

THE IMPACT OF BBA, BIPA and MEDICARE+CHOICE ON LTC (Why Medicare/Medicare Supplement is SHORT-TERM CARE)

(For a complete description of Medicare, Medicare supplement and Medicare+Choice, see Appendix A in “Long-Term Care: Your Financial Planning Guide” on pp. 210-249.)

The Balanced Budget Act of 1997 cut \$115 billion from Medicare for the five-year period 1998-2002. These cuts were largely responsible for 935,000 older Americans losing their HMO coverage in 2000 due to HMO's pulling out, and about one million people falling out of the home health care system. (The number of Medicare home health visits dropped 40% from 1997 to 1998.) Largely because of the drastic impact BBA had on nursing homes and home health agencies specifically and HMOs in general, the Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act of 2000 restored some dollars to Medicare for skilled nursing care, but those provisions expired October 1, 2002, resulting in a \$1 billion decrease in payments.

For state by state patient per day impact, see www.ahca.org/brief/medicare/medicare_index.htm.

A significant change effective October 1, 2002 requires skilled nursing facilities to consolidate billing for physical, occupational and speech therapy along with the room and board, even for those stays that are not covered by Medicare. I believe this will ultimately lead to bundling these charges in the private sector, which will drive up the cost of SNF care and create a need for higher daily benefits to be sold for LTCI.

An important accomplishment of BIPA was to eliminate yet another 15% cut in Medicare home health care reimbursement. The specific amount for home care to be cut by the BBA was \$16 billion, but estimates are that it would have been \$69 billion without any intervention from subsequent legislation. Much of the benefit reduction is being accomplished by the application of the Prospective Payment System for home health care, effective 10/1/00, and for nursing homes which was in by 2002. The rehabilitation providers went under the PPS 4/1/01 and outpatient hospital charges have also been pulled under a prospective payment system for the first time.

Similar to the Medicare DRG system for hospitals, there are 44 Resource Utilization Groups for nursing home payment determinations. There are about 80 Home Health Resource Groups which are used to determine a specific Medicare payment for a

home health episode, based on the nature of the health condition, the care needs of the patient, and local wage rates for home health agency employees. Under the old payment system, home health agencies were reimbursed by the visit, thereby creating an incentive to do more visits. The new PPS provides an incentive for less visits as the cost for each visit is withdrawn from the predetermined amount for the HHRG. The agency may go over on some patients and under on others, but the goal is not to exceed the total reimbursement for all patients. This could result in longer, better quality visits than the one-hour average under the old system, but fewer visits for sure. An example: A wound care patient under the old system might receive 12 weeks of daily visits at \$90 per visit, or a total of \$7,615. The new system might pay for 9 weeks of 3 visits per week at \$90 per visit, or a total of \$2,523.

This means home health agencies will look for creative ways to curtail costs such as using telemedicine and new technology to provide care without a personal visit by a home health aide. The agencies will also have the goal of teaching family members how to provide ongoing care vs. having the home health professional administer the care.

This total change in Medicare reimbursement practices for home health care means a much greater need for long-term care insurance!!

The challenge is to get the home health agencies to realize the profit margin with LTCI is much higher than with the new Medicare PPS. Let's consider the profit margin under the PPS based on an average payment of \$2,691 per 60-day episode of care. That is bounced against an average estimated cost of \$1,996. (The PPS payments were determined by estimating 32 visits per episode when the actuality has been only about 22 visits in the first half of 2001.) In fiscal year 2001, PPS episode payments ranged from \$1,114 for the least intensive group to \$5,947 to the most intensive group. (Source: "Medicare Home Health Care: Payments to Home Health Agencies are Considerably Higher than Costs", General Accounting Office, May 2002)

A LifePlans, Inc. claims study shows that people average 59 hours of care per week (which will likely increase as more funding through LTCI is available). A very conservative estimate is that a \$100 day benefit (\$3,000) will generate \$6,000 for a 60-day period, or even \$4,500 if they have care five days a week instead of seven. That's higher than the PPS payment for the most intensive level of

care, so you know the profit margin would be significantly larger than with Medicare PPS payments.

And benefit payments will be higher than that example, based on the higher daily benefits being purchased in today's policies, especially as purchasers are moving away from lower percentages for home care toward making the home care benefit equal to the nursing home benefit. Using the average \$18/hr for a home health aide, an 8 hr. shift would generate a daily \$144 benefit payment on a reimbursement policy with a DB of \$150.

