The Feasibility of a Long-Term Services and Supports Social Insurance Program for Hawaii

A Report to the Hawaii State Legislature

December 15, 2014

Executive Summary

State of Hawaii

Department of Health

Executive Office on Aging

This project was executed pursuant to a contract with the University of Hawaii Research Corporation, No. UH2104A10. Lawrence H. Nitz, Ph.D., Professor of Political Science, Project Principal Investigator. Executive Summary draft Prof. Krysia Mossakowski, Ph.D.

EXECUTIVE SUMMARY

During this era of health care reform in America, the issue of long-term care for the elderly warrants more attention. This has become a crucial issue because the elderly population is growing rapidly in the United States, and the number with functional and cognitive limitations is increasing as is the need for long-term services and supports.[1] Providing this support is not without financial challenges for the family and our community.

- Baby boomers and other generations can be squeezed between the costs of everyday life and the costs of long-term care for their parents and planning for themselves;[2]
- Women at risk of becoming poor and of having no one to care for them in their own old age;[3]
- Elders seeing their life savings threatened;
- Employers who will lose revenue as employee productivity drops from stress and taking time off to juggle long-term care costs and responsibilities.
- Employed caregivers often have to reduce hours or take early retirement, thus jeopardizing their own financial stability[4].

One of the main factors that make long-term care an especially urgent issue in Hawaii is the aging population profile. Hawaii's rate of growth for the older segment of the population is nearly the highest in the nation (see Figure 1 and 2). Figure 1 is the age distribution of the Hawaii resident population in the year 2000 and Figure 2 is a projection to the year 2040. The pattern is clear: as the older population expands in size, the demand for long-term services and supports will inevitably increase.

[1] Long-term services and supports, also known as long-term care, refer to assistance with activities of daily living, which include bathing, eating, dressing, using the toilet, and transferring one's self out of bed or out of a chair, and assistance with tasks associated with independent living like shopping, cooking, and housework.

[2] Boomers, in particular, faced the loss of 22.4% of their net worth between 2007 and 2010. Lori A. Trawinski, Assets and Debt across Generations: The Middle Class Balance Sheet, 1989-2010. AARP Policy Institute, Middle Class Security Project, January 2013, p. 10.

[3] It is well known that never-married, never-partnered people have fewer potential caregivers.

[4] An additional complication affects women who withdraw from the labor force to become caregivers—their own income and future retirement benefits may be diminished.

