



Long-Term Care --- an Essential Element of Healthcare Reform

This chart book was commissioned by The SCAN Foundation and prepared by Avalere Health.

December 2008



Avalere Health LLC | The intersection of business strategy and public policy

Key Findings

Introduction

The health and long-term care needs of the elderly and disabled are linked closely to the entire healthcare system.

Because of this link, it is important that any reforms of the overall healthcare system include measures to address the particular challenges of our long-term care structure.

Such an inclusive approach to reform has the potential to bolster the effectiveness of healthcare reform, improve quality and reduce costs.

- 1 The majority of Medicaid spending is on services for long-term care users. Health reform efforts can target the healthcare needs of this population in order to strengthen Medicaid for the future.

- 2 Some Medicare post-acute care services may fill-in for long-term care needs. Reform efforts can consider the long-term care needs of the Medicare population in order to improve the quality and cost-effectiveness of these services.

- 3 Medicare and Medicaid spending for dual eligibles is largely uncoordinated and unmanaged. Innovative reform efforts can coordinate and manage these services to improve quality and reduce costs.

- 4 A significant amount of long-term care is privately financed and provided by informal caregivers. Reform efforts can leverage, rather than replace, these private contributions.

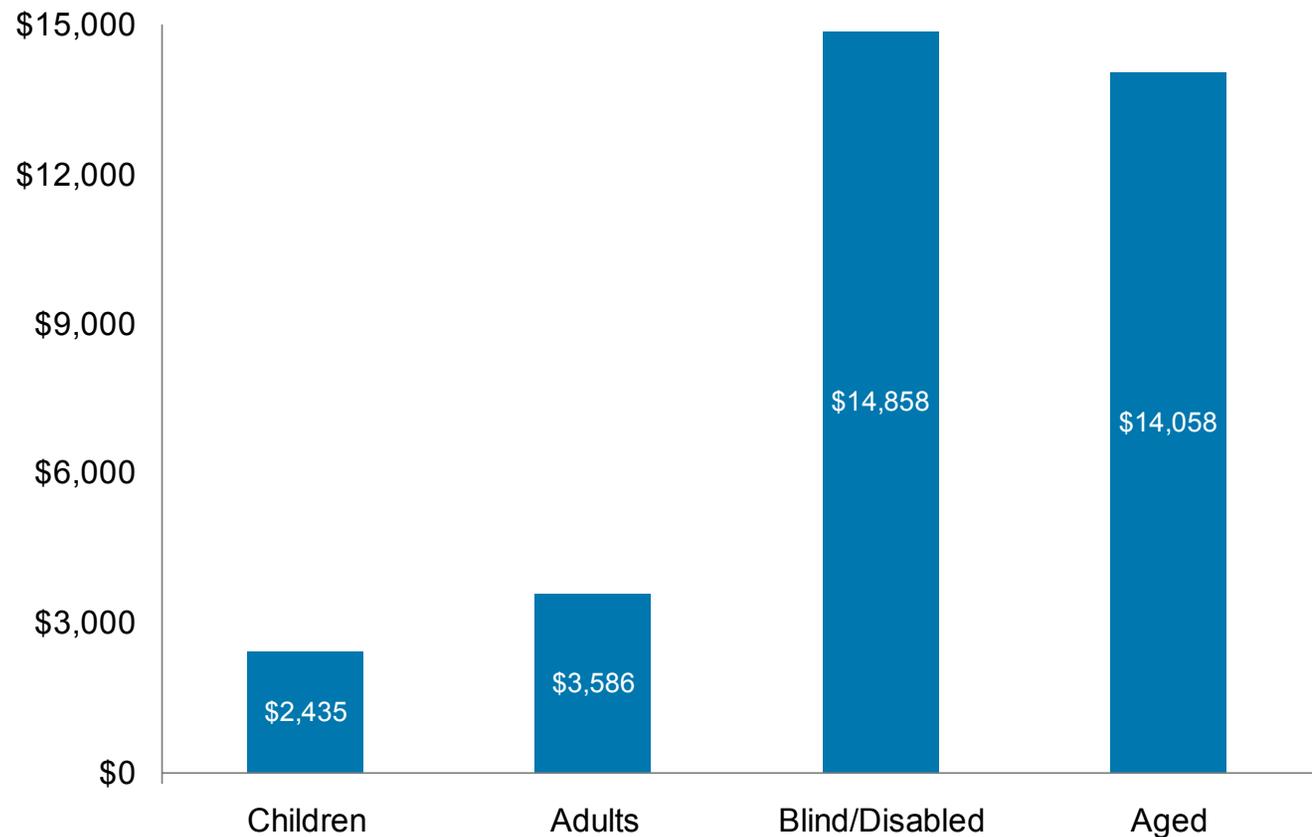
The majority of Medicaid spending is on services for long-term care users. Health reform efforts can target the health care needs of this population in order to strengthen Medicaid for the future.

The majority of Medicaid spending is for acute and long-term care services for the elderly and disabled, the primary users of long-term care. Reform efforts can address Medicaid spending on the long-term care population to try to improve efficiency and quality of care and to lower overall Medicaid costs.

The Elderly and Disabled Consume the Largest Amounts of Medicaid Resources

Medicaid spent close to four times as much on services for the elderly and disabled than on services for children and adults in 2007.

