MYTHS & FACTS

MEDICAID'S ROLE IN LONG TERM CARE: Q & A

Financing long-term care for the nearly 10 million Americans who need services and supports to assist them in life's daily activities continues to challenge the nation. While Medicaid is the nation's major source of financing for long-term care services, paying for over 40% of total long-term care, its role is not well understood. Misperceptions on who qualifies and what is covered are common. The Q & A's about Medicaid's long-term care assistance outlined here provide basic information on Medicaid's role for those with long-term care needs.

Q: Does Medicaid pay the nursing home bill for wealthy seniors?
A: Medicaid eligibility is limited to the very poor or those with large health expenses who have depleted their savings.

Most Americans do not qualify for Medicaid. Medicaid assistance is generally available to people who are disabled and poor enough to qualify for cash assistance through the Supplemental Security Income (SSI) program. To qualify for SSI in 2005, an elderly individual must have a monthly income less than $579 ($869 for a couple) and less than $2,000 in assets ($3,000 for a couple). Some states also allow the "medically needy"—individuals who have high medical bills--to receive Medicaid assistance. In addition, because few people can afford the high cost of nursing home care, 33 states allow individuals at slightly higher income levels (225% of poverty) who have depleted their assets paying for nursing home care to receive help from Medicaid. In all cases, individuals are required to apply their income, including Social Security and pension checks, towards their care costs, except for an average monthly $30 personal needs allowance.

Q: Are middle and upper class elderly shielding their assets to become eligible for Medicaid?
A: Medicaid law precludes coverage of individuals who have transferred assets to others for three to five years.

Although advertising by estate planners abounds, there is little research evidence to support the notion that widespread transfer of assets to gain Medicaid eligibility is occurring. Even with limited resources, most elderly nursing home residents use private resources to pay for all or part of their nursing home costs. Sixty

percent of nursing home residents are not on Medicaid at the time of their admittance into a facility. Studies have found that few elderly have accumulated assets in addition to their homes. In fact, there is evidence that children are transferring money to their elderly parents to help prolong the time period before they qualify for Medicaid. With the annual cost of nursing home care typically exceeding $70,000, the longer an individual remains in a facility, the more likely they are to deplete their financial resources and qualify for Medicaid coverage.

Q: Does Medicaid adequately prevent people from becoming impoverished by long-term care needs?
A: Most Medicaid beneficiaries who need long-term care services have already depleted all of their savings as a condition for qualifying for coverage.

People with long-term care needs and their families pay out-of-pocket for one quarter of the nation's long-term care bill. Because of the high cost of long-term care services, many of these individuals deplete their savings before becoming eligible for Medicaid. Although, some protections exist to protect the financial ability of a spouse to remain in the community, asset amounts are often limited to less than $20,000 and may be inadequate to assure the financial security of an elderly widow.

Q: Are long-term care costs bankrupting Medicaid?
A: Long-term care spending, including nursing home spending, accounts for a large share of Medicaid, but is growing at a modest rate.

Over the last several years, Medicaid acute care spending has been growing faster than long-term care spending. The overall growth in Medicaid spending can be primarily explained by overall health care inflation and the growth of coverage to low-income families and children as families lost jobs and income during the recent recession. The growth in expenditures for the elderly and disabled are primarily driven by the growth in acute care services, such as prescription drugs and in-patient hospital services, not long-term care.

Q: Are states powerless to control nursing home costs?
A: States have tools to control eligibility for long-term care services, payment rates, and nursing home bed supply.

States currently have vast discretion over eligibility for Medicaid long-term care services. Four in ten elderly and disabled receive Medicaid coverage at state option. States can use eligibility levels and preadmission screenings as tools to limit access to nursing home care. States also set the level of provider payment rates and the number of nursing home beds.

Q: Will greater reliance on home and community-based care fix the state budget crisis?
A: Promoting community-based alternatives makes good policy sense, but is unlikely to reduce Medicaid spending and unmet need.

Providing care for people with physical and mental disabilities in safe settings can be expensive. To meet the diverse situations of people who need long-term care, states need to provide an array of long-term care options, ranging from institutional care to community-based supports. Reflecting the desire for more community options, the balance in Medicaid has been shifting with spending on community-based care doubling over the past decade to now account for one in three Medicaid long-term care dollars. Despite these gains, eligibility, enrollment, and funding have been limited and many states have long waiting lists for home and community-based services. According to a recent survey conducted for the Kaiser Commission, there are nearly 200,000 individuals on waiting lists for community-based services. On the nursing home side, the number of residents has been slowly declining from 1.8 million in 1990 to 1.4 million in 2004. Despite this progress, promoting care in the community does not eliminate the need for nursing homes or reduce Medicaid spending unless states cut the level of care for people who stay at home.

Q: Is consumer direction a magic bullet for solving Medicaid's financing challenges?
A: While consumer direction can provide important opportunities for improving the quality of and satisfaction with care, it is not a substitute for adequate financing for long-term care services.

For many people with disabilities and the elderly who need long-term care services, having control over how and where they receive their services is important. Cash and Counseling waivers, and now the Independence Plus waivers, promote consumer direction by giving an individual with disabilities an individual budget to purchase services. Safeguards are necessary to assure that individual budgets are adequate, quality is maintained, and changes in health status or needs are appropriately handled. These arrangements can improve the quality of and satisfaction with care in the community, but may falter if viewed as a tool to achieve cost savings.

Q: Is personal responsibility lacking in the Medicaid program?
A: People who need long-term care rely heavily on care provided by family and friends.

Eighty percent of the elderly with long-term care needs receive help solely from family and friends who are not paid for these efforts. When an individual's care needs become too intensive or caregiving becomes too physically or emotionally

draining, they often turn to more formal arrangements (paid in-home care or nursing homes) and draw on their own financial resources to pay for that care.

Q: Is Medicaid the primary barrier to the expansion of the private long-term care insurance market?
A: Private long-term care insurance is unavailable and unaffordable to many people who need long-term care.

There is little evidence that Medicaid crowds out private insurance. Rather, premiums for private long-term care insurance policies are often too expensive for low-income individuals. The annual premium for a policy purchased by age 65 exceeded $2,000 in 2002. There are also risks associated with purchasing long-term care insurance policies. If a person purchases a long-term care insurance policy when they are in their 50's or early 60's, they maybe unable to keep up with the cost of their premiums as their income declines. Lapses in premium payments typically result in loss of benefits. In addition, policies that do not include inflation protection may not be adequate to cover the costs of care when it is needed in the future. In addition, private long-term care insurance is rarely an option for someone who becomes disabled before age 65.

Q: Are the future long-term care needs of the aging baby boom population unaffordable without major restructuring of Medicaid?
A: States face challenges in financing Medicaid that are driven largely by the nation's rising health care costs and population needs.

Medicaid plays an essential role as the primary source of financial assistance for people who need long-term services and supports, filling gaps in Medicare and in private insurance. Without Medicaid, states would be hard-pressed to meet the needs of their senior and younger disabled populations, resulting in more unmet need and stress on families. Yet, states face real challenges due to inflation in the health care sector driven by increasing technology, the rising number people with disabilities, and a growing number of uninsured. In addition, spending on long-term care varies greatly from state to state. States that currently spend the least on long-term care will probably be faced with the greatest increase in demand. Reducing the nation's commitment to funding Medicaid will not solve these problems, but could undermine needed services and supports for populations with significant health care needs. Planning for the future is likely to require additional investments to meet the responsibilities expected of the program.

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