Of the eight choices implemented November, 1999 by BBA under the new Medicare+Choice program,¹ only HMOs (with and without a point-of-service option) and one private fee for service plan² are operational today in addition to the original Medicare program. A few have drug coverage with co-pays ranging from \$7 to \$20 (brand-name) prescriptions. 70% went from zero premium in 1998 to less than half in 2001. In 2000, 21% of rural beneficiaries had access to a Medicare+Choice plan, compared to 97% of urban beneficiaries (GAO-01-1010T, 7/21/01). To see managed care plans in your area, go to www.Medicare.gov.

Premiums of some Medicare+Choice plans decreased in the first quarter of 2001 as a result of the additional funding provided by BIPA of 2000. (Medicare's minimum payment for each beneficiary went from \$405 to \$525 per person in metropolitan areas and to \$475 in all other areas.) Only a 2% increase is scheduled for 2003, but a risk-adjusted program is supposed to be phased in by 2007, which will base payment more on medical condition. Medicare is doing some of this now based on inpatient hospital days the previous year (Kaiser Foundation, 7/01). Premiums for high-option Medicare supplements increased due to usage of the drug benefit in plans H, I and J.

1 See Appendix A, p. 240 in *Long-Term Care: Your Financial Planning Guide* for the history on the Medicare+Choice program.

2 Sterling Life Insurance Company was available in 27 states, as of March 2002 (Alaska, Arkansas, Arizona, Delaware, Iowa, Illinois, Idaho, Kentucky, Louisiana, Minnesota, Mississippi, Montana, Nebraska, North Dakota, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia. Providers are not allowed to charge more than the Sterling Life payment for services. No network, no drug benefit. \$78/mo. plus the \$54 Part B premium.

Medicare/Medicare Supplement is Short Term Care

Medicare and supplemental coverage to Medicare continue to provide care for three months or less, primarily for sub-acute care: Care is 100% skilled in nursing homes and a mixture of skilled and custodial for home health care. (In 1995, Medicare paid 45% of home health care and in 2000, that number had dropped to 28%, per the Centers for Medicare and Medicaid Services, 2002)

Don't expect this to change because Medicare spending is growing again. It went from a 9% growth rate in 1997 to a decline of 1% in 1999, then grew only 3% in 2000. The Congressional Budget Office predicts Medicare will average 7.2% annual growth through 2012. Medicaid is projected to average 8.8% for that time frame. Adding a drug benefit will be on top of the Medicare growth.

Health Coverage for Older Americans, Fall 1999

Employer-Sponsored:	33% (84% have RX coverage)
Medicare Supplements:	24% (27% of these have RX coverage)
QMB: ³	11% (all have RX coverage)
Medicare+Choice (HMO):	17% (87% of these have RX coverage)
Medicare Only:	12.5%
Other: ⁴	700,000 (all have RX coverage)

62% of over 65 have drug coverage:⁵

- Employer retiree plans: 9.7 million
- Medicare supplement: 2.3 million
- QMB (Medicaid for low-income:): 3.4 million
- Medicare HMO: 5.2 million
- No drug coverage: 12.9 million
- Other: 700,000

THE AVERAGE AMOUNT SPENT BY MEDICARE SUPPLEMENT POLICYHOLDERS IN 1998 FOR OUT-OF-POCKET EXPENSE WAS \$2,700, MUCH HIGHER THAN THE AVERAGE OUT-OF-POCKET OF \$1,255 FOR PEOPLE WITH NO SUPPLEMENTAL COVERAGE TO MEDICARE!⁶

3 Qualified Medicare Beneficiary (low income and asset people dually eligible for Medicare and Medicaid).

4 Includes VA and State sponsored plans

5 Laschober, Kitchman, Neuman, and Strabic, "Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996-1999", Health Affairs, Project HOPE, February 27, 2002

*includes the average Medicare supplement premium of \$1,300

Question: Have you considered that people with significant assets and income may decide to self-insure balances to Medicare? Even prescription drugs don't represent a huge threat to most Medicare beneficiaries.....only 13% had annual RX of \$2,000 or more in 2001; 10% had \$4,000+ and 4% had \$6,000+⁷

Summary: The more successful managed care plans are in paying for short-term care by covering balances to Medicare, the more money Americans will have to pay for long-term care insurance!

6. "Medigap Insurance: Plans Are Widely Available But Have Limited Benefits And May Have High Costs", General Accounting Office, GAO-01-941, July, 2001

7 "Medicare Chart Book", Kaiser Foundation, Fall 2001, p. 58