Figure 1. Age Distribution for the Resident Population of Hawaii, 2000

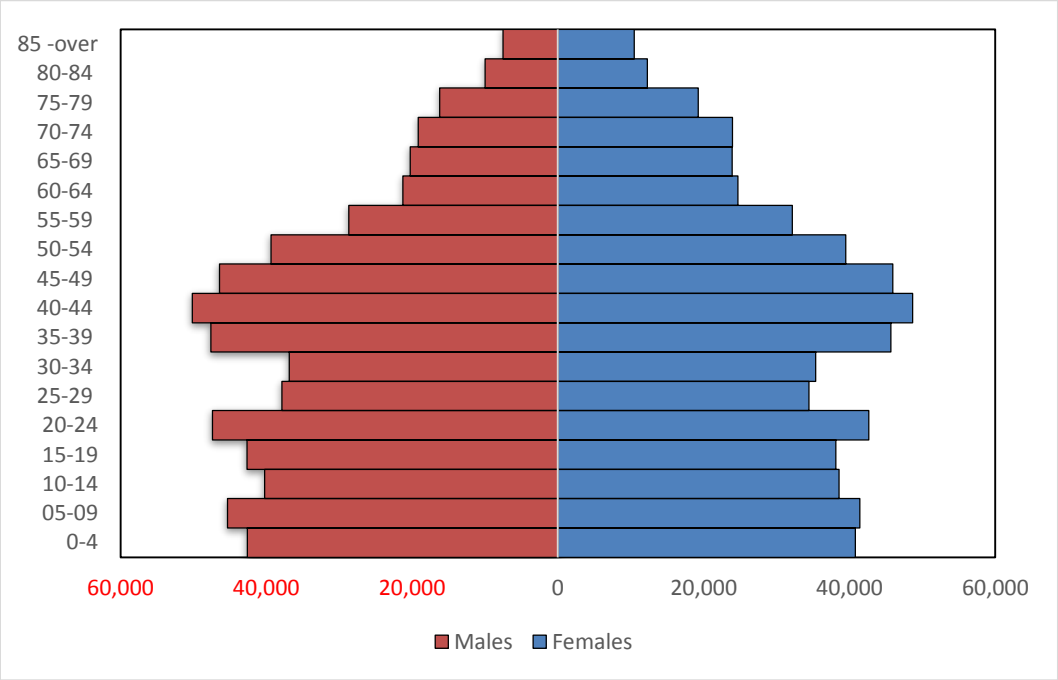
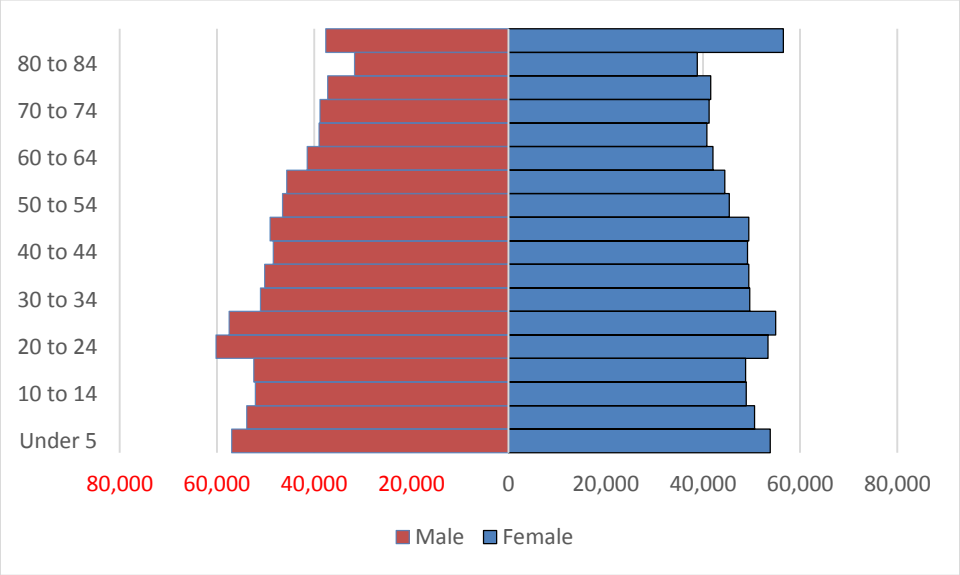


Figure 2. Age Distribution for the Resident Population of Hawaii: 2040



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Unfortunately, the majority of individuals in need of long-term care cannot afford to pay out-of-pocket, while most families cannot afford long-term care insurance, and many who qualify for public assistance programs experience economic hardship paying for services in their penultimate stage of life. It has been estimated that 70 percent of individuals 65 years and older can expect to need long-term care sometime in the future. Thus, the ongoing challenge of providing and financing long-term care raises a key question: How can each state in the nation better help the elderly to maintain their quality of life and age with dignity? This report examines the feasibility of a long-term services and supports social insurance program for the state of Hawaii.

The report highlights the extensive problems of addressing long-term care needs.

1. Baby boomers and other generations are stressed by not only financial difficulties of the costs of everyday life, but also long-term care for their parents as well as planning ahead for themselves.
2. Many families fear that their life savings will be threatened because of the expenses associated with long-term care. This fear may become a reality if they are be forced to completely alter their quality of life:
    a. Converting housing assets to pay for long-term care costs via sale or reverse mortgages;
    b. Liquidating non-housing assets to pay for nursing home costs; continuing to pay for private long-term care insurance, while struggling to avoid a lapse in their payments to prevent a consequent loss of coverage;
    c. "Spending down" to the income and asset levels required for Medicaid to pay for long- term care costs.