2007 Estimated Medicaid per Enrollee Spending

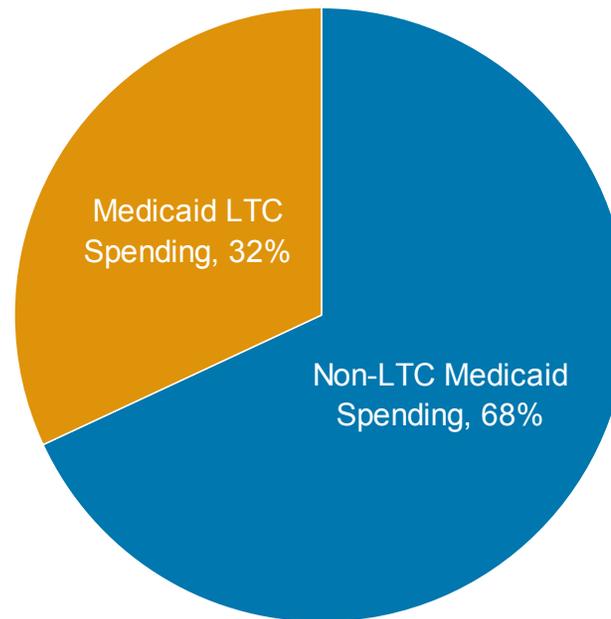


Source: Centers for Medicare & Medicaid Services. 2008 Actuarial Report on the financial outlook for Medicaid.

Close to One-Third of Medicaid Spending Pays For Long-term Care Services

In 2007, long-term care accounted for nearly one-third of the \$312 billion in overall Medicaid spending. As the elderly population grows, long-term care spending will grow as a percent of total Medicaid, creating significant pressure on federal and state budgets.

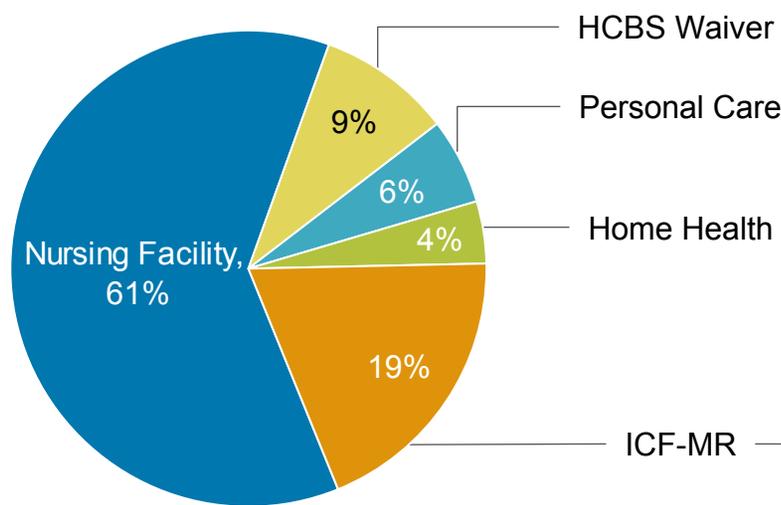
2007 Medicaid Long-Term Care (LTC) Spending as Percent of Total Medicaid Expenditures



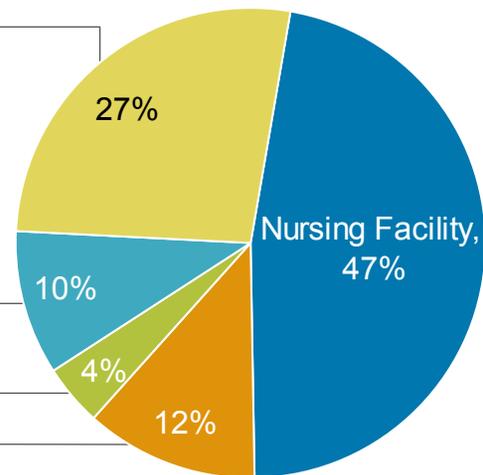
Total 2007 Medicaid Expenditures = \$312 Billion

Since 1995, a portion of Medicaid long-term care spending has shifted from institutional care to home and community-based services and personal care, which many beneficiaries prefer. However, institutional care still accounts for the majority of Medicaid long-term care spending, nearly 60 percent (nursing facilities + ICF-MR).*

1995 Estimated Medicaid Long-Term Care Expenditures = \$49 Billion



2007 Estimated Medicaid Long-Term Care Expenditures = \$101 Billion



Source: Burwell, B., Sredl, K., and Eiken, S. Medicaid expenditures for LTC services, 1995-2007. HCBS.org.
 *HCBS = home and community-based services; ICF-MR = intermediate care facilities for the mentally retarded

The 85 and Older Population Has the Greatest Need for Long-Term Care Services

Within the elderly population, the age 85 and older sub-group has the greatest need for long-term care, and is growing as a percentage of the overall elderly population. The rate of long-term care need among this population is nearly four times as high (36 percent) as the rate in the age 65 to 84 population (10 percent).

