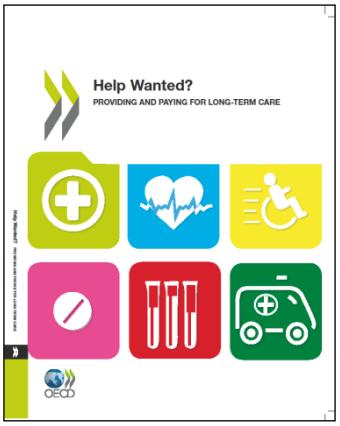
United States

Long-term Care

18 May 2011

Highlights from *Help Wanted? Providing and Paying for Long-Term Care*, OECD Publishing, 2011.



- The United States spent 1% of its GDP on Long-Term Nursing Care in 2007. This share is expected to at least double by 2050.

- Over the same period, the demand for LTC workers as a share of the working population is set to increase by at least 1.5 times, raising the questions of whether current policies to attract and retain care workers are sufficient to meet future demand.

- In some OECD countires, foreign-born care workers form a structural component of the long-term care (LTC) workforce. In the United States, about 25% of direct care workers are foreign-born (EU-15 average of about 10% of workers in the health and other community service sector), while about 4 per cent of the registered nurses are foreign-trained (about 6% among selected OECD countries). Still, options for legal entry of foreign-born are limited. Only a few countries, such as Australia and Canada, have immigration programmes that can apply to long-term care workers.

- The United States is one of the very few OECD countries – together with England – where LTC coverage is provided through safety-net programmes and targeted to the poor, as part of Medicaid. With France, the United States has one of the most developed markets of private LTC insurance. However, it remains a niche product, which principally serves the segment of the population with relatively higher income and accumulated assets. The relatively greater success with private long-term care insurance in France – about 15% of the population aged over 40 years is covered in France, compared to 5% in the United States – can be explained with the development of simpler products in France, which mainly provide a cash-benefit to eligible dependent people.

- The United States is introducing a voluntary, publicly-managed LTC insurance programme as part of new health-care legislation (so-called, Community Living Assistance Services and Supports, CLASS Act). The CLASS Act includes a number of interesting features such as automatic enrolment with the option of opting out as well as the provision of cash rather than in-kind benefits.

- By encouraging care in the community and personal choice, CLASS will help to address one of the main shortcomings of existing arrangements: the bias towards institutional care in Medicaid, which is costly and may not necessarily provide the best care for the user. However, mechanisms to safeguard proper use of the cash, like those in place in France and the Netherlands, should be considered, in order to mitigate the development of unregulated care labour markets or misutilisation of funds. For instance, in France, cash benefits must go towards expenses incurred in line with a personalized support plan identified with a social-medical team.

- The CLASS Act has the potential to broaden access to some basic LTC protection to more Americans and raise awareness among the working-age population that people need to plan for future LTC needs. Yet, the voluntary nature of CLASS creates significant uncertainty with respect to the participation rate as well as the composition of the participants in the pool of insurees. The risk is that certain assumptions over enrolment rates might not materialise, translating into significant higher premium.

OECD (2011), *Help Wanted? Providing and Paying for Long-Term Care*, Paris,
www.oecd.org/health/longtermcare and www.oecd.org/health/longtermcare/helpwanted

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Key Facts

- About 15.8% (OECD average 15%) of the United States population is aged over 65 and about 3.7% (OECD average 4%) over 80.
- The United States spent 1% of its GDP on Long-Term Nursing Care in 2007 (OECD average 1.5%), of which 0.6% was spent on public care (OECD average 1.2%) and 0.4% was spent on private care (OECD average 0.3%).
- In 2008, the United States had an estimated total of 1.6 million LTC beds in an institutional setting, which is equivalent to about 42 long term care beds per 1000 persons aged 65 and over (selected OECD country average of about 44 beds).
- In 2006, the United States was estimated to have 4.3 million formal Long-Term Care workers, which is equivalent to about 2.2 per cent of its working population (selected OECD country average of about 1.5 per cent) (OECD Health Data, 2010).

Background

Currently, the United States is restructuring its existing health care system, which in all probability will alter the terms of funding and dispensing of many long-term care (LTC) services. A key area of interest is the proposal for the Community Living Assistance Services and Supports Act (CLASS Act) which would create a voluntary disability insurance program designed to assist in maintaining independence by providing cash benefits for those with functional disabilities to purchase non-medical services, including informal homecare. At the present time Medicaid is the chief public funder of Long-Term Care, while private contributions and out-of-pocket payments are currently responsible for the largest total payment for LTC. Whereas the framework of Medicaid is largely organized through the federal government, its implementation, enforcement and dispersion are state run.