Therefore, the state of Hawaii needs to identify a more effective way to ease the financial burden of long-term care.

As a result of Hawaii's aging population profile and the increasing need for long-term services and supports , the state has vital tasks. These tasks are set out by the United States Administration on Aging's broad national policies for defining and providing mechanisms for aging in place, expanded choice, and quality control of aging services. It is the responsibility of the states to actually build the mechanisms for providing these services.

- The states must administer the eligibility reviews for Medicaid programs, set rules, and negotiate payment and other implementation details with the federal government.
- Medicaid services address some of the needs of Hawaii's older citizens:
    - Only after a test of sufficient poverty status to qualify for benefits;
    - A large segment of the population is not eligible.

- The federal health insurance program, Medicare, primarily for people who are 65 years of age or older, does not sufficiently finance long-term care services;
    - Many Americans falsely believe that it is their safety net.
    - Medicare covers short-term assistance with post-acute care services.
    - Medicare covers just the first 100 days in a certified skilled nursing home after hospitalizations and provides limited home health benefits.

Because of the escalating pressure on state budgets for institutional long-term care and the widespread inability of most families to plan for paying institutional care costs, the legislature passed Act 224 in 2008, which created the Hawaii Long Term Care Commission.[5] The Long Term Care Commission evaluated different ways for funding long-term care in Hawaii. In 2012 the Commission released its final report, with a set of recommendations in response to the legislative directive:

- Construct a long-term care education and awareness campaign
- As a source of private long-term care funding, encourage life insurance Support funding for Kupuna Care
- Do not enact tax incentives for the purchase of private long-term care insurance
- Enact a mandatory limited public long-term care insurance program in Hawai'i
- Reconstruct the regulation of domiciliary care facilities, including Adult Residential Care Homes, Extended Care Adult Residential Care Homes, Community Care Foster Homes, Assisted Living Facilities, and nursing homes
- Strengthen Aging and Disability Resource Centers and expand their role
- Consolidate Hawai'i state departments responsible for long-term care into a single agency or department to improve accountability, policy coordination and efficiency (HLTCC 2012).

In response to the Long Term Care Commission's report, funding was provided for this feasibility study of a mandatory limited term, limited benefit social insurance program. The fundamental characteristics of the 2014 program options are: Mandatory membership; limited benefit periods; and limited benefit amounts.

The proposed program allows for more effective coordination of benefits for care providers, and may help prevent a more rapid loss of Activities of Daily Living (ADL) performance levels. Moving the first payments forward represents a substantial benefit for the family. Therefore, the benefit helps people at a critical stage in their disability.

[5]Long-term care proposals have previously been made in Hawaii. A brief review of the history of long-term care proposals in Hawaii is covered in this report. Since the late 1980s, Hawaii's legislature and the Executive Office on Aging have worked on approaches for covering long-term services and supports needs for Hawaii's elders. The Hawaii HOPE proposals from 1992 and the Care Plus proposal from 2003 are discussed in the report and in a historical appendix

The program would be administered by a Board of Trustees of the Hawaii Long Term Care Benefits Trust Fund. The composition of the board is detailed in this report as well as the duties and responsibilities of the trustees, together with their fiduciary and other obligations.

How would an existing long-term care insurance (LTCI) policy fit into this proposed program?

The programs discussed here share a set of common characteristics that will make comparison of outcomes and effects possible.

- An initial limited indemnity benefit of $70 per day, a substantial share of the cost of home care or similar non-institutional services.
- A graduated inflation adjustment.
- A limit of 365 days of not necessarily consecutive service.
- Common HIPAA disability trigger requiring hands-on assistance with 2 or more Activities of Daily Living (ADLs) or cognitive impairment (senility or Alzheimer's disease).
- A 30 day elimination period before payment of benefits.
- No underwriting of an individual's risk of care, providing that they were not receiving long-term supports or services at the beginning of membership.
- A 10 year process of incrementally vesting the full value of the benefit or "de-vesting" in the even a person fails to meet membership requirements. This serves to protect against predatory migration, and also safeguards the interests of folks who have been long-term contributors.