Rate of Long-Term Care Need by Age Group*

Age Group	Rate of Long-Term Care Need
65 - 84	10%
85 and older	36%

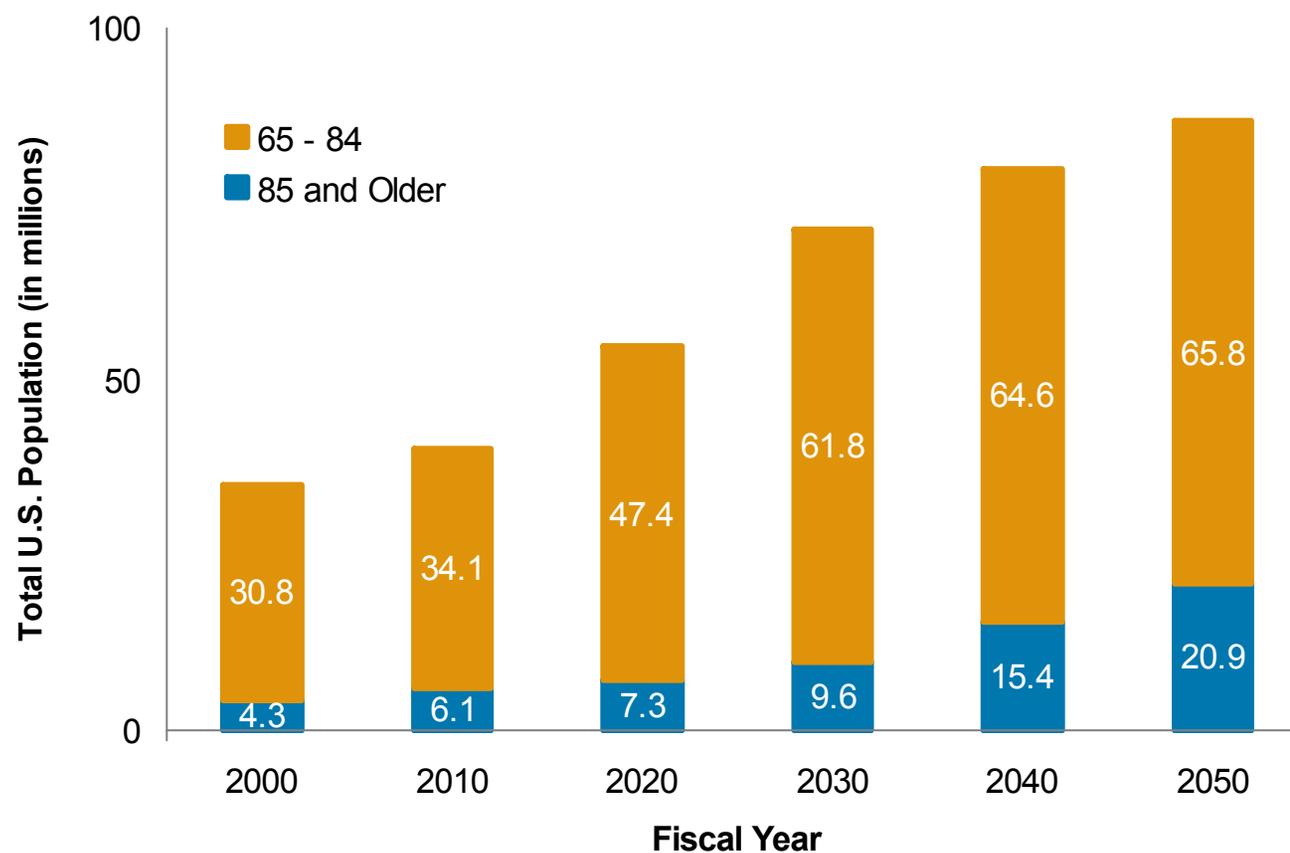
Source: Avalere Analysis of Medicare Current Beneficiary Survey 2005 Access to Care data.

*Long-term care need defined as receiving help with one or more of six activities of daily living (ADLs).

Demand for Long-Term Care Services Will Likely Increase as the 85 and Older Population Grows

Not only is the over age 65 population expected to grow from about 40 to 80 million between 2010 and 2040, the proportion of those over age 85 is expected to be nearly one-fifth of the elderly population by 2050.

Total Projected Elderly Population in the United States Through 2050



Source: U.S. Census Bureau.

Some Medicare post-acute care services may fill-in for long-term care needs. Reform efforts can consider the long-term care needs of the Medicare population in order to improve the quality and cost-effectiveness of these services.

Although Medicare does not cover long-term care, some Medicare post-acute care services that transition beneficiaries from acute to long-term care settings may be filling-in for long-term care needs. Reform efforts can consider the long-term care needs of the Medicare population and Medicare's role in filling those needs.

The Difference Between Part A and Part B Home Health for Elderly in Need of Long-Term Care Suggests That Some Part B Services Fill-In for Long-Term Care

Medicare Part A pays for home health services provided after an acute hospital stay and Medicare Part B covers home health services ordered by a physician, not after a hospital stay.

Medicare Part B per capita home health spending for the elderly long-term care population (defined as those who receive help with one or more activities of daily living (ADLs) is almost twice as much as Part A per capita home health spending, suggesting that Medicare home health Part B services may be filling a need for long-term care.

