The Challenge of Financing Long-Term Care

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THE CHALLENGE OF FINANCING LONG-TERM CARE

JUDY FEDER*

Despite the continued political battle surrounding the Affordable Care Act, even critics recognize that insurance is essential to assure access to health care and protection against financial catastrophe associated with its costs. Although insurance is similarly essential to assuring access and financial protection for long-term care—the need for personal help with basic daily tasks like bathing, eating, or toileting—insurance protection is lacking. Private health insurance doesn’t cover long-term care, and few Americans have private long-term care insurance, which typically costs a lot, offers limited value, and is subject to premium increases that can cause purchasers to lose coverage they have paid into for years. On the public side, Medicare—which older people and some younger people with disabilities rely on for health insurance—does not cover long-term care. The federal-state Medicaid program does serve as a valuable last resort for people who need long-term care, but its protections (especially for care at home) vary considerably from state to state and become available only when people are, or have become, impoverished taking care of themselves.

As a result, families bear enormous responsibility for caregiving at substantial physical and economic cost; overall access to long-term care falls short of demonstrable need; and individuals and families who need care are at risk for its potentially catastrophic costs. As the population ages, the inadequacy and inequity of current long-term care financing mechanisms will only increase. Enactment of an effective insurance system, with public protection at its core, is essential to protect Americans against the unpredictable, catastrophic risk of needing expensive, extensive long-term care.

* Judy Feder, Ph.D., is a professor and founding dean of the McCourt School of Public Policy at Georgetown University and a Fellow at the Urban Institute in Washington, D.C. This paper draws extensively on JUDY FEDER & HARRIET KOMISAR, THE IMPORTANCE OF FEDERAL FINANCING TO THE LONG-TERM CARE SAFETY NET (SCAN Found. ed., 2012), available at http://www.thescanfoundation.org/sites/thescanfoundation.org/files/Georgetown_Importance_Federal_Financing_LTC_2.pdf. Statistics have been updated, as noted.
I. THE NEED FOR LONG-TERM CARE IS A RISK, NOT A CERTAINTY

Although the risk of needing long-term care rises at older ages, people of all ages are at risk—and even at older ages, whether and the extent to which a person may need long-term care varies widely among individuals. Among people under the age of sixty-five, less than two percent have long-term care needs, but they constitute over five million of the roughly twelve million people who need long-term care.

Among people now turning age sixty-five, an estimated three in ten will not need long-term care during the rest of their lives, while two in ten will need five or more years of long-term care.

Even among people aged 65 and over, the need for long-term care is a risk, not a certainty—years of care need vary considerably.²

Percent of people now age 65, by estimated years of needing care after age 65

<table>
<thead>
<tr>
<th>Years needing long-term care after age 65</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero</td>
<td>31%</td>
</tr>
<tr>
<td>1 or less</td>
<td>17%</td>
</tr>
<tr>
<td>1-2</td>
<td>12%</td>
</tr>
<tr>
<td>2-5</td>
<td>20%</td>
</tr>
<tr>
<td>More than 5</td>
<td>20%</td>
</tr>
</tbody>
</table>

The bulk of long-term care today is provided not by public programs, but by families.³ Most people who need long-term care (over eighty percent of people with long-term care needs living at home) rely solely on family and friends to provide it and do not receive paid services.⁴ For many people, that may be as it should be—families doing what families do. But the health and economic costs of caregiving can be substantial.⁵ And families cannot always provide the full amount, intensity, or type of care that is needed. Accordingly, spending on long-term care varies enormously. Though just over forty percent of people

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⁴. Kaye et al., supra note 3, at 15.
now turning age sixty-five are predicted to incur no care costs at all, expenses for the costliest five percent are estimated in the hundreds of thousands of dollars.

### SPENDING VARIES EVEN MORE

Distribution of Future LTC Expenditures for Persons Turning 65, All Sources

<table>
<thead>
<tr>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero</td>
<td>42%</td>
</tr>
<tr>
<td>Less than $10,000</td>
<td>19%</td>
</tr>
<tr>
<td>$10,000 - $25,000</td>
<td>8%</td>
</tr>
<tr>
<td>$25,000 - $100,000</td>
<td>14%</td>
</tr>
<tr>
<td>$100,000 - $250,000</td>
<td>11%</td>
</tr>
<tr>
<td>More than $250,000</td>
<td>5%</td>
</tr>
</tbody>
</table>

Note: Expenditures are calculated as the discounted present value, in 2005 dollars, of future spending.