An existing LTCI policy which starts benefits after 100 days of paid services only begins payments a good way through the benefit period offered by these proposed packages. The programs discussed in this report offer a level of benefits that can be delivered in the home or in community settings. For persons with no private LTCI policy, the 365 day benefit may be stretched by not using services every day. Because the proposed Hawaii social insurance package provides benefits without setting income or asset limits, it may reduce the pressure to consume f income and assets to qualify for Medicaid benefits for some families not at the poverty level.

Essentially, the goal of these prospective programs is to propose a limited length of benefit that will capture the largest share of the population. The 365 days of services will not cover lifetime care, and is not targeted at covering the costs of nursing home care. The duration of care can bridge the family's ability to adjust schedules, arrange work hours, and keep caregivers' regular jobs and benefits safe—especially those of women in the labor force who are not yet ready or able to retire. This form of relief may prove to be one of the most important to protect current caregivers from tough financial circumstances when they become older.

The Long Term Care Commission recommended a "Working Population" model. This poses a fundamental question: What are the consequences of building a program for a limited population versus the whole population? Experience with Hawaii's 1973 Prepaid Health Care Act reveals that the definition of "working" is complicated for purposes of a social insurance program. In the Prepaid Health Care Act case, the floor is 19 hours per week—but for over three weeks a month. Working 18 hours per week or for only 3 weeks does not qualify an employee for employer-paid health insurance. It is not uncommon in Hawaii for people to be working multiple part-time jobs and there is no effective way to count the two or three part-time jobs as "full time employment." Defining "working" for purposes of long-term services and supports insurance can be similarly difficult. Two additional options to address the "working" definition are also discussed.

Other critical questions addressed in this report include: Why social insurance? Why not general funds financing? Why not only private long-term care insurance?

- A social insurance program can cover a population because it takes all of the cases, some high risk and some low.
- Over time the population comes to resemble the lowest risk cases.
- This works only if the program takes everyone. When it does so, it shares the risk across the entire group.

The level of services that will provide the most immediate direct service can vary over time. The family clearly needs assistance early in the disability experience.

- At the beginning, however, there may be little need for continual care, and even less for full service nursing home residency.
- More people will use assistance in their homes or community settings than will experience long nursing home stays.
- Most people prefer to stay in their homes as they age.
- A program that begins early provides peace of mind for the family, which would otherwise not be possible with a benefit structure that required longer waiting periods.

What does care at home or in the community cost? It is expensive if not provided by a family member. According to the Genworth Survey for Hawaii (2014), the median cost for homemaker services is $23 per hour, home health services is $25 per hour, and the cost for adult day health care is $74 per day. In general, persons with 2 ADL deficiencies can manage quite well in their own homes with additional care or in community facilities, such as day-care or day-health centers