Medicare Parts A and B per Capita Spending on Home Health Services by ADL* Group

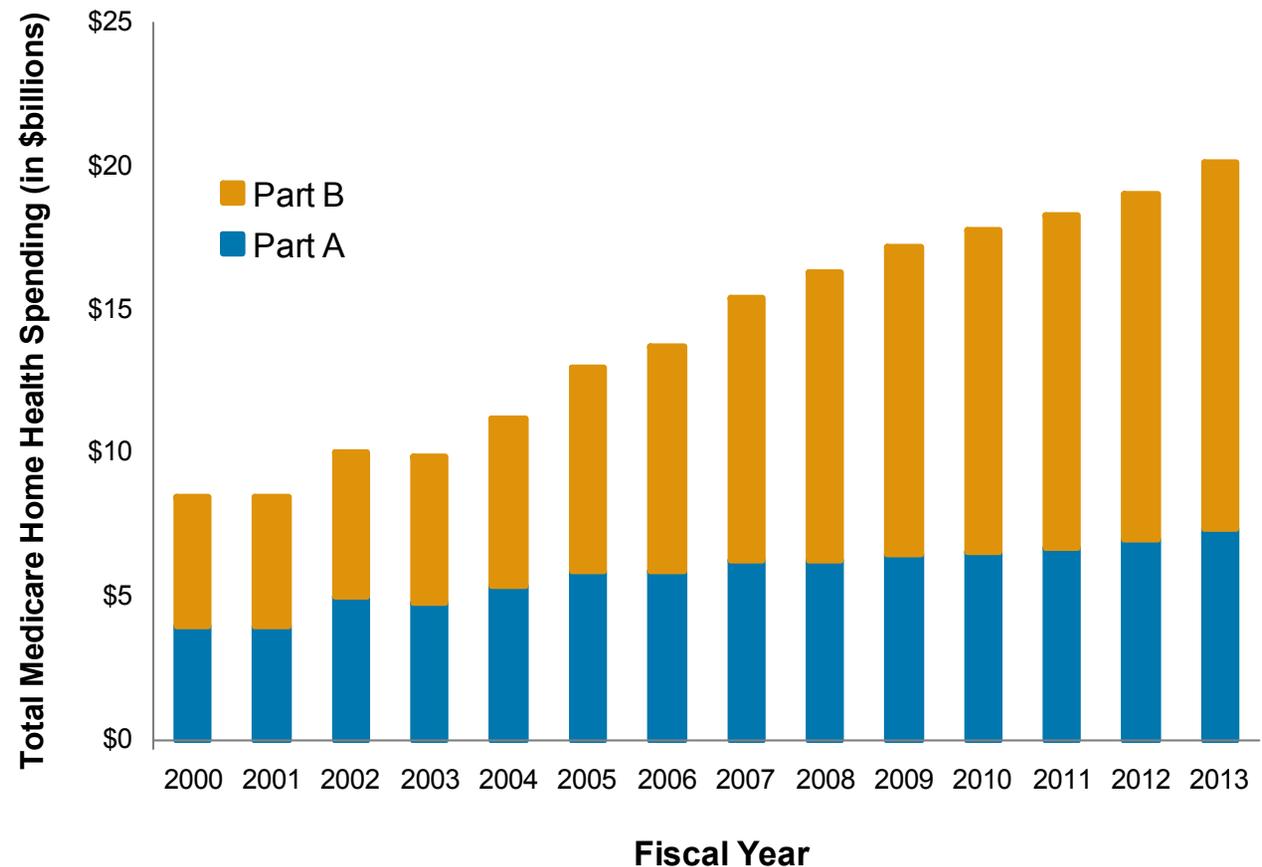
ADL Group	Part A per Capita Home Health Spending	Part B per Capita Home Health Spending
65 and older with no ADLs	\$96.35	\$76.29
65 and older with 1 or more ADLs	\$442.95	\$812.43

Source: Avalere analysis of the Medicare Current Beneficiary Survey 2005 Access to Care data.
*ADL = Activities of daily living

The Majority of Home Health Care Spending is Financed Through Part B

Most Medicare home health spending was expected to be financed through Part A; however the majority of Medicare home health spending through 2013 is projected to be financed through Part B.

Medicare Parts A and B Actual and Projected Home Health Spending from Fiscal Years 2000-2013

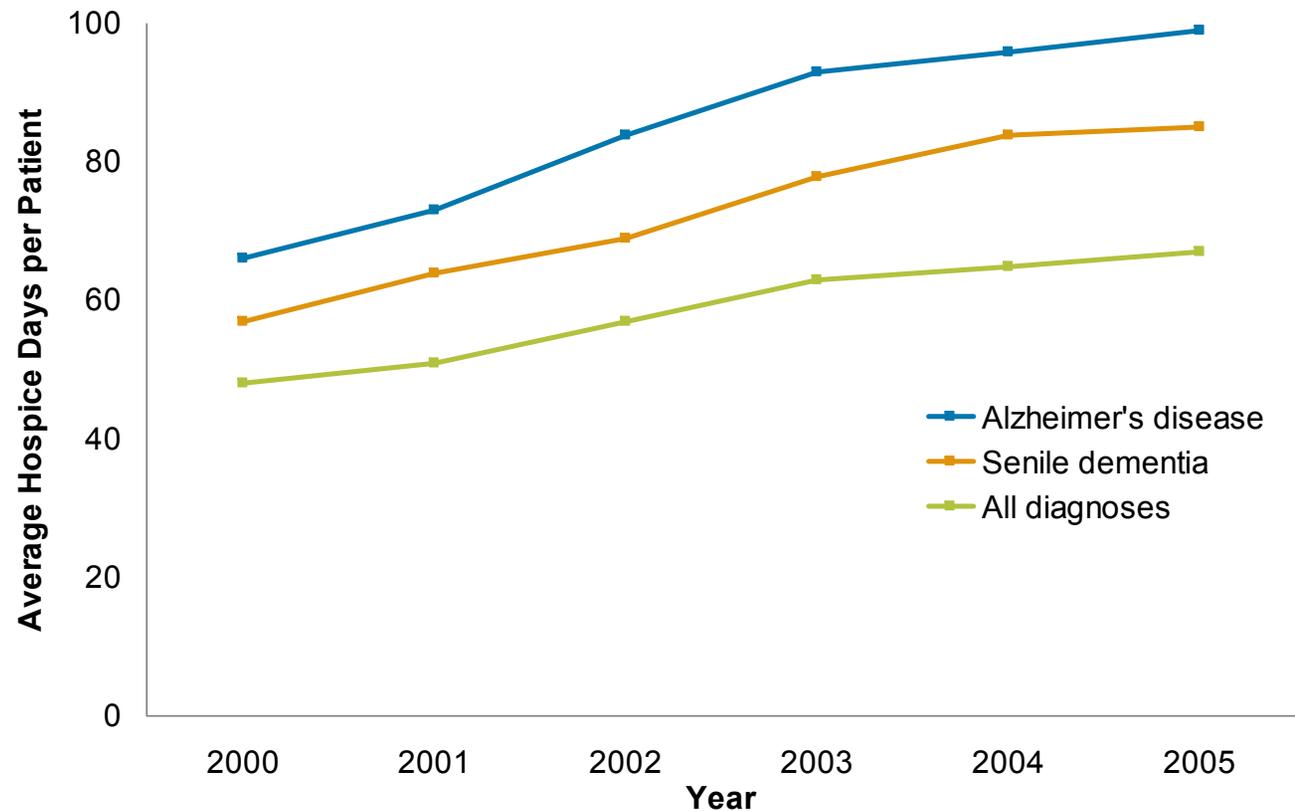


Source: Centers for Medicare & Medicaid Services (CMS), Office of the Actuary. Unpublished.

