INSIGHT on the Issues

Medicaid: A Program of Last Resort for People Who Need Long-Term Services and Supports

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Most older people need some long-term services and supports during their lifetimes. Nearly a third of older people are projected to deplete their life savings and turn to Medicaid for assistance as their ability to care for themselves declines. Designed as a program for people with low incomes and few assets, Medicaid is a safety net of last resort for those whose needs exceed what unpaid family and friends can provide, and who exhaust their resources paying out-of-pocket for care.

Pathway to Medicaid

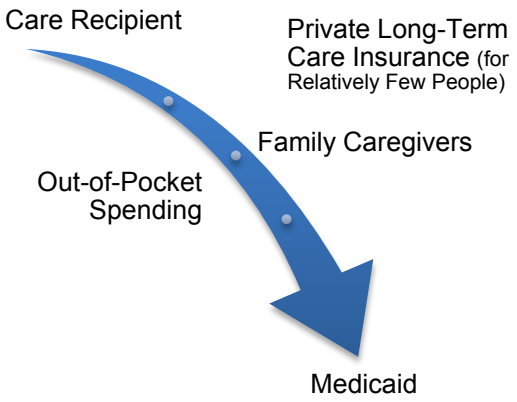
Approximately 11 million adults have disabilities requiring long-term services and supports (LTSS), slightly more than half (57 percent) of whom are 65 or older.[1] Roughly 7 out of 10 people turning age 65 will need LTSS during their lifetimes, on average, for 3 years.[2]

Family caregivers are the first line of assistance for most people with LTSS needs, and they provide the bulk of care. But family caregivers cannot do it all, and those who need paid services often deplete their life savings and must rely on Medicaid. This report describes the pathway to Medicaid, as people exhaust their life savings because of the costs and duration of needs associated with LTSS.

Medicaid is the largest payer for LTSS.

In 2011, combined federal and state Medicaid spending for LTSS was more than $131 billion.[3] About 4.4 million people—1.6 million in institutions and 2.8 million in the community—receive Medicaid assistance with LTSS. Even though they represent only 7 percent of Medicaid recipients, the services received by LTSS beneficiaries account for 30 percent of total Medicaid expenditures.[4] Covered Medicaid LTSS can vary widely by state but generally include services ranging from personal care at home to nursing home care. While a relatively small percentage of all older persons qualify for Medicaid by spending down their assets, Medicaid is the primary payer for more than 60 percent of long-stay nursing home residents because of its high cost.[5]

Figure 1
Pathway to Medicaid



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Unpaid caregivers provide the overwhelming majority of LTSS.

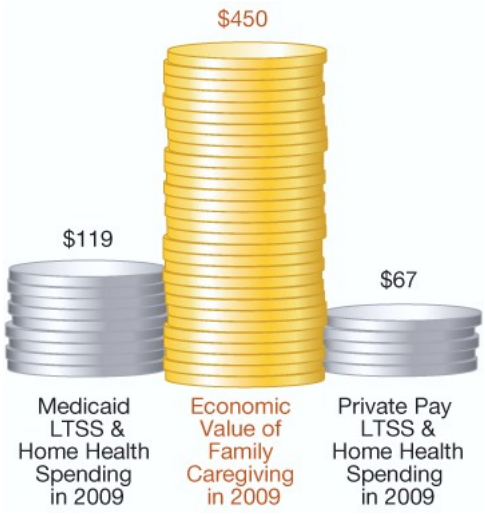
Only half of older people with LTSS needs will ever live in a nursing home, and many of them will stay for short periods. The rest will receive care in their homes or other residential alternatives (such as assisted living). Roughly 6 in 10 will rely exclusively on family caregivers for assistance. The average duration of care for those who rely only on family care is 1.4 years, but nearly one in four older persons (23 percent) will rely exclusively on family for 2 or more years.[6] Nearly half (46 percent) of family caregivers reported performing tasks typically provided by nurses even though most reported receiving no training.[7] Family caregivers experience higher health risks than noncaregivers because of the physical and emotional stress of caregiving.[8]

Some 42 million people aged 18 or older provide unpaid LTSS for all ages and disabilities in the United States, at any given time. The estimated economic value of this care amounts to $450 billion annually, greater than total Medicaid spending for both medical care and LTSS.[9]

LTSS are costly and can wipe out life savings.