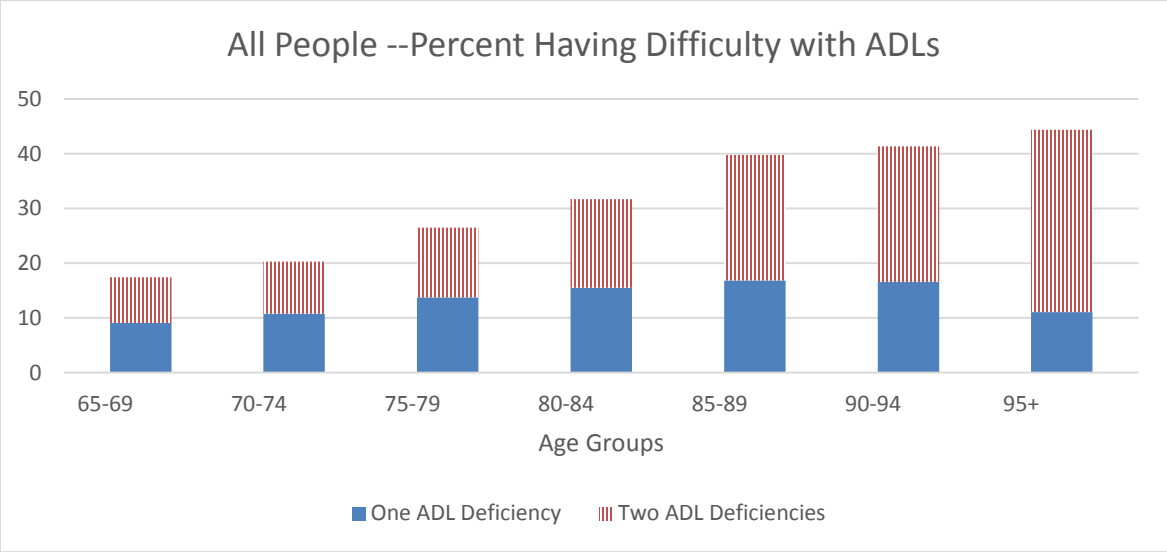
Therefore, this report opens the following important questions: What is the level of expenditure that most of our citizens can afford? At what level of benefit does the program maximize the sharing of risk? Which levels of care come first in the effort to restore or compensate for ADLs that cannot be continued without assistance? Several contemporary

studies have examined the use of assistance, notably "assistive devices" by consumers to help with ADLs and disability related to aging.

Hawaii's adoption of the Aging Disability Resource Centers (ADRC) program allows the State to test the relationship between measured disability and the provision of services without pressing strict mathematically specified measurement standards. Because the ADRC is available for broad assessment purposes, and Kupuna Care can disburse services to individuals whose income is not so low as to qualify for Medicaid.

The Medicare Current Beneficiary Survey shows an increasing proportion of people have difficulty with one or more ADLs as age increases. Figure 3 illustrates the distribution of one and two+ ADL deficits in the 65+ Medicare population.

Figure 3. Percentages of Population with One or Two and More ADL Difficulties



Each of the prospective programs in this report will have membership requirements for eligibility, (e.g., 2 ADL deficiencies), and a procedure for vesting of the program benefits with Hawaii residents. Social insurance programs for a whole nation define "membership" as citizenship and residency, or by some other global performance standard. In addition, American citizens moving across borders raise constitutional issues which can make defining "membership" or "residency" for a state-funded program problematic. Whether outmigration would be increased by mandatory membership is also examined. As long as a definition for *eligibility* allows all residents to qualify on the same basis, equal treatment can be provided.

One of the main purposes of this report is to present basic program options to be considered. Actuarial policy models were created for this report to provide the most comprehensive benefits to the Hawaii population as defined in each of the alternative versions of a social

insurance long-term services and supports program. The Long Term Care Commission\ suggested beginning an examination of a financing program targeting the working population of Hawaii. One critical variant is targeting the whole population for program financing. The financing options include fixed premiums, and graduated premiums based on the income tax, or a surcharge on the General Excise Tax.

The four proposed social insurance long-term services and supports programs are: (1) the flat premium program for working Hawaii residents; (2) the flat premium program for whole population; (3) the income-tax surcharge program for the working population; and (4) the General Excise Tax surcharge for the whole population.

First, the "working" model takes advantage of the fact that the working population is younger and generally healthier than the total population. This advantage works out over time, but initially the effect is that the flat premiums are substantially smaller than those which might be established for a whole population model. Implementing a program targeted initially at "working" people poses both a definitional question and a mechanism question: What does "working" mean? How is the qualifying information collected?

Special Features of the Flat Premium "Working Population" Program

- Premiums charged by an adjustment to Hawaii Resident Income Tax Return (N13).
- Spousal coverage incorporated via the tax return for couples filing joint returns.
- Program requires a functional definition of "working."
- Premium or tax must be incremented by the legislature every year to compensate for population aging and in-migration of mature adults.

