



FINANCIAL PLANNING

Proposed revamp provides for the development of an integrated system that will combine dollars from both Medicare and Medicaid as needed.

Will Long-Term Care Be Covered by the Government? Maybe

By Michael E. Leonetti

For the first time, the federal government has admitted that its Medicare program shares responsibility with state-run Medicaid systems for the public cost of long-term care. Bruce Vladeck, director of the U.S. Health Care Financing Administration, which oversees the two programs, said that President Clinton's proposed budget provides for the development of an integrated system that will combine dollars from Medicare and Medicaid as needed.

The change would end the currently fragmented approach, which causes older patients to be "bounced from one site to another," he said. At present, long-term care clients are served in one site or another for reasons having little to do with real cost efficiency, rational systems development, or client preference.

In a recent presentation at the annual meeting for the American Society on Aging, Mr. Vladeck made clear that the President's budget proposal is an initial step to what will prove to be a long, complicated, and politically in-

tense process. One major hurdle will be developing the political support favoring the integrated approach among policymakers who have long been in a "stalemate" over approving any system change that might shift the onus of payment between the federal and state governments.

Additionally, a consensus must emerge supporting a "beneficiary-centered" system among professional groups likely to be concerned about losing dollars and control, if the present reimbursement strategy is altered. The current strategy bases payment on the location where the care is provided, such as in a nursing home or in a rehabilitation hospital. The new proposed method would give a single, pre-set or prospective payment rate to a healthcare provider, who would manage any necessary post-hospital care for the patient, regardless of whether it was delivered in a skilled nursing facility, at home, or in another place. A site-neutral payment system would permit providers to assess the individual's needs, social supports,

and resources, and to order the required bundle of services in any appropriate location.

Almost \$20 Billion

Mr. Vladeck emphasized that the revamped system is not an expansion of Medicare, but would be financed by federal funds already being spent inefficiently. In spite of convictions within the Health Care Financing Administration for the past 30 years that long-term care was not a Medicare problem, the program's spending on continuing care has grown to the present range of \$17 billion to \$20 billion a year. "We are in this business whether we want to be or not," Vladeck stated.

Medicare's rapidly increasing home care benefit is almost \$14 billion in 1997. Even though home care was originally identified as a short-term, post-acute care service, the average Medicare patient receiving home care now gets about 75 visits. That's long-term care service.

Not only are Medicare-covered hospitalizations often needed by nursing home patients, but an increasing amount of ancillary charges for the roughly one million low-income nursing home residents on Medicaid comes from Medicare's Part B outpatient program.

Billions of Medicare dollars now being spent can provide considerable room to maneuver to gain some savings and still improve and probably expand the kind of services available. For example, the Health Care Financing Administration estimates that Medicare would save from \$10 billion to \$12 billion dollars in six years by converting payment for home care to a prospective payment approach. The annual cost of the home health benefit is now rising by 10% to 15% per year, two to three times larger than the level of general economic inflation. Also, Mr. Vladeck expects that expansion of the operation using Operation Restor Trust anti-fraud program will realize significant gains from Medicare as it expands beyond the initial five-state demonstration project.

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Much of the technical groundwork for achieving the seamless payment system long set by advocates and professionals in aging is now completed or well under way. For example, the new uniform needs assessment instrument is in its second generation of field testing. Mr. Vladeck explained that after years of testing and designing different patient assessment forms for hospital discharge planners, nursing home nurses and those processing initial home care admission evaluations, Health Care Financing Administration staff realized "we are asking the same questions . . . maybe we don't need three separate sets of instruments but can begin to move toward an integrated system."

Additionally, the need to integrate family and other informal caregivers into the formal system is important. Because of legal, professional, and theoretical hang-ups, we either ignore caregivers or roll right over them in most of the existing programs. It is not only economically irrational in the long run, or irrational in terms of people

getting the best kinds of services, but it is also fundamentally incorrect.

Mr. Vladeck, who has been the Health Care Financing Administration director for nearly four years, confirmed at a press conference that he intends to announce his return to the private sector later this year. Co-author of the groundbreaking book on nursing homes, "Unloving Care," Mr. Vladeck said that developing the long-term proposal was among his top goals. The initial plan is like the tip of the iceberg—90% of the change that has occurred below the surface will become evident to people in the coming years.

Monitoring the developments in the long-term care area will become more and more important in the near future. As the government wrestles with Medicare, Medicaid, and Social Security issues (as outlined in the Financial Planning column of the May *AALJ Journal*), the integration of long-term care issues makes it that much more of a tangled web. However, integrating this type of care into the system makes sense from an administrative and distribution of

care standpoint. Additionally, it gives politicians a way to "enhance" the existing healthcare system provided by the government, which would further allow them to politically justify the cost changes that might be necessary for such a program to be implemented.

It will also be interesting to see how private insurance carriers respond to this issue, as the sale of long-term care coverage would seem to be a product whose demand would significantly increase in the future. Should the government adopt some type of integrated plan to include certain long-term care benefits, it is likely that private carriers will make modifications to their long-term care contracts. Thus, we may end up with insurance coverages whose benefits are analogous to Medicare supplemental plans, which are designed to dovetail with current Medicare benefits.

All of these issues can have a significant impact on one's retirement planning and, thus, these developments warrant our continued attention. I will do my best to keep you informed. 🐾

New Designation Allows Investors to Find True Fee-Only Financial Planners

Investors looking for a fee-only financial planner—that is, one whose compensation is in no way tied to commissions or other incentives—often are confused by the term due to a lack of strict guidelines. To end the confusion, the National Association of Personal Financial Advisors (NAPFA) has recently instituted a certification mark for pure fee-only financial planners. The new NAPFA certification mark will be given to any financial planner who can demonstrate that they practice on a truly fee-only basis. Look for this mark, shown above, or membership in NAPFA, if you are seeking a fee-only financial planner.



The National Association of Personal Financial Advisors is a non-profit association of fee-only financial advisors. Individuals can contact NAPFA at 1-800-366-2732 for a list of members by location.