Part B home health benefits for participants in LTCP; (2) estimating the cumulative lifetime long-term care costs of participants; and (3) determining where the Medicare catastrophic benefit would be triggered so that it costs no more than the savings from opting out of Medicare Part B home health benefits. To simplify this calculation, it could be done assuming that all beneficiaries participate and that they all have the same catastrophic benefit trigger (i.e., it is not income-related).
2. *Assume base trigger is \$100,000*. This would be the maximum lifetime coverage amount that people who exceed the income threshold would be required to buy to qualify for the Medicare catastrophic coverage.

Beneficiaries could buy more coverage if they choose. However, this would delay the initiation of the Medicare catastrophic benefit.

An alternative design would be to not require participants in the LTCP to forego their Part B home health benefits. It could be that this results in a larger, healthier set of participants which would lower the private long-term care premiums.

### ***Payment***

Private insurers typically pay rates that are charged to private pay nursing home residents and home care recipients. The market is not big

enough for the insurers to be able to negotiate set rates with providers. However, they do not generally pay rates in excess of the pre-determined daily benefit amount. Instead they pay the lesser of the daily benefit amount that was determined at the time the policy was purchased or the amount charged by the provider.

Medicare does not currently cover comprehensive long-term care so there are no payment methodologies in place to draw upon for this newly created benefit. We proposed to use existing Medicare post-acute payment rates for the long-term care providers except where the service is not currently covered by Medicare as a post-acute service. In this case, Medicare will continue paying the private insurance rate. An alternative approach is that Medicare pays the current post-acute payment rate or the previous private insurance rate, whichever is lower. However, we do not believe this methodology should be permanent. Rather, CMS should develop fair and appropriate prospective rates for Medicare payment of new long-term care benefits. Otherwise, the system will essentially reflect a cost-based reimbursement system which would lead to inefficiencies in provision of long-term care and overpayment by Medicare.

## **Medicaid**

States would have the option of extending Qualified Medicare Beneficiary (QMB)-like assistance to its dual eligibles. Under this option (like under QMB) states would pay for long-term care premiums for individuals up to 100 percent of poverty. In addition, they would pay for any cost sharing incurred by individuals. This eligibility category, like others in Medicaid, could not be designed to selectively enroll some and not all eligible individuals. Payments under this option would be matched at the regular Medicaid matching rate.

Nothing in this policy would change state Medicaid medically needy or spend down programs. To the extent that individuals enrolled in this program also incur significant health care expenditures, including any excess payments

beyond what the long-term care insurance policy covers, and otherwise qualify for Medicaid, payments for these “dual eligibles” would be treated as they are for other benefits (Medicare primary, Medicaid “wrapping around” Medicare).

### **Financing**

Option 1 for setting the base trigger, by design, should come close to being budget neutral. Option 2, which links the Medicare catastrophic benefit to an insurance policy with a \$100,000 maximum lifetime coverage, could increase Medicare’s cost. If it does, a variant would be to require participants to give up both Medicare Part A and B home health. Federal budget savings would result from replacing the Part A home health benefit with private insurance payments, although this would increase the number of participants reaching their lifetime maximum and qualifying for the new Medicare long-term care benefit. Participation in the program might be also be affected since participants must give up a greater amount of up-front coverage in return for a catastrophic benefit. Regardless, there should be offsets from Medicaid because the individuals enrolled in this option would rarely become eligible for Medicaid (unless they lapse into the traditional Medicare benefit and get an abbreviated benefit period).

### **Marketing and Administration**

CMS would have ultimate responsibility for evaluating and approving prospective private insurance policies. CMS would fund and conduct outreach and include a description of the LTCP in the standard materials it sends to new Medicare beneficiaries. The CMS materials would include a chart showing the level of catastrophic benefit that seniors at different income levels would receive (there would also be an internet-based tool that would calculate it more precisely), information necessary to contact all of the participating insurance companies, and a copy of the short form necessary to qualify for coverage. CMS would provide names and addresses of all Medicare beneficiaries for private long-term care insurance companies to send pre-approved marketing

materials. In addition, participating insurers may contact Medicare beneficiaries by phone during the open enrollment period only if the beneficiaries have indicated to CMS — through a mail-back form — their interest in being contacted.

Information about the LTCP would be developed by CMS and distributed by both CMS and the Social Security Administration. It would be developed by a panel consisting of long-term care insurers, health insurance agents and counselors, consumer representatives, and marketing experts.

## **Discussion**

This proposal, to link private long-term care insurance to an income-related Medicare catastrophic benefit, attempts to address several serious problems: low participation in an expensive private long-term care market where products are often low quality and participants are mostly higher income. To mitigate against these problems, we, first, income-relate the catastrophic benefit to both encourage less wealthy beneficiaries to participate and to ensure that more of the costs for the higher-income seniors are covered by the insurance, not Medicare. Because we maintain Medicare's current home health benefit for those who do not participate, the proposal does not penalize those who prefer the current system. And, since this option would be offered through Medicare, it may gain more enrollment than pure private-sector initiatives. It is also hoped that making this a once-in-a-lifetime option, when seniors are age 65, will simultaneously increase their interest in enrollment and result in lower premiums than seniors would pay if they purchase long-term care insurance when they are older.