Recent Growth in Hospice Lengths of Stay Suggests That Some Hospice Services May Fill a Need for Long-Term Care

Medicare covers palliative care and support services for beneficiaries who are terminally ill and have a life expectancy of six months or less. Increasing hospice lengths of stay, particularly for those with a catastrophic long-term care event of Alzheimer's disease or senile dementia, suggests that the Medicare hospice benefit may be addressing a shortfall in long-term care services.

Average Hospice Days per Patient for Select Diagnoses, 2000-2005



Source: Medicare Payment Advisory Commission (MedPAC). Report to the Congress: Reforming the Delivery System. June 2008.

Medicare May Subsidize Shortfalls in Medicaid Long-Term Care Through Skilled Nursing Facility Payments

Medicare pays for some portion of daily skilled nursing facility (SNF) care for up to 100 days following a three-day hospital stay. Margins from Medicare post-acute care payments are often used to subsidize Medicaid long-term care nursing facility rates that do not cover the cost of care.

Medicare and Medicaid Average Nursing Facility Rates, Payments, and Net Payments, 2005 - 2006

Year	Medicare Margin	Medicaid Shortfall	Net Payments
2006	\$3.31 Billion	(\$4.68 Billion)	(\$1.37 Billion)
2005	\$2.82 Billion	(\$4.60 Billion)	(\$1.78 Billion)

Source: BDO Siedman, LLP, and Eljay, LLC, A Report on Shortfalls in Medicaid Funding for Nursing Home Care, Sept. 2007; Eljay, LLC, A Report on Shortfalls in Medicaid Funding for Nursing Home Care, Oct. 2008. Medicare margin percentage derived from March 2008 Medicare Payment Advisory Commission Report to Congress.

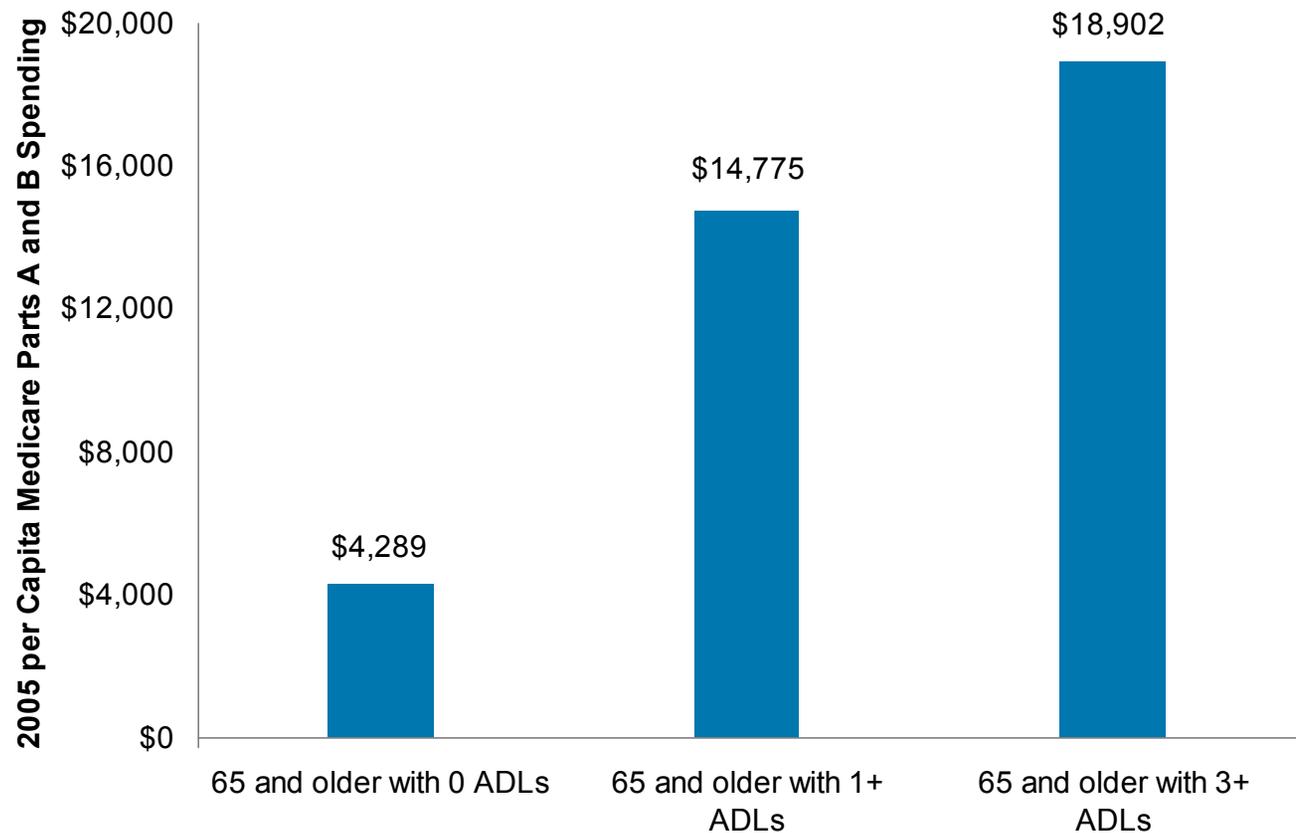
Medicare and Medicaid spending for dual eligibles is largely uncoordinated and unmanaged. Innovative reform efforts can coordinate and manage these services to improve quality and reduce costs.

