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Chestnut Hill, Mass.: Center for Retirement Research at Boston College, April 2007

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MEDICAID AND LONG-TERM CARE: HOW WILL RISING COSTS AFFECT SERVICES FOR AN AGING POPULATION?

BY HOWARD GLECKMAN*

Introduction

By mid-century, the nation will be spending more on Medicaid, the joint state/federal health program for the poor, than it currently spends on national defense.¹ Much of this projected growth will be generated by the rapidly expanding demand for long-term care due to an aging population. Therefore, both states and the federal government are exploring ways to restrain the program's growth, but no initiatives to date have significantly slowed the trend.

This *brief* explores trends in Medicaid spending on long-term care and the implications of its rapid growth for taxpayers and for the needs of an aging population. The first section defines long-term care. The second section describes Medicaid's role in financing it. The third section describes the impact of Medicaid on state budgets. The final section assesses efforts to rein in Medicaid spending.

What is Long-Term Care?

Today, about 10 million Americans need long-term care.² In contrast to acute medical care, which is usually intended to help a patient recover from an injury

or illness, long-term care is aimed at assisting those with long-term chronic illnesses to manage their daily lives in relative comfort and security. Such assistance may include help with eating, bathing or toileting, cooking, or visits to an adult day care center.

While medical care is usually delivered in a doctor's office or hospital, long-term care is often provided at home or in an institutional setting such as a nursing home or assisted living facility. More than 80 percent of those receiving long-term care do so at home.³ Most long-term care is provided by an unpaid family member or friend. Care at home may also be supplemented by a professional health aide or personal assistant.

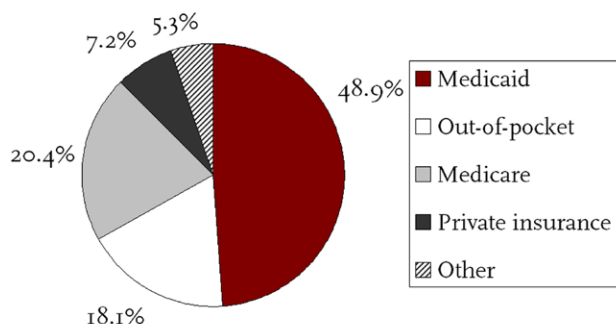
Long-term care needs are often very different for two distinct groups: the elderly and the disabled. The aged who require long-term care are typically widows in their 80s who live alone, have little income, and may be suffering from dementia or other mental impairment. Nearly 70 percent of those who are 65 today will require some long-term care before they die. They will need care for an average of three years, and one in five will require this assistance for five years or more.⁴

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The non-elderly disabled may have been born with a physical or mental disability, or suffered traumatic injury in their young adulthood. Thanks to advances in medical technology, these people — who once would have died at a young age — now live many years. Their families are often in severe financial distress. Unlike many elderly, they have had little opportunity to build up retirement savings or home equity, and may have spent much of their savings paying for acute medical care. For example, the lifetime cost for a 25-year old who suffers a major spinal cord injury is nearly \$3 million.⁵

Other forms of long-term care are also very expensive — with average annual costs of about \$34,000 for home care services and more than \$75,000 for a private room in a nursing home.⁶ These costs far exceed the financial resources of most families. Those who impoverish themselves paying for these services are likely to turn to the government to help finance their long-term care costs.

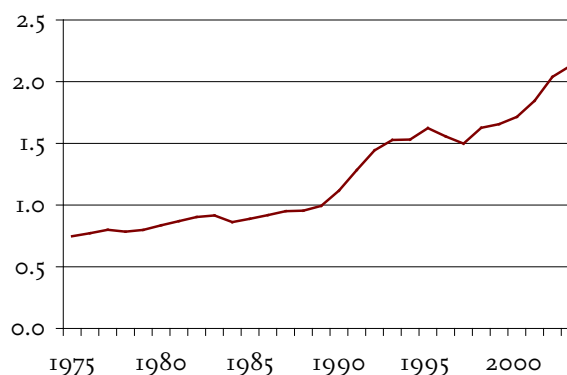
FIGURE 1. FUNDING SOURCES FOR LONG-TERM CARE, 2005



Source: Komisar and Thompson (2007).