The prospect of giving up Medicare Part B home health benefits and paying an additional premium may dissuade many Medicare beneficiaries from choosing this option, especially in the first few years. As a result, insurers and the Medicare program face a difficult challenge in explaining to potential

purchasers the advantage of participating in the Medicare Long-Term Care Program. However, the potential advantages are significant and they include: guaranteed lifetime long-term care coverage without necessarily accessing Medicaid, greatly increased flexibility in coverage compared to current Medicare and Medicaid benefits (such as assisted living and informal caregiver benefits), and the government's guarantee that the insurance policy is reliable and high quality.

Balancing price and consumer protection is also a major challenge in designing any policy to promote private long-term care insurance, including this one. Because long-term care insurance requires individuals to make a significant financial commitment, the policies must be high quality and reliable. Therefore, we have required that all policies include automatic compound inflation protection, and that beneficiaries retain the ability to switch insurers or disenroll if the premiums rise as the result of inadequate reserves. Disenrollment would always result in the payment of cash or an equivalent amount of benefits and policy holders can disenroll even if premiums do not increase. These protections would increase the insurance premiums but would be important to be worthy of the Medicare endorsement. To help offset these premiums, and for consistency with the goal of encouraging planning for long-term care expenses before they occur, we limit enrollment to elderly who are not currently receiving long-term care services (as determined through a short questionnaire similar to the one used in the Federal Long-Term Care Insurance Program).

Private insurers have expressed concern over similar consumer protection features offered through the Medicaid Partnership Program because these features make the policies more expensive and therefore harder to sell than others. Insurer participation may be higher in this proposal, however, if they conclude that the value of offering a Medicare-endorsed product outweighs the expense of these protections. For example, agents can market

Medicare-partnered long-term care insurance as providing access to potentially higher quality nursing home care than in some Medicaid programs — a message that is consistent with current sales practices. Another advantage for the insurers is that they can rely — to some extent — on government-financed marketing and information materials, an advantage similar to that of the Federal Long-Term Care Insurance Program.

Finally, this proposal has several potential disadvantages and advantages. The disadvantages of this option are that, despite its potential benefits, Medicare beneficiaries may not choose to give up a home health benefit and pay an additional premium — one that may still be relatively expensive. As a result, the number of people choosing this option may be relatively small. In addition, the resources redirected from a Medicare home health benefit may not be adequate to cover the costs of the catastrophic long-term care Medicare benefits — necessitating additional general revenue or offsets like eliminating the Part A home health benefit for participants to secure budget neutrality. In addition, insurers may not participate in large enough numbers to guarantee beneficiaries access to a second insurance plan if their initial plan raises the premium. It may be unrealistic to expect a second insurer to enroll a new beneficiary if their previous premium was set too low in the first place. As a result, a major difficulty of this program is guaranteeing beneficiaries that their premiums will not increase. Finally, this program does not offer solutions to the cost issues facing people currently needing long-term care, especially people with disabilities under age 65.

That said, we hope that its potential advantages outweigh its disadvantages. It takes significant steps to reduce the price of long-term care insurance for low- and middle-income individuals through an income-related catastrophic benefit. It permits all elderly (within six months of enrolling in Medicare Parts A and B) to enroll as long as they are not currently receiving long-term care benefits. It requires all policies to provide long-lasting and

reliable benefits through automatic compound inflation protection and nonforfeiture benefits. It redirects existing Medicare and Medicaid spending to guarantee flexible, lifetime long-term care coverage through private insurance and Medicare. And, it offers private insurers the opportunity to offer more benefits for lower prices and receive an endorsement from a large government health care program. This proposal, like many in the area of long-term care, has some risks and uncertainty, but the risk of the status quo, given the imminent retirement of the baby boom generation, may be greater.



Georgetown University Long-Term Care Financing Project  
*Working Papers*

- No. 1 **Medi-LTC: A New Medicare Long-Term Care Proposal**  
John Cutler, Lisa M. Shulman, and Mark Litow
- No. 2 **The Life Care Annuity: A Proposal for an Insurance Product Innovation to Simultaneously Improve Financing and Benefit Provision for Long-Term Care and to Insure the Risk of Outliving Assets in Retirement**  
Mark J. Warshawsky
- No. 3 **Forced Savings as an Option to Improve Financing of Long-Term Care**  
James Knickman
- No. 4 **Long-Term Care Policy Option Proposal: Consumer Controlled Chronic, Home, and Community Care for the Elderly and Disabled**  
Marty Lynch, Carroll Estes, and Mauro Hernandez
- No. 5 **A Federal Catastrophic Long-Term Care Insurance Program**  
Christine E. Bishop
- No. 6 **Linking Medicare and Private Health Insurance for Long-Term Care**  
Anne Tumlinson and Jeanne Lambrew
- No. 7 **A Trade-Off Proposal for Funding Long-Term Care**  
Yung-Ping Chen
- No. 8 **A Proposal to Finance Long-Term Care Services Through Medicare With an Income Tax Surcharge**  
Leonard E. Burman and Richard W. Johnson

**About the Project**

The *Georgetown University Long-Term Care Financing Project* pursues analysis designed to stimulate public policy discussion about current long-term care financing and ways to improve it. The project is funded by a grant from The Robert Wood Johnson Foundation. More information about the project and other publications can be found at <http://ltc.georgetown.edu>.