Benefits and Eligibility Criteria

***Medicaid*:** Medicaid is a jointly funded social health insurance program consisting of the federal and state governments, designed as a means-tested program to assist people with limited income to pay for medical expenses. Whereas states have mandatory benefits which must be offered, including institutional nursing facility services and home health care services for individuals who are entitled to nursing facility services, the majority of services are at the discretion of the states. Eligibility requirements for Medicaid are based on income and personal assets and vary by state. To receive Medicaid coverage for Long-Term Care services, physical as well as financial conditions must be met. Commonly, in order for recipients to receive Medicaid coverage participants will first have to "spend down" or exhaust personal resources. Medicaid allows for consumer choice and enables participants to choose their own provider such as doctor or home health care aide service, provided that the facility participates in the Medicaid program. Once a recipient is enrolled in Medicaid, they will receive a Medicaid card which must be presented to the facility offering services in order for the facility to properly redeem payment. States may require Medicaid recipients to be responsible for a small co-payment.

Medicare: Medicare was created to provide health care coverage for people aged 65 and older. However, Medicare does not cover costs associated with Long-Term Care services. Similar to Medicaid, Medicare is a publically funded social insurance program. Whereas Medicaid is jointly funded by federal and state governments and is the primary source of public funding for Long-Term Care service, Medicare is funded through the federal government. Medicare is designed to cover medical expenses, such as doctors appointments and hospital visits as well as cover the cost of health care. Additionally, Medicare covers hospice care and short-term home doctor visits associated with hospitalization.

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Service Provision

Long-Term Care services vary depending on need of the recipient. Facility-based programs are available for those who can no longer live independently and are in need of consistent monitoring, as well as assistance with basic ADLs. Home and community-based services are offered for individuals who are in need of minimal assistance with ADLs and are capable of partial-independence.

Facility-Based (Institutional) Long-Term Care Services: The scope of care offered varies depending on the organization of the facility and the need of the recipient. While service-delivery differs across states, facility-based service providers are obligated to fulfil state licensure standards in order to operate legally. In order for Medicaid recipients to utilize their Medicaid benefits in a facility setting, the facility must participate in the Medicaid system. Additionally, there are facilities which are privately funded and will not accept Medicaid recipients. Several institutional providers offer assistance with medications and higher care needs, while others only provide housing and housing related services. All offer 24-hour supervision and assistance with ADLs. Some common forms of facility-based LTC providers are: Adult Foster Care, Board and Care Homes (residential care facilities), Continuing Care Retirement Communities (CCRC), and Skilled Nursing Facilities (nursing homes). There is variation in the intensity of care provided by the facility, for example assisted living traditionally does not provide medical assistance as a nursing home would. While facility-based services can be extremely expensive, they can be particularly helpful for recipients who require extensive care that family or friends are unable to facilitate due to cost, time or medical expertise.

Home and Community-Based Services: Home and community-based services (HCBS) are both public and private initiatives which assist recipients to continue to live at home and remain active in the community. These services are customarily delivered in conjunction with other home-based services provided by family members or friends and medical services provided by doctors. Adult Day Care Programs (ADC) or senior centres allow participants to have a place to spend time during the day when family members are at work. Other forms of HCBS are home visits from geriatric care managers or social workers, which will assist in coordinating and managing LTC needs. Private agencies are available as well, which can provide meal deliveries and assist with transportation needs. Respite care, which allows informal care workers to have relief in their caring responsibly, also fall under the umbrella of home and community-based services.

Workforce

Formal LTC workers in an institutional setting are often burdened with physical strain, long irregular hours, and a low pay scale with little room for advancement, leading to high turnover rates. Evidence suggests that the majority of LTC caregivers are middle-aged employed women providing in home care services for a widowed parent (US Department of Health and Human Services: http://www.longtermcare.gov/LTC/Main_Site/Understanding_Long_Term_Care/Services/Services.aspx). There is a shift towards creating state support for informal caregivers in the form of cash benefits or in-kind services, such as child care, transportation reimbursements and respite accessibility. The CLASS Act will provide recipients of LTC the freedom to choose between formal and informal caregivers, allowing the recipients to have more autonomy.

References

OECD 2009-2010 Questionnaire on Long-Term Care Workforce and Financing

OECD (2010) *OECD Health Data 2010*, Paris.

OECD Social and Labour Demographics Database 2010