The program they most often turn to is Medicaid, which has become the nation's principal source of payments for professional long-term care services for the elderly and disabled (see Figure 1). In 2005, Medicaid paid \$101 billion for long-term care, nearly half of total national spending on these services.⁷ Individuals paid 18 percent of the costs out-of-pocket. Medicare, the federal health program for seniors, paid 20 percent.⁸ Private long-term care insurance covered only 7 percent of costs.

FIGURE 2. MEDICAID SPENDING AS A SHARE OF GDP, 1975-2003

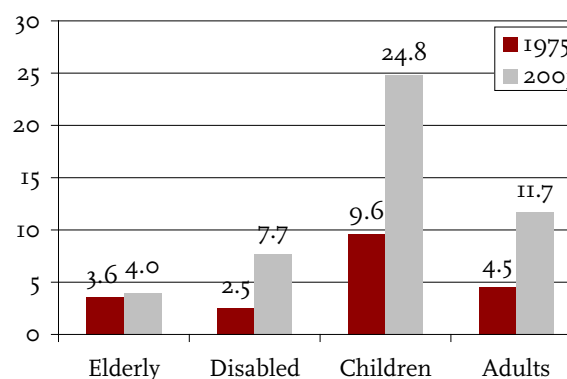


Sources: Author's calculations from Centers for Medicare and Medicaid Services (2006a) and Bureau of Economic Analysis, 1975-2003.

Medicaid and the Costs of Long-Term Care

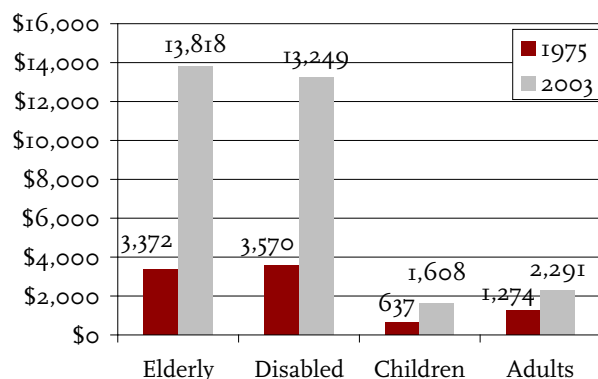
Total Medicaid costs have grown rapidly in the past three decades, rising from 0.7 percent of GDP in 1975 to 2.1 percent in 2003 (see Figure 2). This growth has been driven both by an increasing number of beneficiaries and higher costs per beneficiary. For example, the number of disabled in Medicaid more than tripled between 1975 and 2003 — from 2.5 million to 7.7 million (see Figure 3a). And the cost for each elderly and disabled beneficiary roughly quadrupled (see Figure 3b).

FIGURE 3A. MEDICAID BENEFICIARIES, IN MILLIONS, 1975 AND 2003



Source: Centers for Medicare and Medicaid Services (2006a).

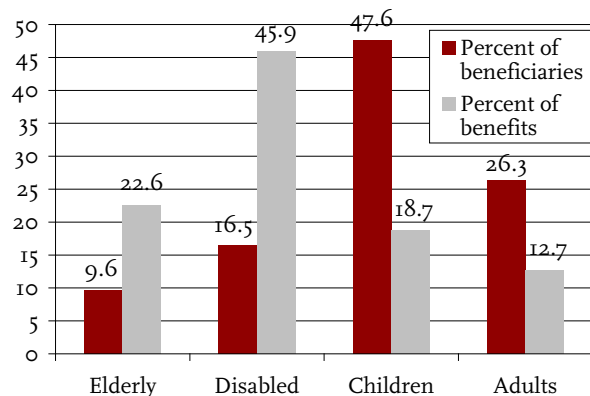
FIGURE 3B. MEDICAID COSTS PER BENEFICIARY, 1975 AND 2003 (2003 DOLLARS)



Sources: Congressional Budget Office (2006) and author's calculations from Centers for Medicare and Medicaid Services (2006a).

