Insight on the Issues

Medicaid: A Last Resort for People Needing Long-Term Services and Supports

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LONG-TERM SERVICES AND SUPPORTS ARE COSTLY AND CAN WIPE OUT LIFE SAVINGS

It is estimated that about half (52 percent) of older Americans will need *high* levels of long-term services and supports (LTSS) to help them with everyday needs at some point in their lives.[1] Most of them will rely on family caregivers or pay for this care with their income and savings.

The price tag for LTSS can be very expensive. For older people who need paid services, the lifetime costs will average about $266,000.[2] In 2016, the median annual cost of a private room in a nursing home was about $92,000, and the base price for assisted living was about $44,000. In the same year, the median cost for a home health aide to provide care at home was $20 per hour; with an individual receiving 30 hours a week of homemaker services on average, the annual cost was about $31,000 (see figure 1).[3]

FIGURE 1
Private Pay Cost of Long-Term Services and Supports

	National Median Annual Rate, 2016	Median Annual Cost of Care as a Percent of Median Income for Households Age 65+
Homemaker Services	$ 31,200 (Based on 30 hours a week)	76%
Adult Day Health Care	$17,680 (Based on five days per week)	43%
Assisted Living Facility	$43,539	106%
Nursing Home (Private Room)	$92,378	225%

Note: State Medicaid programs typically pay lower rates.

Sources: Genworth 2016 Cost of Care Survey, April 2016. US Census Bureau, 2015.

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According to the US Census Bureau, the median income of older households was $40,971 in 2015. Savings are also limited. According to the Survey of Consumer Finances, median savings—total financial assets—for households age 65+ were $40,500 in 2013.

These high costs help explain why 18 percent of older adults are projected to receive Medicaid coverage for LTSS at some point from age 65 to the end of their lives.[4] Older adults generally turn to Medicaid for assistance after a long journey through progressively increasing disability until they reach the point at which their needs exceed the ability of family caregivers and the costs of supportive services have depleted their personal resources.

Those who had higher incomes at age 65 but who at some time rely on Medicaid to help pay for their LTSS and health care are typically individuals who have lived into their mid- to late 90s.[5] For all older Americans, Medicaid is a critical safety net when long-term disabilities occur and personal resources to pay for assistance run out.

FAMILY CAREGIVERS, A BEDROCK OF LTSS, CANNOT DO IT ALONE

Family caregivers are the first line of assistance for most people with LTSS needs; they provide the bulk of support. About 40 million family caregivers provided unpaid LTSS to adults with self-care needs in the United States in 2013. The estimated economic value of this care amounts to $470 billion annually, which is as much as the sales of the four largest US technology companies (Apple, IBM, Hewlett Packard, and Microsoft) combined of $469 billion in 2013–14.[6]

Most older adults with health or functional needs depend exclusively on family caregivers for assistance. The average duration of care for those with high needs who rely only on family care is five years. More than one in three (35 percent) family caregivers of older adults with high needs provide care for five to 10 years, and 15 percent provide care for a decade or longer.[7] Many endure emotional, physical, and/or financial hardships.

Family caregivers' unpaid services allow individuals to remain in their homes and communities and help delay or prevent the need for institutional care. However, the supply of family caregivers is decreasing owing to the aging of the population, increases in life expectancy, and shrinking family size.[8]

FEW PEOPLE HAVE PRIVATE LONG-TERM CARE INSURANCE

Private resources account for most paid LTSS, but the overwhelming majority of these private expenditures are paid out of pocket rather than from insurance.[9] Private long-term care insurance paid out roughly $9 billion in 2014, which is less than 5 percent of the nation's LTSS bill. About 7.2 million people have private long-term care insurance,[10] less than 5 percent of people ages 40 and older.[11]

Take-up rates for these products are low. Most consumers cannot afford the premiums. Many private long-term care insurers have exited the market, and annual premiums have increased significantly.[12] Meanwhile, many consumers mistakenly believe that LTSS are covered by Medicare or private health insurance, while others fail to qualify for insurance because of medical underwriting. Medicare pays for limited skilled nursing home and home health services, but only if certain criteria are met and, for skilled nursing home care, only after a hospital stay of at least three days.

MEDICAID IS A SAFETY NET

Approximately 17.4 million adults ages 65+ and people with disabilities of all ages relied on Medicaid in fiscal year 2013;[13] 17.4 million people represented about 5.5 percent of the total population in the United States in 2013.[14] Of these 17.4 million Medicaid enrollees, 10.5 million (roughly 60 percent) were children and adults under the age of 65 who qualified for Medicaid because of a disability, and 6.9 million (roughly 40 percent) were adults ages 65 and older.[15]

Medicaid is the largest public payer for LTSS. In fiscal year 2014, combined federal and state Medicaid spending for LTSS was roughly $152 billion. Roughly one out of three Medicaid dollars—32 percent of all Medicaid spending—goes toward LTSS.[16]

More than 4.8 million people received Medicaid assistance with LTSS in 2012. Slightly more than

half (55 percent) of them were under age 65, including children under age 21 (16 percent) and adults under the age of 65 (39 percent).[17] These different populations—children, younger adults with disabilities, and older adults—have diverse needs that can be met with similar LTSS.[18]

As a program for people in financial need, Medicaid requires that applicants meet income and asset tests as well as demonstrate functional need for services. Income standards are tied to the poverty level or candidates' receipt of Supplemental Security Income (SSI), depending on the state in which the applicant lives and the applicable eligibility category. In most states, an individual must have $2,000 or less in assets.[19]

Beyond the standard qualification for Medicaid LTSS based on poverty or receipt of SSI, 33 states allow older people and adults with disabilities whose incomes exceed the normal eligibility standards to qualify for Medicaid if they also have high medical and LTSS expenses that reduce their remaining income and savings within the eligibility standards.[20] These "medically needy" programs enable individuals with very high medical and LTSS expenses to receive Medicaid assistance once they have "spent down" their own resources.