For those who incur costs for LTSS, the price tag can be very high. In 2011, 22 percent of LTSS costs were paid out-of-pocket.[10] These data underestimate total out-of-pocket costs for LTSS, as they do not include payments for assisted living or other residential service options. A 65-year-old couple can expect to incur, on average, $63,000 in lifetime costs (present value) for nursing home services, which does not include the costs associated with assisted living and other LTSS costs.
Five percent of older couples will incur lifetime nursing home costs in excess of $260,000.[11] These high costs help explain why nearly a third (30 percent) of older persons are projected as likely to receive Medicaid LTSS assistance at some point in their lives.[12] Figure 3 illustrates the national median costs for a range of LTSS.

Figure 2
Economic Value of Family Caregiving: Annual Spending in Billions of Dollars



Source: AARP Public Policy Institute, *Across the States 2012: Profiles of Long-Term Services and Supports*, September 2012.

Few people have private long-term care insurance.

Estimates based on claims data indicate that private insurance pays for only 3 to 10 percent of the nation's LTSS bill. Currently, about 7 to 8 million people have private long-term care insurance.[13] Take-up rates for these products are low in part because many consumers cannot afford the premiums. The average annual premium for private long-term care insurance was $2,283 in 2010 for policy holders of all ages.[14] Moreover, most consumers mistakenly believe they are covered by Medicare or private health insurance,[15] and others fail to qualify because of medical underwriting. Medicare pays for limited skilled nursing home care after a hospital stay

Figure 3
Private Pay Cost of Long-Term Services and Supports, 2013

	National Median Daily Rate
Home Health Aide Services	$78* ($30,326 annually based on 30 hours per week)
Adult Day Health Care	$65
Assisted Living Facility	$113 ($41,400 annually)
Nursing Home (Private Room)	$230 ($83,950 annually)

Source: Genworth 2013 Cost of Care Survey. March 2013.
*Based on 4 hours per day.
Note: Medicaid typically negotiates a lower rate.

and for some home health services, but only if certain criteria are met.

A variety of federal and state initiatives have created incentives to purchase long-term care insurance with the hope of limiting Medicaid expenditures. The underlying problem with these approaches, as some researchers have recently noted, is that "The Medicaid spend down population and the population who can afford private long-term care insurance have little overlap."[16] The characteristics of the spend down population are discussed below, but several researchers have concluded that various attempts to promote the purchase of private long-term care insurance have done little to increase coverage and are likely to benefit those who are relatively well off more than they benefit the Medicaid program.[17,18]

Medicaid is a safety net for people who have spent their savings on LTSS.

Medicaid provides an important safety net for people who have exhausted their retirement savings on the high costs of health care and LTSS. Those who receive Medicaid must contribute their remaining incomes and assets to defray the cost of services they receive, and an estimated 95 percent of those who will receive Medicaid over their lifetimes make some out-of-pocket contribution. On average, Medicaid beneficiaries who use LTSS will contribute $35,000 out-of-pocket for this care, and 10 percent will spend $100,000 (in 2005 dollars) or more out-of-pocket over the course of their lives.[19] This is the most recent analysis available; out-of-pocket costs are likely higher today.

As a program for people in financial need, applicants must meet both income and assets tests in addition to demonstrating the functional need for services. Income standards are tied to the poverty level or Supplemental Security Income (SSI), depending on the applicant's eligibility category and the state.[20] In most states, to be financially eligible for Medicaid LTSS, an individual must have $2,000 or less and a couple must have $3,000 or less in assets.[21] With a private room in a nursing home costing on average nearly $84,000 per year, many people soon exhaust their resources and need to turn to Medicaid. Thirty-five states plus the District of Columbia allow older persons and adults with disabilities whose incomes exceed the normal eligibility standards to qualify for Medicaid if they also have high medical

expenses that reduce their remaining income to within the income eligibility standards.[22] These "medically needy" programs enable individuals with very high medical or LTSS expenses to receive assistance from Medicaid.

