Factors Affecting the Cost of Long-Term Services and Supports

The Hilltop Institute
analysis to advance the health of vulnerable populations

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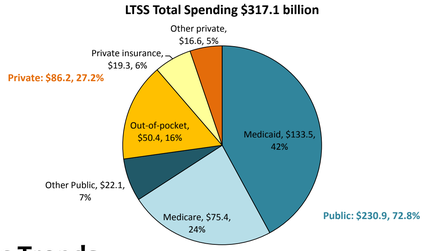
Background

Long-term services and supports (LTSS)—the provision of medical, social, and personal care services on a recurring or continuing basis to persons with functional limitations due to a physical, cognitive, developmental, or chronic health condition—is essential for many older individuals and persons with disabilities. The need for LTSS becomes greater as Americans live longer and in many cases experience extended years of disability. However, an increase in demand is only one factor contributing to the increase of LTSS expenditures. The components of cost drivers influencing LTSS delivery and financing are often poorly differentiated and explained.

The Hilltop Institute sought to provide insight into separate issues that influence the cost of LTSS. Researchers examined the contributions of demographic trends, financial factors, and recipient service goals and preferences. A research synthesis was completed in order to better describe how various factors both independently and collectively impact LTSS costs.

In 2011, an estimated $317.1 billion was spent on LTSS. This represents 13.9 percent of the $2.3 trillion spent on personal health expenditures in the United States. LTSS are paid by a variety of public and private sources. Figure 1 shows the breakdown of payment sources for LTSS.[1]

Figure 1. LTSS Total Spending in 2011, by payer



Demographic Trends

Over the next 40 years, the number of Americans aged 65 years and older will more than double to 88 million in 2050; those aged 85 and older will more than triple.[2]

An aging society is bringing with it increases in co-morbidities, with one in five Medicare beneficiaries having five or more conditions[3] and greater amounts of functional limitations. Often it is the limitations in activities of daily living (ADLs) that trigger the need for LTSS services, and these tend to increase with age as shown in Table 1.[4]

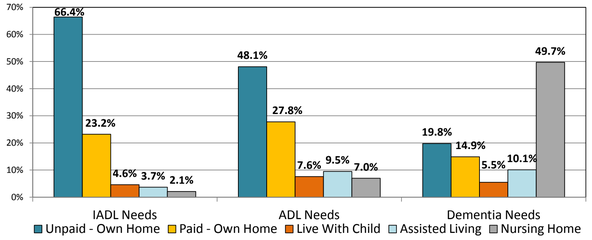
Table 1. Limitation in ADLs, by Age Group (in Thousands)

Age	Population	No ADL Limitations	1 ADL Limitation	2 ADL Limitations	3 ADL Limitations
18-44 Years	110,531	110,045	93	111	276
45-64 Years	72,224	71,298	219	203	500
65-74 Years	18,613	18,060	130	119	299
75-84 Years	12,625	11,846	179	154	439
85+ Years	3,894	3,191	181	133	378

Consumer Preferences

Due to the personal nature of LTSS, individuals like to make their own decisions about not only the type of care received, but also the person who provides the care and in what setting. Factors affecting care preferences include: 1) functional status, 2) household composition, 3) availability of family and friends who can provide care, and 4) expectations of future need. Older adults would rather receive in-home care and live alone or with their spouse than with extended family or in a nursing home.[5] The relative desirability of LTSS options varies based on the anticipated duration of the condition and the types of impairments for which care is required, as shown in Table 2.

Table 2. Preference for Setting by Scenario of Need



Financial Factors

LTSS expenditures are driven by cost increases related to technology advances, employee wages, and the underlying costs of medical supplies, pharmaceuticals, social services, and transportation.[6] Demand for nursing aides, medical assistants, personal care aides, and home health aides will increase significantly in future decades. Meeting this need will be difficult; the industry will face either a shortage of workers or an increase in staffing costs to recruit and retain a larger pool of skilled workers. Home health aides and personal care aides, totaling 3 million in 2008, are projected to be the third and fourth fastest-growing occupations in the country between 2008 and 2018; job openings will increase by 50 percent and 46 percent, respectively.[7]

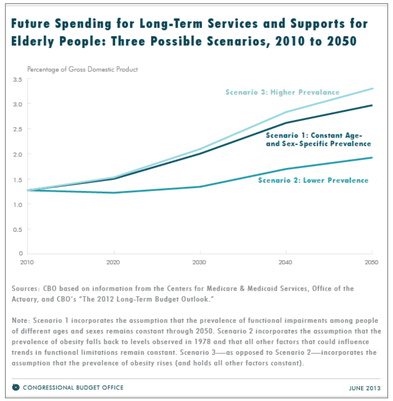
A household financial factor affecting LTSS is the amount of planning accomplished earlier in life. Most Americans do not sufficiently plan for their future LTSS needs. Table 3 shows responses from a survey asking adults aged 50 years and older about their degree of preparation for dealing with health care expenditures. The percentage of individuals who had already taken steps to secure insurance or to begin saving is quite low.[8]

Table 3. Plans for Dealing with Health Expenditures

	Already Done	Plan to Do in the Future	No Plans to Do This	Haven't Decided
Buy long-term care insurance	12.8%	13.5%	50.5%	21.9%
Save specifically for large health expenses and/or LTSS	6.2%	15.1%	53.0%	24.0%
Sell house or use equity if needed for health bills and/or LTSS	2.5%	13.0%	56.2%	26.9%

Policy Implications

With current LTSS expenditures accounting for an estimated 1.3 percent of gross domestic product (GDP), CBO has projected future expenditures to range from 1.9 percent of GDP to 3.3 percent of GDP by 2050.[9] These projections raise several questions.



1. What viable public and private long-term care financing proposals exist, and how can consensus be reached on implementing them?
2. What is an appropriate mix of financial and regulatory responsibility among the federal government, state governments, and the private sector on LTSS?
3. Will increased activity around chronic care management forestall the need for sustained LTSS?
4. How can consumer choice and preferences help drive both quality and value in LTSS delivery?
5. Can incentives be identified that will effectively support working adults as they plan for their future long-term care needs?

Careful consideration and working toward a successful resolution of these questions are essential to assure access to quality long-term care, to provide affordability for individuals, and to predict costs for families and payers.

References

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