Unfortunately, that kind of spend down is not rare. In a major study from 1996/1998 to 2008, nearly 10 percent of people ages 50 and older without Medicaid spent down their resources during the study period, forcing them to seek Medicaid support.[21] People who spent down their resources and qualified for Medicaid had substantially lower incomes and assets at the start of the study period than those who did not exhaust their resources. The majority (57 percent) of them had incomes in the bottom quartile (below $15,940), and 81 percent had nonhousing assets of less than $14,000 (not including IRAs). 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).[22]

Medicaid beneficiaries must contribute a significant amount of their incomes toward the cost of LTSS. Although Medicaid allows people living in nursing homes to retain a limited monthly portion of their income for personal care needs (ranging among states from $30 to $105 per month in 2010), the rest of their income must go toward paying for their nursing home care.[23] States also are required to 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. However, the spouse of a married Medicaid beneficiary who is institutionalized is allowed to keep some income. States allowed these spouses who live in the community to retain between $2,002.50 in income a month (federal minimum) and $3,022.50 a month (federal maximum) in 2017.[24]

CONCLUSION

Medicaid covers a variety of services, ranging from personal care to nursing home care, for people of all ages who have physical, cognitive, or mental impairments. Medicaid is an important safety net to cover the high costs of health care and LTSS for people who have exhausted their funds. Few people can qualify for or afford private long-term care insurance. Most older adults who need LTSS depend on family and friends for care. For those who need paid assistance, few options are available to help them pay for the high cost of LTSS—leaving them to rely on Medicaid as a last resort once they have spent their life savings paying for care.

Acknowledgment

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Endnotes

1 Note: Using microsimulation modeling, the Urban Institute estimated that 52 percent of Americans turning 65 between 2015 and 2019 will develop a Health Insurance Portability and Accountability Act–level disability of having two or more limitations in activities of daily living that are expected to last at least 90 days or need for significant supervision for health and safety threats due to severe cognitive impairment. M. Favreault and J. Dey, *Long-Term Services and Supports for Older Americans: Risks and Financing*, Issue Brief (Washington, DC: Office of the Assistant Secretary for Planning and Evaluation revised February 2016), https://aspe.hhs.gov/sites/default/files/pdf/106211/ElderLTCrb-rev.pdf.

2 Ibid.

3 *Genworth 2016 Cost of Care Survey* (April 2016), https://www.genworth.com/about-us/industry-expertise/cost-of-care.html.

4 Favreault and Dey, *Long-Term Services and Supports*.

5 Ibid.

6 S. C. Reinhard, et al., *Valuing the Invaluable: 2015 Update* (Washington, DC: AARP Public Policy Institute, July 15, 2015), http://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf.

7 National Academies of Sciences, Engineering, and Medicine, *Families Caring for an Aging America* (Washington, DC: The National Academies Press, 2016), https://www.nap.edu/catalog/23606/families-caring-for-an-aging-america.

8 D. Redfoot, L. Feinberg, and A. Houser, *The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers* (Washington, DC: AARP Public Policy Institute, 2013), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/baby-boom-and-the-growing-care-gap-insight-AARP-ppi-ltc.pdf.

9 Favreault and Dey, *Long-Term Services and Supports*.

10 E. C. Nordman, *The State of Long-Term Care Insurance: The Market, Challenges and Future Innovations*, CIPR Study Series 2016-1 (Kansas City, MO: National Association of Insurance Commissioners & the Center for Insurance Policy and Research, May 2016).

11 Calculated by AARP Public Policy Institute, using US Census Bureau Vintage 2015 population estimates.

12 E.C. Nordman, *State of Long-Term Care Insurance*.

13 MACPAC, Analysis of MSIS Data as of December 2015. *MACStats: Medicaid and CHIP Data Book* (2016), https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-14.-Medicaid-Enrollment-by-State-Eligibility-Group-and-Dually-Eligible-Status-FY-2013.pdf.

14 US Census Bureau estimates for 2013.

15 MACPAC, *MACStats: Medicaid and CHIP Data Book*.

16 S. Eiken, et al., *Medicaid Expenditures from Long-Term Services and Supports (LTSS) in FY 2014* (Cambridge, MA: Truven Health Analytics, April 15, 2016), https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf.

17 Note: This number is an underestimate because data do not include people who enrolled in a comprehensive managed care program. S. Eiken, *Medicaid Long-Term Services and Supports Beneficiaries in 2012* (Cambridge, MA: Truven Health Analytics, September 16, 2016), https://www.medicaid.gov/medicaid/ltss/downloads/ltss-beneficiaries-2012.pdf.

18 Commission on Long-Term Care, *Report to the Congress* (Washington, DC: Commission on Long-Term Care, September 30, 2013), https://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf.

19 M. O. Watts, et al., *Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015* (Washington, DC: The Henry J. Kaiser Family Foundation, March 2016), http://kff.org/medicaid/report/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-in-2015/.

20 Ibid.

21 J. Wiener, et al., *Medicaid Spend Down: New Estimates and Implications for Long-Term Services and Supports Financing Reform* (Washington, DC: RTI International, March 21, 2013), file:///C:/Users/wfgrage/Downloads/rti_medicaid-spend-down_3-20-13%20(2).pdf.

22 Ibid.

23 Watts et al., *Medicaid Financial Eligibility*.

24 2017 SSI and Spousal Impoverishment Standards, https://www.medicaid.gov/medicaid/eligibility/downloads/spousal-impoverishment/2017-ssi-and-spousal-impoverishment-standards.pdf

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