Reflecting the high per beneficiary costs for seniors and the disabled, almost 70 percent of Medicaid's benefits go to these two groups (see Figure 4) even though they comprise only about 25 percent of Medicaid enrollees. Not surprisingly then, Medicaid's financial pressures will accelerate rapidly in two decades as the Baby Boomers begin to reach their 80s, the years when many seniors need intensive long-term care. Not only will this large generation produce a substantial increase in the number of elderly, but a growing percentage of retirees may not be able to afford long-term care due to pressures on traditional sources of retirement income.⁹

FIGURE 4. MEDICAID BENEFICIARIES AND BENEFITS BY TYPE OF BENEFICIARY, 2006



Source: Author's calculations from Congressional Budget Office (2006).

About one-third of Medicaid spending goes to long-term care services for 3.4 million enrollees.¹⁰ About 55 percent are elderly, while 34 percent are disabled. The remaining 11 percent are adults and children who qualified for coverage on the basis of income or a category other than disability.¹¹

To be eligible for Medicaid long-term care, individuals must meet two basic tests: 1) they must be unable to care for themselves; and 2) they must have few assets and little income.¹² Many middle-income seniors and disabled initially pay out-of-pocket for long-term care, because they exceed the asset or income limits. Eventually, however, many exhaust their assets and become eligible for Medicaid. For example, as many as half of nursing home residents who are admitted as private pay patients run out of funds during their stay and become Medicaid beneficiaries.¹³

Within these broad eligibility criteria, states are given considerable flexibility in determining eligibility. Both the Clinton and Bush administrations have been extremely liberal in granting waivers from federal Medicaid rules, giving states even more leeway in how they run the program. As a result, state spending on long-term care varies widely. In 2004, states spent an average of \$304 per resident on such services. But New York paid \$833, while Nevada spent \$102.¹⁴

Medicaid and the States

Medicaid is operated as a federal entitlement program. As a result, its costs automatically rise as the eligible population increases or medical inflation grows. But unlike Medicare, Medicaid costs are also shared by the states. The federal share of Medicaid averages 57 percent, but varies widely. States with relatively low personal incomes receive more federal money relative to program costs than those with higher personal incomes. In fiscal 2005, for instance, the federal government paid 70 percent of Alabama's costs compared to only 50 percent of Connecticut's.¹⁵

State spending on Medicaid needs to be looked at closely, because it is often cited in two ways: what might be thought of as a gross cost and as a net expense. In fiscal 2006, states spent 22.2 percent of their total budgets on Medicaid, even more than the 21.5 percent they allocated to elementary and secondary education. However, because Washington reimbursed a large portion of that money, states spent 18.1 percent of their general funds on the program.¹⁶

Recently, the growth in Medicaid costs has slowed sharply. In fiscal year 2006, program costs grew by just 2.8 percent, the slowest rate since 1996. It was the first time since 1998 that Medicaid spending grew more slowly than state tax revenues.¹⁷ But this period of relative fiscal comfort will be brief. The Centers for Medicare and Medicaid Services project no further slowing in the growth of overall health spending over the next decade.¹⁸

Can Medicaid Cost Growth Be Contained?

Policymakers have been exploring how to curb the growth of Medicaid spending on long-term care. Options include encouraging consumers to buy private long-term care insurance; attempting to move care out of nursing homes and into home and community-based settings; and shifting beneficiaries into private managed care plans. Congress and the states are also making Medicaid eligibility more restrictive. Finally, some experts suggest that technology can help. Evidence to date, however, suggests that none of these changes has yet had a meaningful impact on current spending, and these fixes are unlikely to significantly reduce future cost pressures.