II. THE COST OF LONG-TERM CARE CAN EXCEED THE RESOURCES OF PEOPLE WHO NEED IT

When paid care is necessary, its costs can far exceed most families’ resources. In 2012, personal assistance at home averaged twenty-one dollars per hour, or almost $22,000 annually for twenty hours per week of assistance, and adult daycare center services cost an average of seventy dollars per day, or about $18,000 on an annual basis for five days of services per week. For assisted living services averaged $42,600 for a basic package of services. For people who need the extensive assistance provided by nursing homes, the average annual cost was $81,000 for a semi-private room, but varied widely among markets and exceeded $100,000 a year in many of the country’s most expensive areas.

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6. See Kemper et al., supra note 2, at 335-50 (noting that expenditures are calculated as the discounted present value, in 2005 dollars, of future spending).
8. Id. at 4-5.
9. Id. at 4, 18-25.
EXTENSIVE LONG-TERM CARE IS A CATASTROPHIC EXPENSE

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Average Price in 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Home</td>
<td>$81,030 annually, semi-private room</td>
</tr>
<tr>
<td></td>
<td>$90,520 annually, private room</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>$42,600 annually for basic package</td>
</tr>
<tr>
<td>Home Care</td>
<td>$21 per hour</td>
</tr>
<tr>
<td></td>
<td>20 hours per week = $21,840 annually</td>
</tr>
<tr>
<td>Adult Day Services</td>
<td>$70 per day</td>
</tr>
<tr>
<td></td>
<td>5 days per week = $18,200 annually</td>
</tr>
</tbody>
</table>

The mismatch between the costs of these services and the resources of the people who need them is dramatic. Focusing on the older people who are most at risk of needing long-term care, fewer than one-third of people age sixty-five and over have incomes equal to or greater than four times the federal poverty level\(^\text{11}\)—at about $44,000 for an individual age sixty-five or older or $56,000 for an older couple in 2013.\(^\text{12}\) Most people’s incomes are clearly well below what is necessary to pay for institutional or intensive home care.

Although, in theory, savings can help fill the gap between income and service costs, in practice, savings are inadequate to the task. For people of working age who need long-term care, their disability often comes well before they have a chance to accumulate savings that might help pay for long-term care costs. Most older people also lack assets sufficient to finance extensive care needs. In 2013, half the population over age sixty-five living in the community had savings of less than $73,000—insufficient to cover the average cost of a year in the nursing home.\(^\text{13}\)

III. INSURANCE FAILS TO PROTECT AGAINST THE UNPREDICTABLE RISK OF NEEDING LONG-TERM CARE

Given the unpredictability and catastrophic nature of extensive long-term care needs, heavy reliance on savings to finance them is never likely to work. Insurance is the best way to protect against the risk of unpredictable,\

10. Id.
potentially catastrophic expenses. But private insurance for long-term care has never really gotten off the ground and—in recent years—several insurance companies have given up on trying to market a successful product. Only about seven million people are estimated to currently hold any type of private long-term care insurance, and most purchasers have relatively high incomes. Unfortunately, many people in their fifties and early sixties are accumulating insufficient resources to cover basic living expenses in retirement, let alone to finance potential long-term care needs. In addition, available long-term care insurance policies offer limited and uncertain benefits—raising questions about the wisdom of purchase. Policies limit benefits in dollar terms in order to keep premiums affordable, but therefore can leave policyholders with insufficient protection when they most need care; and policies have often lacked the premium stability that can assure purchasers of their ability to continue to pay in year after year, in order to receive benefits if and when the need arises.

IV. MEDICAID PAYS FOR MOST LONG-TERM CARE BUT ITS PROTECTIONS ARE LIMITED AND VARIABLE

It is not surprising, then, that people turn to Medicaid when they need long-term care. To qualify for Medicaid protection, individuals must have low income and savings to begin with, or exhaust the resources they have in purchasing medical and long-term care. Given how high service costs can be, the opportunity to qualify for Medicaid when the costs exceed an individual’s income and savings is essential to assure that people have access to care. But Medicaid limits the availability of care at home, where most people prefer to stay, and recipients of Medicaid benefits in nursing homes are required to spend all of their income on their nursing home care (subject to limits for people with spouses at home), except for a small “personal needs allowance” of thirty to sixty dollars in most states.