Recent research indicates that nearly 13 percent of people aged 65 and older in 1998 spent down their savings and became eligible for Medicaid by 2008. More than half (54 percent) of people who spent down their assets and qualified for Medicaid did so to pay for LTSS: nursing home care (33 percent), personal care at home (7 percent), or both (14 percent). The remaining 46 percent of people who spent down their assets did so to pay for health care costs. A recent report found that 46 percent of people die with virtually no assets, often because they had inadequate resources to pay for unanticipated expenses related to health or LTSS.[23]

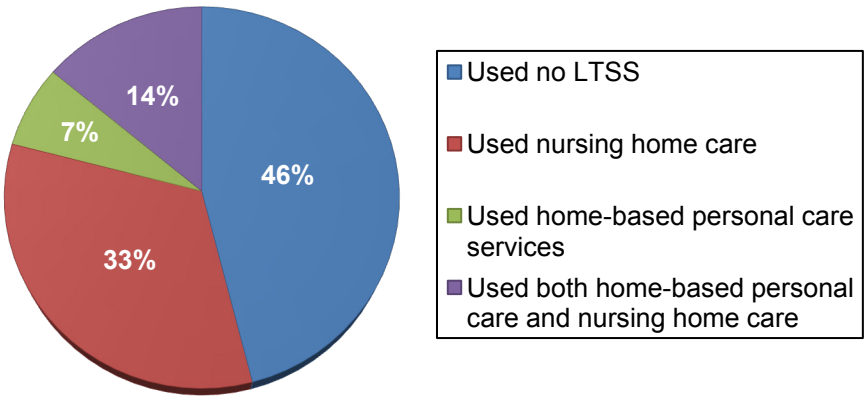
Not surprisingly, people who spent down to Medicaid had substantially lower incomes and assets than those who did not exhaust their resources. The majority (57 percent) of those who spent down between 1998 and 2010 had incomes in the bottom quartile in 1998 (below $15,940), and 81 percent had nonhousing assets of less than $14,000 (not including IRAs). Nonetheless, nearly 40 percent of those who spent down were middle income (middle two quartiles), and only 3 percent were in the highest income quartile ($61,000 or more).[24]

Medicaid beneficiaries often must contribute a significant amount of their incomes toward the cost of LTSS. For people in nursing homes, Medicaid allows them to retain a limited monthly allowance for personal care needs ranging among states from $30 to $101 per month in 2010.[25] States also must recover the costs of LTSS and other related Medicaid services from the estates of most beneficiaries. This process can include the state placing a lien against the beneficiary's property, including his or her home.

Medicaid denies LTSS coverage to those who transfer or shield assets to qualify.

When a person applies for Medicaid LTSS coverage, the state conducts a review to see if the applicant has transferred assets to family members or others to become financially eligible for

Figure 4
How People Spent Down Assets before Qualifying for Medicaid



Source: J. Wiener, W. Anderson, G. Khatutsky, Y. Kaganova, and J. O'Keeffe, *Medicaid Spend Down: New Estimates and Implications for Long-Term Services and Supports Financing Reform*, 2013.

Medicaid. Although Medicaid exempts certain transfers such as paying off debt, an individual is disqualified for Medicaid coverage for a period of time if they transfer assets for less than fair market value. The Deficit Reduction Act of 2005 tightened Medicaid rules to ensure that people could not become eligible for Medicaid by inappropriately shielding their wealth, though states still vary in the information they obtained for verifying applicant assets.[26]

Transfers of significant amounts of assets to achieve Medicaid eligibility appear to be rare. Even using a very low threshold of $500, those who spent down to Medicaid were half as likely to transfer wealth to children (25 percent compared to 47 percent who did not spend down) or to relatives (5 percent compared to 9 percent who did not spend down).[27]

Conclusion

Family caregiving continues to be the bedrock of LTSS for people who experience disabilities. For those who need paid assistance, Americans currently have few options to help them pay for the high cost of LTSS. Private insurance is helpful for those who can qualify and can afford it. But for those who do not have insurance and have spent down their life savings paying for LTSS, Medicaid continues to provide a critical safety net.

Endnotes

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Insight on the Issues 81, May, 2013

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