Long-Term Care Insurance

One way to reduce the taxpayer burden of long-term care is to shift costs to individuals by encouraging them to purchase private long-term care insurance. In 2006, Congress expanded the Partnership Act, which allows seniors who purchase long-term care insurance to increase the amount of the assets they may protect while still becoming eligible for Medicaid. For example, if an individual purchases a \$300,000 long-term care policy, he could retain assets up to \$300,000. Under the new provisions, 22 states plan to begin such programs in 2007.¹⁹ However, in the four states that have operated a Partnership program for many years, results have been disappointing.²⁰ In part, the low demand for long-term care policies is a result of their cost. A high-end policy for a 62-year-old couple can cost between \$7,600 and \$11,500 per year.²¹

Home and Community-Based Care

States are making a major effort to keep more Medicaid recipients at home or in small community-based

settings, rather than in nursing homes. Thirty-eight states plan to expand their home and community-based care in 2007.²² Proponents argue that allowing the aged and disabled to remain at home both improves their care and saves money.

Although many recipients prefer to remain home, it is unclear whether home-based care will reduce overall costs or improve quality. An extensive survey of prior research concluded that “expanding home and community-based services does not reduce aggregate long-term care expenditures, although average per consumer costs are less than nursing home care in many studies.” The reason is that many individuals who currently receive care at home receive unpaid assistance from family members. If Medicaid began spending more on home care services, demand for these paid services might increase, offsetting any cost savings gained by shifting away from nursing homes.²³ In terms of quality of care, quality measures for these patients appear much too crude to determine whether they are getting “better” care.

Managed Care

States are also seeking cost control through managed care.²⁴ In these programs, private firms are paid an annual per patient capitation fee to manage both the medical and long-term care needs of Medicaid-eligible seniors. The hope is that these vendors will better identify and control disease, as well as co-ordinate the care of those suffering from multiple illnesses. To date, only about 2 percent of Medicaid beneficiaries are in managed care plans.²⁵ While one study suggests that such programs may save money,²⁶ overall, little evidence suggests significant cost savings.

Asset Protection

Policymakers have been concerned that many seniors use sophisticated financial techniques to artificially transfer assets in an effort to meet the program's impoverishment requirements. In response, a new 2005 law requires states to review asset transfers that occur within five years of the time a person becomes eligible for Medicaid. However, little evidence indicates that such problems are widespread, or that states could generate major cost savings by prohibiting them.

Most asset transfers among nursing home patients are made by those who never qualify for Medicaid. Of those who do become Medicaid eligible after a period of paying for nursing home care on their own, just 5 percent had cash transfers of more

than \$50,000.²⁷ Experts estimate that even with the toughest crackdown, states are not likely to recover more than 1 percent of total Medicaid spending for long-term care.²⁸

Technology and Cost Savings

Some policy experts believe that two technologies may help control costs. The first is assistive technologies that would make it possible for people to care for themselves, such as automated pill dispensers that would help people properly take medications on their own. The second is new drugs themselves, for diseases such as Alzheimer's, that could limit the need for long-term care.

Conclusion

The goal of government long-term care policy should be to provide the best possible quality of life for the elderly and disabled in the most cost-effective way. It should not merely become an exercise in saving money. However, unless policymakers are willing to make major changes, Medicaid will threaten to crowd out spending for other services citizens have come to expect from government, force substantial tax increases, or both.

This *brief* described the existing Medicaid system, its cost pressures, and experiments aimed at reducing cost growth. Subsequent *briefs* will look at the role of private long-term care insurance, describe how other developed nations provide such care, and explore ideas for fundamental change in the way long-term care is financed and delivered in the United States. The fundamental question that reformers must answer is whether this care should be provided as part of the nation's structure of social insurance, whether it should be an individual responsibility, or some combination of the two.