The second program involves extending the flat premium program to the whole population, which simplifies the definition of eligible beneficiary, but extends the risk profile of the population initially covered.

Special Features of the Flat Premium "Whole Population" Program

Because the bulk of the population is included, there is no need to define "working" for purposes of program membership.

The third program features an income tax surcharge because the Long Term Care Commission requested a proposed program option with a graduated fee. The effect of an addition to the income tax, by surcharge or rate increase, is to adopt the existing graduation plan. This effect is usually progressive, such that people earning more income pay more for the program.

However, there are distinct disadvantages to any income-tax based program because any increase in income tax is not very popular among members of the public.

Special Features of the Income Tax Surcharge "Working Population" Program

- Premiums charged by rate surcharge adjustment to Hawaii Resident Income Tax Return (N11 or N13).
- Spousal coverage incorporated via the tax return for couples filing joint returns.
- Tax collections increase automatically as income goes up, and should need legislative adjustment only rarely.

The fourth and last option is the General Excise Tax Long Term Services and Supports Trust Fund, which would provide program support beyond the population of Hawaii income tax filers. More than one third of the General Excise Tax (GET) is paid by people passing through Hawaii, such as tourists. Thus, the incidence of a GET adjustment would not only affect Hawaii residents. In order to allocate benefits to eligible Hawaii residents it would be necessary to build a membership tally from an administrative procedure, such as the income tax return. Note that in this program no money would be collected from the income tax return.

Special Features of a General Excise Tax Based "Whole Population" Program

- Premiums charged by single rate adjustment to the Hawaii General Excise Tax.
- Spousal coverage and membership information incorporated via the ID information on the tax return for couples filing joint returns and for persons filing individual returns.
- Tax collections increase automatically as expenditures in the Hawaii economy grow, and should need legislative adjustment only rarely.

The focus of the analysis of the programs is their solvency. To allow meaningful comparisons, the four programs share the same benefit package. Key flow of funds figures and tables are presented for each of the four programs in this report. The fundamental standards are that each program must not pay out more than it takes in, and that it must always maintain a fund balance more than sufficient to meet the next year's expected benefit payments.

To summarize in brief:

- The premium based program for the working population requires an initial premium of $12 per month, which is increased 5% each year. The flow of funds is consistently positive; a surplus appears in the last decades of computation.
    - Extension of the premium based program to the whole population requires an initial premium of $17.50 per month, with a 5% annual increase.
    - The increase covers the cost of inflation increments in benefits and the additional growth in the older segments of the population.
    - The whole population premium based model is not as robust as the premium model limited to working members.
- The model for insuring the working population by way of an income tax surcharge requires an addition to the Hawaii Resident Income Tax of 0.70%.
    - This program option is short-term solvent and the fund ratio declines steadily. This steady decline violates one of the rules of thumb of long-run solvency—that the fund ratio should be broadly increasing at the end of the planning period.
    - Thus, the projection shows that it would be advisable to provide a steady growth in the amount added every year.
- The whole-population program based on a General Excise Tax (GET) surcharge of 0.4% is solvent over the entire 75 year period.
    - Beyond the year 2060 a surplus appears.
    - This program is funded from an addition to the GET, and is thus paid by everyone, including visitors to Hawaii.

In closing, this report further discusses the policy implications of the four program versions and some important caveats. Finally, remarks on tax incentives for long-term care insurance purchase and public/private partnership insurance options are offered. The Hawaii Long Term Care Commission recommended against enacting tax incentives as well as promoting "Public/Private" programs. In conclusion, the ultimate question of whether the long-term services and support needs of older residents should be covered in part by a social insurance program, rather than fully financed by privately purchased insurance or Medicaid is a broad policy decision. It cannot simply be answered by the actuarial pricing models shown in this report. The choice of a broad financing strategy is a policy decision for Hawaii's legislature that addresses a priority for Hawaii's people.