Large amounts of both Medicare and Medicaid spending covers acute and long-term care services for the elderly and disabled in need of long-term care. Many of these individuals are eligible for both public programs. Reform efforts that simultaneously address Medicare and Medicaid acute and long-term care needs for the long-term care population could produce more efficient and higher quality care.

Medicare Spends Almost 4.5 Times More Per Person on the Elderly in Need of Long-Term Care

Elderly Medicare beneficiaries receiving help with three or more activities of daily living (ADLs) constitute only 7 percent of the Medicare population but account for nearly 25 percent of Medicare spending. These beneficiaries consume nearly 4.5 times more per person in Medicare spending (\$18,902) than those without disabilities (\$4,289).

2005 Medicare Parts A and B per Capita Spending

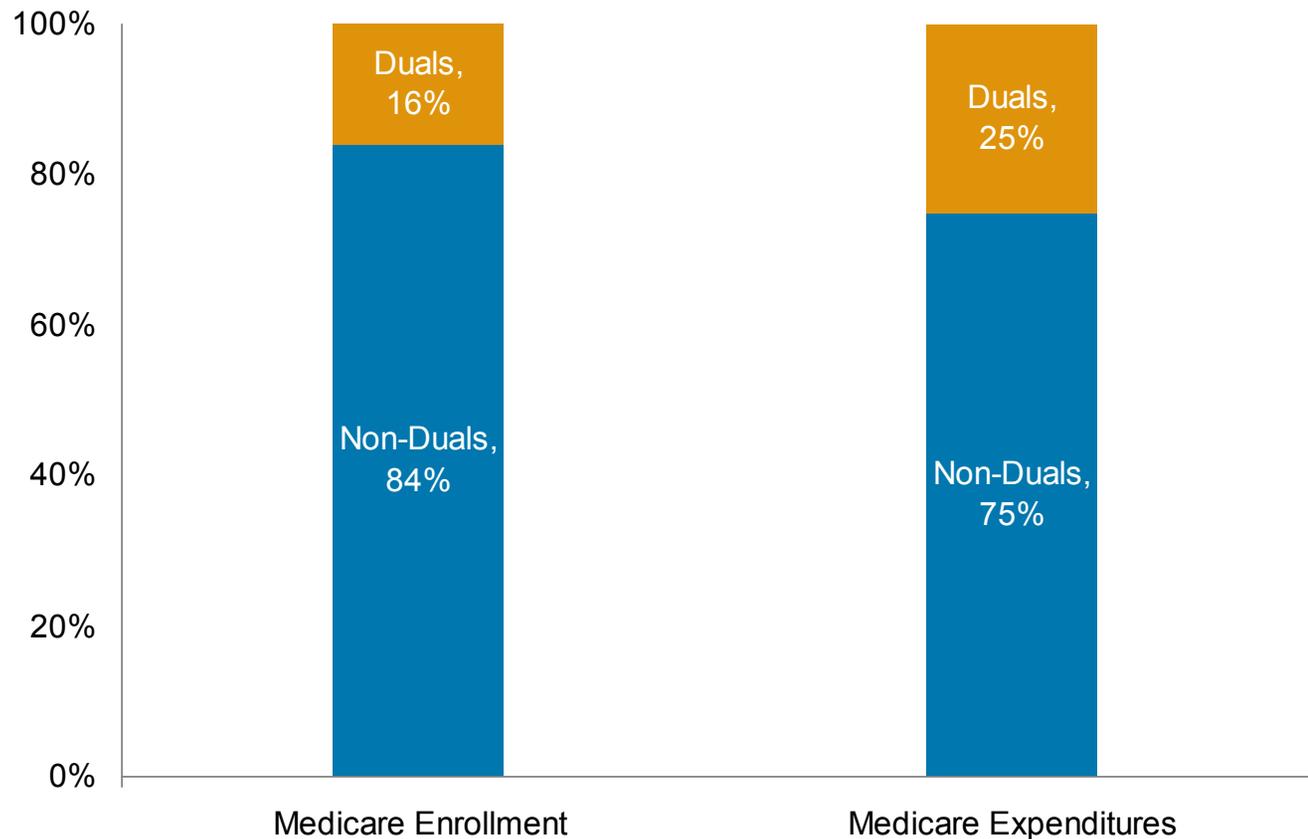


Source: Avalere analysis of the Medicare Current Beneficiary Survey 2005 Access to Care data.

Dual Eligibles Also Consume a Disproportionate Share of Total Medicare Spending

Compared to non-dual eligible Medicare beneficiaries, the dually eligible are more likely to be in poor health or disabled, live in a long-term care facility, and have two or more chronic conditions. The dually eligible account for one-quarter of Medicare expenditures.

Estimated Medicare Enrollment and Expenditures, FY 2005



Source: Centers for Medicare & Medicaid Services. Medicare Current Beneficiary Survey 2003 Section 8. How do Dual Eligible Medicare Beneficiaries compare to Non-Dual Eligible Medicare Beneficiaries?; MedPAC. June 2008 Data Book.