Endnotes

- 1 By 2045, projected Medicaid spending is 6.5 percent of GDP — 3.7 percent by the federal government and 2.8 percent by the states (Kronick and Rousseau, 2007). In 2006, spending on national defense was 4.0 percent of GDP (Congressional Budget Office, 2007).
- 2 Komisar and Thompson (2007).
- 3 Georgetown University (2003).
- 4 Kemper, Komisar, and Alecxih (2005).
- 5 National Spinal Cord Injury Statistical Center (2006).
- 6 Metlife (2006).
- 7 Komisar and Thompson (2007).
- 8 Despite a common misconception, Medicare is not designed to provide long-term care. It does pay for nursing home and home health assistance, but usually only for rehabilitation services or other post-acute treatment. The program normally pays for such care only after a patient has been released from a hospital and, even then, for just a limited amount of time.
- 9 Munnell, Golub-Sass, and Webb (2007).
- 10 The budget figure is from Centers for Medicare and Medicaid Services (2006b) and the number of beneficiaries is from Sommers, Cohen, and O'Malley (2006).
- 11 Sommers, Cohen, and O'Malley (2006).
- 12 Under the asset test, a couple living together may keep only \$3,000 in liquid assets in most states. If one spouse is in a nursing home, the other is allowed half of the couple's assets, up to \$101,640 (U.S. Department of Health & Human Services, 2007). Couples are also allowed to retain their home up to a home equity limit of \$500,000 or — at the discretion of individual states — up to \$750,000. Under the income test, generally, a person receiving home care may earn no more than \$623 per month, the level at which an individual becomes eligible for Supplemental Security Income (SSI). For persons in a home and community-based waiver program, the limit is generally equal to 300 percent of the SSI standard. Those with incomes in excess of these levels must contribute the difference to the cost of their care.
- 13 Weiner, Sullivan, and Skaggs (1996).
- 14 O'Brien (2005).
- 15 Henry J. Kaiser Family Foundation (2007).
- 16 Henry J. Kaiser Family Foundation (2007).
- 17 Urban Institute and Kaiser Commission on Medicaid and the Uninsured (2006).
- 18 Centers for Medicare and Medicaid Services (2006b).
- 19 Urban Institute and Kaiser Commission on Medicaid and the Uninsured (2006).
- 20 These states — California, Connecticut, Indiana and New York — began their programs between 1992 and 1994. However, only 211,972 long-term care Partnership policies have been purchased since that time, and 172,477 remain active. Just 2,761 people, or 1.3 percent of policyholders, have ever received benefits (U.S. Government Accountability Office, 2005).
- 21 A high-end policy might insure \$200 per day for life, with a 5 percent inflation adjustment and a 90-day waiting period (the high-end policy estimate is from The Baker/Brown Company). Even a more modest policy — insuring \$150 per day for 4 years, with a 90-day waiting period — carries stiff premiums, with a 65-year old likely to pay \$2,346 annually (Johnson and Uccello, 2005).
- 22 Urban Institute and Kaiser Commission on Medicaid and the Uninsured (2006).
- 23 Weiner and Brown (2004).
- 24 This effort parallels the shift to Medicaid managed care for younger, non-disabled Medicaid recipients.
- 25 Saucier, Burwell, and Gerst (2005).
- 26 Kane, et al. (2003).
- 27 Waidmann and Liu (2006).
- 28 Waidmann and Liu (2006).

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The Center for Retirement Research at Boston College was established in 1998 through a grant from the Social Security Administration. The Center's mission is to produce first-class research and forge a strong link between the academic community and decision makers in the public and private sectors around an issue of critical importance to the nation's future.

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The Center for Retirement Research thanks AARP, AIM Investments, CitiStreet, Fidelity Investments, John Hancock, Nationwide Mutual Insurance Company, Prudential Financial, Standard & Poor's, State Street, and TIAA-CREF Institute for support of this project.