Long Term Care in the United States: How Can Financing Be Improved Through Government Policy
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Introduction and Background

Long term care (LTC) is the largest financial liability facing American citizens today. By 2020, the number of people 65 years old will reach 54 million; they will represent one in six Americans. The number of individuals 85 and older will be 7 million. The average annual cost of long-term care will be $140,000 per patient by 2030. Increasing costs associated with long-term care (LTC) will put an increasing burden on families; the costs of LTC are expected to exceed $207 billion by 2020 (see table 1).

Increasing costs have also affected the government, as it is the primary purchaser of LTC through both Medicare and Medicaid. Government funding was responsible for 56% of all LTC in 1995. Currently Medicaid pays for forty percent of all LTC. These public dollars are targeted for the elderly poor.

Some states recently have had significant budget shortfalls and have needed to limit services. Cuts in LTC services provided by Medicaid have come from four principle areas: 1) limiting eligibility 2) reducing services 3) decreasing reimbursement 4) changing institutional and community services.

Prior to 1985, LTC insurance barely existed. The number of people with LTC insurance has been increasing over the last fifteen years. More than six million LTC policies were sold by 1999. One study published in The Gerontologist indicated high patient satisfaction with their LTC policies. Patients indicated it was easy to file their claims and they were able to access care within their homes.

The average premium for LTC insurance in 1995 was $1,806. The average income for purchasers of LTC insurance was $37,000. However, 68% of purchasers had incomes less than $35,000 and assets less than $63,000. An above-the-line tax deduction would allow more people to afford long-term care insurance and would help protect their assets. If people retain their assets, they do not become eligible for Medicaid; therefore, state and federal spending on LTC is reduced.

The backbone of the current long-term care system is informal or donated care. Almost two thirds of eligible individuals receive some care on an informal basis. Only one in twenty eligible individuals receives no informal care. Donated care is usually provided by family members who have variable skills. The estimated value of the donated care is $45 to $94 billion per year.

Currently, LTC is financed through complex system of public and private dollars, which creates problems in trying to determine who is eligible for certain services. Medicare’s LTC benefits are limited (typically ninety days) and Medicaid reaches only the poor or those who become poor through catastrophic expenditures. Individuals with LTC needs eventually may receive assistance from Medicaid, but must often ‘speak down’ – impoverishing themselves before assistance becomes available.

Projections of Long-Term Care Expenditures for the Elderly (in billions of 2000 dollars)

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Private LTC</th>
<th>Out of Pocket</th>
<th>Other</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>29.8</td>
<td>39.6</td>
<td>60.6</td>
<td>a</td>
<td>a</td>
<td>123.1</td>
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<tr>
<td>2010</td>
<td>34.3</td>
<td>46.3</td>
<td>70.4</td>
<td>a</td>
<td>a</td>
<td>160.7</td>
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<tr>
<td>2020</td>
<td>42.8</td>
<td>56.7</td>
<td>82.4</td>
<td>a</td>
<td>a</td>
<td>207.3</td>
</tr>
<tr>
<td>2030</td>
<td>49.3</td>
<td>66.8</td>
<td>94.7</td>
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<td>a</td>
<td>252.1</td>
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<tr>
<td>2040</td>
<td>55.7</td>
<td>76.8</td>
<td>104.8</td>
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</tbody>
</table>

Conclusions

It is clear from the long history of legislative efforts that there is no easy solution to providing access to affordable long-term care. Medicaid remains the payer of last resort and is the backbone for low-income patients. However, it is not sustainable for Medicaid to remain the major financer of LTC. In this country, patients demand choice when making their healthcare decisions. Choices should continue to be available when making decisions about long term care, both in terms of financing and in the delivery of the care. Choices should include the option of group enrollments through payroll deduction as part of a cafeteria plan of benefits. The federal government currently has this option for its employees. For example, a 41-year old male can obtain the premium policy for approximately $115.00 per month, and could combine the policy with a tax-deductible medical savings account. Tax incentives should be an option for people who cannot obtain coverage through an employer. Previous studies have shown that tax incentives are a wise investment in that they encourage patients to use resources responsibly and effectively in order to meet their individual healthcare needs.

References

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