15. Id.

Some argue that people “transfer” their assets in order to qualify for Medicaid rather than exhaust their assets before they qualify, allowing even well-to-do people to qualify for Medicaid benefits. But evidence shows the following realities: (1) few older adults have the income or wealth that would warrant such transfer; (2) people in poor health are more likely to conserve than to exhaust assets; (3) for the elderly population as a whole, transfers that occur are typically modest (less than $2,000); and (4) transfers associated with establishing eligibility are not significant contributors to Medicaid costs.18

Despite Medicaid’s importance, its protections vary considerably from state to state and, most, if not all, states fall short of meeting people’s needs. Variation takes multiple forms. The first variation is in the breadth or narrowness of its eligibility requirements and the share of people in need of care each state’s program serves. The states with the most extensive coverage are estimated to reach about two-thirds of low-income adults with long-term care needs—about three times the share in the states with the least extensive programs. Half the states reach only about a third of this population.19

18. FEDER & KOMISAR, supra note 3, at 5.
19. Id. at 6
MEDICAID PARTICIPATION VARIES ACROSS STATES

Percent of low-income adults needing long-term care with Medicaid support, 2007

Note: Estimated in each state as the ratio of the approximate number of people receiving Medicaid long-term services and supports to adults age 21 or older who reside in a nursing home or who reside in the community with income at or below 250% of the federal poverty level and have difficulty with bathing or dressing.

Even greater variation among state programs is apparent when comparing states’ Medicaid long-term care spending per low-income state resident. Medicaid long-term care spending per low-income state resident in the highest spending states (averaging $3,000 in federal fiscal year 2009 in the five highest states) is about six times the amount of the lowest spending states (averaging $500 in the five lowest states). The range is still larger—from about $1,600 to about $200, or eight to one—for Medicaid’s non-institutional long-term care services for people in the community, the setting where most people with long-term care needs reside. For older people and people with physical disabilities, nursing homes and other institutional services continue to dominate spending in most states, with substantial variation across the nation.


21. Id. at 6; Steve Eiken et al., Medicaid Expenditures for Long-Term Services and Supports: 2011 Update, THOMSON REUTERS (October 31, 2011); U.S. CENSUS BUREAU, POVERTY STATUS BY STATE: 2010 (2011) [hereinafter POVERTY STATUS BY STATE]. See FEDER & KOMISAR, supra note 3 (construing POVERTY STATUS BY STATE, supra note 21, and Eiken et al., supra note 21, for state expenditures in federal fiscal year 2009) (also construing POVERTY STATUS BY STATE, supra note 21, for number of state residents with income below 200% federal poverty level in 2010).
Medicaid spending varies across states. Medicaid long-term care spending per state resident with income below 200% of poverty level, 2009

This variation in the availability of home and community-based care services across states, particularly for older people and people with physical disabilities, has enormous consequences in terms of access to adequate care. Unlike most Medicaid services, which the law requires be made available to all people eligible, home and community-based care services are subject to enrollment caps. Most states have limits on enrollment and establish waiting lists for care at home. Most people who have long-term care needs are, in fact, at home—and depend primarily on family for the services they need. But surveys have shown that many people living at home are receiving insufficient care and, as a result, are at a heightened risk of negative consequences—like falling, soiling themselves, or going without bathing or eating. Analysis indicates that the prevalence of unmet needs for long-term care, though significant across the country, is lower in states with greater availability of services at home.

22. FEDER & KOMISAR, supra note 3, at 6 (construing Steve Eiken et al., Medicaid Expenditures for Long-Term Services and Supports: 2011 Update, THOMSON REUTERS (October 31, 2011) for Medicaid expenditures in federal fiscal year 2009; also construing POVERTY STATUS BY STATE, supra note 21, for number of state residents with income below 200% of the federal poverty level in 2010).
MEDICAID SUPPORT FOR CARE AT HOME VARIES ACROSS STATES

Percent of Medicaid long-term care spending on non-institutional services, 2009 for older adults and people with physical disabilities

<table>
<thead>
<tr>
<th>Lowest state</th>
<th>4%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average of 5 lowest states</td>
<td>11%</td>
</tr>
<tr>
<td>Median state</td>
<td>28%</td>
</tr>
<tr>
<td>Average of 5 highest states</td>
<td>63%</td>
</tr>
<tr>
<td>Highest state</td>
<td>79%</td>
</tr>
</tbody>
</table>

The current inadequacy and inequity in Medicaid is only likely to grow with the aging of the population. The percentage of the population age eighty-five and older is expected to increase by more than one-quarter by 2030 (from 1.8% in 2010 to 2.3% in 2030) and to more than double by 2050 (to 4.3%).