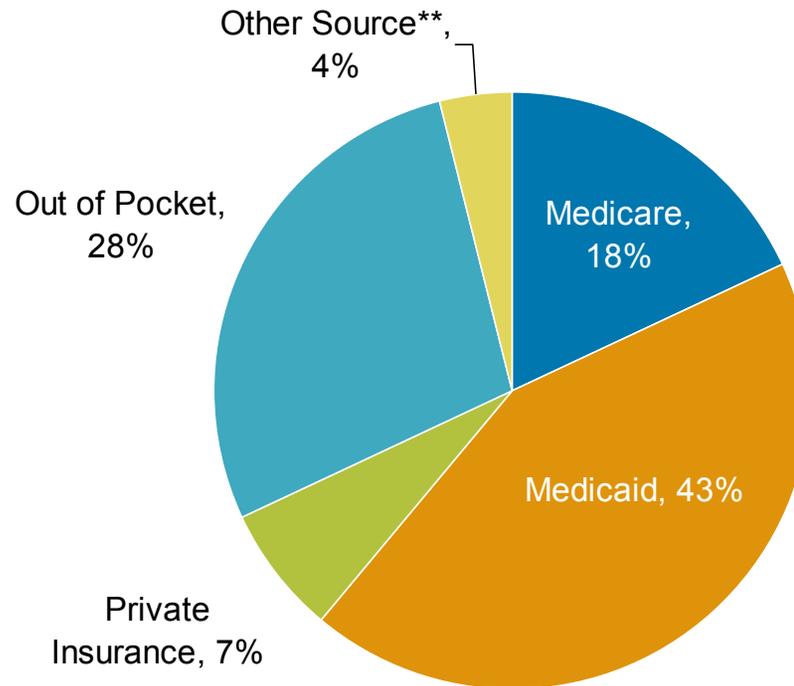
A significant amount of long-term care is privately financed and provided by informal caregivers. Reform efforts can leverage, rather than replace, these private contributions.

Individuals and their families pay for and provide many long-term care services. This amount of dedicated resources indicates a willingness on the part of individuals and families to contribute to the cost of long-term care. Reform efforts can emphasize complementing and supporting, rather than replacing, these private contributions to long-term care.

Thirty-Five Percent of Long-Term Care is Privately Financed

In 2006, individuals and their families contributed an estimated \$64 billion in private out-of-pocket spending on long-term care. In addition, families and communities played a central role in the nation's long-term care system by providing unpaid care giving valued at \$350 billion.*

2006 Sources of Payment for Long-Term Care (Home Health, Nursing Facility, and Assisted Living Care) as a Percent of Total Payments



Total 2006 Payments = \$231 billion

Source: 2006 CMS National Health Expenditure Data; Medicaid Expenditures for Long-Term Care Services: 2006 by Brian Burwell, Kate Sredl, and Steve Eiken; National Investment Center for the Seniors Housing and Care Industry MAP Data and Analysis Service, estimates include spending on assisted living, dementia care, and board and care homes.

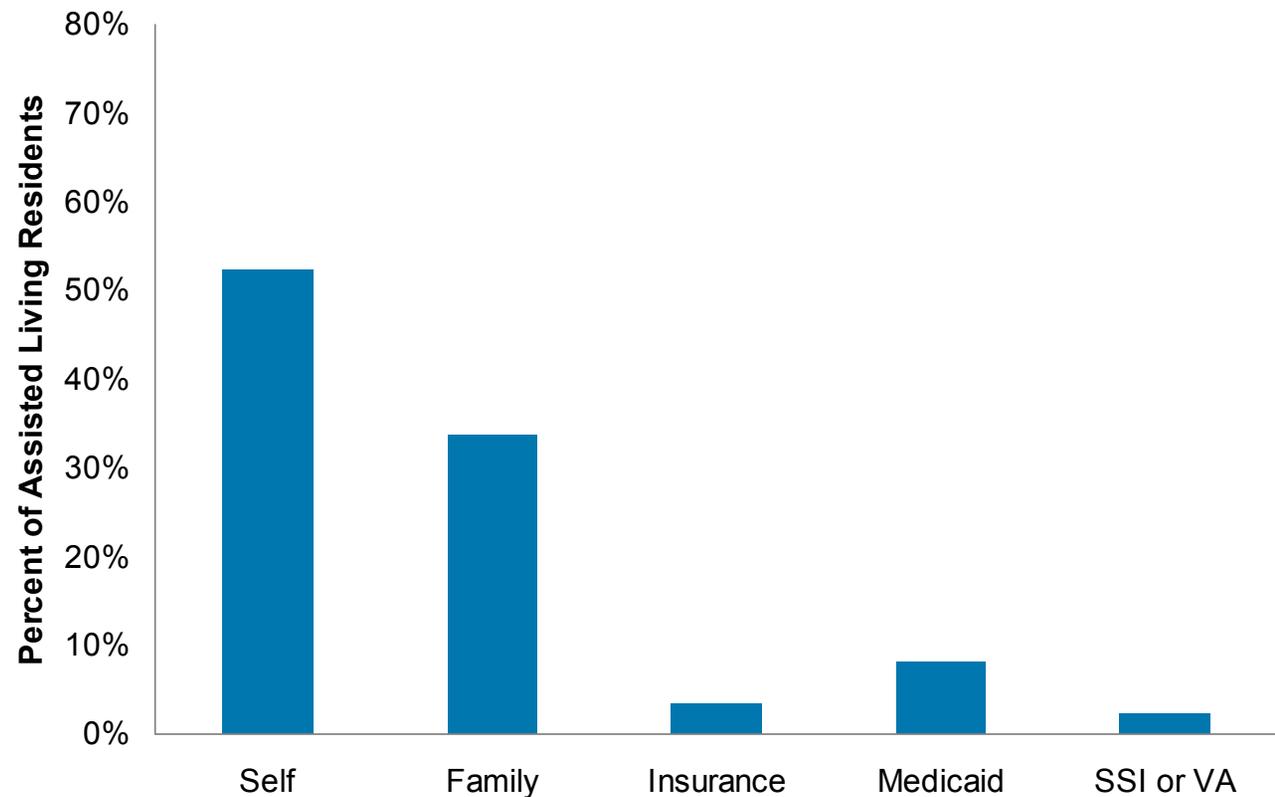
*Gibson, Mary Jo, Ari N. Houser, In Brief: Valuing the Invaluable: A New Look at the Economic Value of Family Caregiving, AARP Public Policy Institute, June 2007.

