Executive Summary

Many Wisconsin residents rely on long-term care services because of frailty or a disability. Although most long-term care is provided informally by family members, formal services also are provided in nursing homes, intermediate care facilities, and community-based settings. In 1996, Wisconsin spent approximately 1.2 billion Medicaid dollars to pay for long-term care services for those who could not afford them. This report provides an overview of long-term care for elderly and nonelderly individuals, discusses the role of the family in providing care, and proposes strategies for reducing the rate of increase in long-term care spending.

Robyn Stone is the executive director and CEO of the International Longevity Center and is the former U.S. Acting Assistant Secretary for Aging. According to Dr. Stone, long-term care includes a broad range of services needed by people with chronic illness or disabling conditions over a long period of time. In 1995, approximately 13 million Americans of all ages needed long-term care. Current estimates indicate that the older U.S. population will more than double between now and the year 2040. Because 57% of all users of long-term care are over age 65, this trend will substantially increase the future demand for long-term care services.

In 1995, approximately 80% of disabled older adults living in the community received informal care from family members. Currently, the competing demands of child care, employment, and elder care place a significant strain on family caregivers. A recent study indicates that the larger the number of problems family caregivers report, the greater the chance that their care recipients will be institutionalized. As such, several initiatives have attempted to help relieve family stress, including the Family and Medical Leave Act, "family friendly" work policies, respite care programs, and caregiver support groups. In addition, some states have begun to pay family members rather than hiring strangers to provide care.

For those individuals who need them, formal services are available in nursing homes and community-based settings. Funding for such services comes from a patchwork of public and private dollars. The most significant funding source is Medicaid, which spent approximately $50 billion on long-term care in 1995. Other funding mechanisms include the Medicare program, which primarily covers acute care and home health service costs; private insurance, which finances a small proportion of nursing home and home care costs; and private dollars. In recent years, some states have moved toward a managed care approach to providing long-term care services, and some have sought to integrate acute and long-term care services. In addition, many policymakers and consumers have called for an increase in assisted living services, as well as a larger emphasis on consumer direction.

In the second chapter of this report, Joshua Wiener, principal research associate at the Health Policy Center of the Urban Institute, describes the under-65 population who uses long-term care services. Advocates for younger people with disabilities have suggested that long-term care providers must move beyond the goals of keeping people safe, clean, and well fed to maximizing independence and self-sufficiency.

Although the use of institutions by younger people with disabilities is declining, this type of care is still common, particularly for individuals with developmental disabilities. Advocates for younger people believe that institutional care should be replaced with home and community-based alternatives. Although this would result in lower costs per person, costs might increase if a larger number of people opt to use home and community-based options.

Services for younger people with disabilities are financed through many sources, including state and federal programs, out-of-pocket payments, and private insurance. In 1993, nearly 40% of Medicaid spending on long-term care went to services for nonelderly people. Because Medicaid applicants must meet eligibility requirements based on an inability to work, the current system of care tends to encourage dependence rather than independence.

In the third chapter of this report, Joshua Wiener discusses three general strategies that states have used to control the rate of increase in long-term care spending. The first involves offsetting state spending for long-term care. Specifically, some states have encouraged individuals to purchase private long-term care insurance. Recent studies indicate that if employers offer group rates for insurance, Medicaid expenditures could decline as much as 31% and the number of nursing home residents could fall by as much as 17% by the year 2018. So far, however, less than one tenth of 1% of middle-aged people have long-term care insurance. Other states have attempted to offset state spending by reducing Medicaid estate planning, whereby individuals transfer, shelter, and underreport assets to appear poor enough to qualify for Medicaid-financed nursing home care. States also have sought to recover the cost of Medicaid long-term care from the estates of beneficiaries who have died. Between 1991 and 1996, estate recovery in Wisconsin increased from $471,000 to more than $9.7 million. Finally, some states have sought to shift long-term care costs from the state to the federal government by maximizing Medicare financing of long-term care services.

A second general strategy for saving money is reorganizing health care delivery in ways that make care more cost effective and efficient. One way is to integrate acute and long-term care services through managed care. This practice has several benefits, including the potential of improving quality of care. However, many long-term care advocates are concerned that managed care providers have little experience with older adults, that financial pressure may shortchange long-term care, and that care would become less consumer directed. A second reform strategy is to expand home and community-based services. Policymakers will need to consider, however, if an increased number of people would consider using long-term care if more attractive options become available.

A third general strategy for reducing costs involves the use of tradi-tional cost-saving methods, such as controlling the supply of providers and lowering reim-bursement rates, which was recently made possible through the repeal of the Boren Amendment. Although both of these methods have the potential to save money in the short term, each has potential drawbacks. For example, decreasing the supply of providers does not decrease the demand for services. In addition, cutting reimbursement rates too much has the potential to negatively impact the quality of long-term care services.