THE U.S. POPULATION IS AGING

Percentage of the population that is age 65 and older, 2010 to 2050


It is among this population that the need for long-term care is most substantial. Nearly three in ten people age eighty-five years or older have moderate to severe long-term care needs—three times the proportion among seventy-five to eighty-four year-olds.

![Diagram showing the risk of needing long-term care increases with age.](image)

The risk of needing long-term care increases with age.

What is certain is that the greater the imbalance between the older population and the working-age population, the greater the challenge states will face in sustaining, let alone improving, the adequacy of long-term care services.

V. AN EFFECTIVE LONG-TERM CARE INSURANCE MUST HAVE A PUBLIC CORE

The absence of effective insurance against the risk of needing long-term care is a market and policy failure. The need for extensive, expensive long-term care is precisely the kind of catastrophic, unpredictable risk for which we typically rely on insurance to spread costs. If, as is often claimed, people should “prepare” to manage this risk, they must have a reliable insurance mechanism to which they can contribute. Experience indicates that public social insurance must be the core of that mechanism; private insurance can play a complementary role, but even its proponents estimate that building future policy around a private market will, at best, leave eight in ten Americans uninsured.

When enacted, the Affordable Care Act included a modest version of a public insurance core. The Community Living Assistance Services and

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27. FRANK ET AL., supra note 14, at 2.
Supports Act (CLASS) was designed to provide a limited daily cash benefit to people with functional impairments who make at least five years of payments beginning during their working years (and continue to pay premiums thereafter). But CLASS relied on voluntary participation and was required to be fully premium-financed—conditions the Administration found impossible to satisfy without modifications in the law. The Administration therefore suspended implementation and Congress formally repealed CLASS in 2013.

VI. THE REAL LONG-TERM CARE FINANCING CHALLENGE WILL BE MUSTERING POLITICAL WILL

As baby boomers become caregivers and then care recipients, they may well press policymakers to return to the financing issue—creating an opportunity to enact effective public insurance. Clearly, establishing a new social insurance program will pose an enormous political challenge, especially since its effectiveness will depend on broad financial participation and enhancement of currently inadequate investment in long-term care services. To mitigate that challenge, public benefits could be limited, rather than comprehensive, and could emphasize, or even facilitate, people’s planning for future long-term care needs. For example, benefits could be designed to vary with an individual’s lifetime income—including a waiting period that would be shorter for people with lower incomes, longer for people with higher incomes. With a clear income-related benefit schedule, people could know well in advance the likely risk or “hole” they should plan to fill (or the protection they might want to supplement) from personal resources or private insurance, should they become impaired. This type of public structure would not replace personal responsibility or eliminate a role for private insurance; rather its establishment of a core public benefit would make personal responsibilities more manageable and private insurance more workable.

Support—both political and financial—for public long-term care insurance will require a fundamental change in attitudes toward long-term care. Policymakers and the public must recognize that the need for long-term care is the kind of unpredictable, catastrophic risk that individuals and families cannot be left to bear on their own; that access to affordable long-term care services

29. See Letter from Kathleen Sebelius, Sec’y, U.S. Dep’t of Health & Human Servs., to Congress (Oct. 14, 2011) (stating there was no viable path forward for CLASS implementation); see also American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 642, 126 Stat. 2313, 2358 (repealing the CLASS Act).
30. The author developed this proposal as a member of the Congressional Long-Term Care Commission. See LONG-TERM CARE COMM’N, A COMPREHENSIVE APPROACH TO LONG-TERM SERVICES AND SUPPORTS I (2013).
must be a social, not just personal, responsibility. Until that happens, policy will continue to fail people, young and old, now and in the future, who need long-term care.