**Other source includes Veterans Affairs and other state and local programs

Most Assisted Living Facility Care is Privately Financed by Residents or Their Families

More than half of assisted living residents pay for their assisted living fees themselves, while family members pay the assisted living fee for more than one-third of assisted living residents. Reform efforts can leverage these private resources.

Source of Payment for Assisted Living Facility Fees

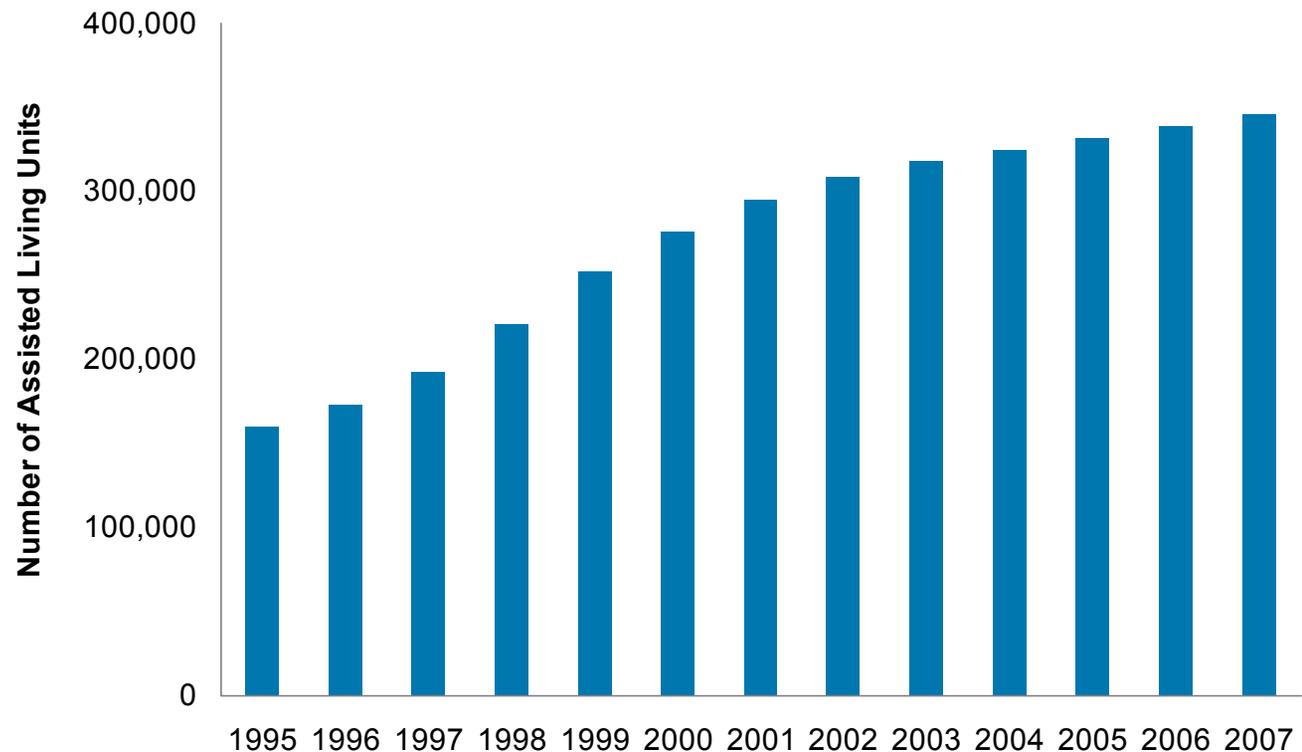


Source: 2006 Overview of Assisted Living, jointly produced by AAHSA, ASHA, ALFA, NCAL, and NIC, available www.nic.org

Individuals and Families' Willingness to Privately Pay for Assisted Living Care May Have Contributed to Rapid Growth

In 1995, only an estimated 160,000 assisted living units existed in the top 100 metropolitan statistical areas. By 2008, the number of units had grown, at an average annual rate of about 7 percent, to about 350,000. Reform efforts can complement and support the willingness of individuals and families to contribute to long-term financing.

Growth in the Number of Assisted Living Units



Conclusion

Policies to reform long-term care have the opportunity to strengthen current health reform efforts. The long-term care population accounts for significant shares of Medicaid and Medicare spending. Any efforts to reform these programs should consider the roles of Medicaid and Medicare in financing acute and long-term care services for the elderly and disabled. In addition, reform efforts can also include innovative ways to coordinate and manage the healthcare needs of the elderly and disabled that are beneficiaries of both Medicare and Medicaid. Reform efforts can also leverage the significant amount of long-term care that is financed and provided privately in order to support and complement individual and families' efforts.

The SCAN Foundation is an independent nonprofit foundation dedicated to advancing the development of a sustainable continuum of quality care for seniors that integrates medical treatment and human services in the settings most appropriate to their needs and with the greatest likelihood of a healthy, independent life. The SCAN Foundation supports programs that stimulate public engagement, develop realistic public policy and financing options, and disseminate promising care models and technologies. The SCAN Foundation was created through a contribution by SCAN Health Plan, a nonprofit Medicare Advantage organization based in California.

Avalere Health is a leading advisory company focused on business strategy and public policy. It serves a diverse client base, which includes Fortune 500 healthcare technology companies, federal government agencies, and major medical foundations. The company is organized into seven substantive areas - Medicare, Medicaid, Reimbursement, Long-Term and Post-Acute Care, Health Information Exchange, Evidence-Based Medicine, and Education. Anchored by a comprehensive research engine and staffed by experts in business, medical product commercialization, and health policy, Avalere provides strategic guidance, objective analytic research, and quality educational programs focused on the full range of healthcare issues facing our nation.

Charts may be reproduced or reprinted for free distribution with specific attribution to The SCAN Foundation and Avalere.