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Long-Term Care and Medicaid: The Critical Role of Public Financing

Judith Feder, Ph.D.

Professor and Dean

Georgetown Public Policy Institute

Georgetown University

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Judith Feder, Ph.D.
Professor and Dean
Georgetown Public Policy Institute
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Executive Summary. Policy debate about the nation's health and retirement entitlements has generated discussion of current and future policy toward long-term care financing. Medicaid, the nation's long-term care safety net, is at the heart of that discussion. Those who view long-term care financing as solely a budgetary issue see the primary policy question as "how to reduce Medicaid spending on long-term care," both now and in the future. Hence the disproportionate cuts in Medicaid contained in the president's budget and the congressional budget resolution. By contrast, analysis of people's needs and resources indicates that the primary policy question should be "how best to strengthen Medicaid's—or, more broadly, the government's—capacity to assure affordable access to long-term care." This essay provides that analysis—describing who needs long-term care, why Medicaid does—and should—provide a safety net, why expanded rather than reduced public support is essential, and what options exist for providing it. The argument, in brief, is as follows:

- Today, 10 million people of all ages are estimated to need long-term care, close to 40 percent of whom are under the age of 65. Among the roughly 8 million who are in community settings, one in five report getting insufficient care, frequently resulting in significant consequences—falling, soiling oneself, or inability to bathe or eat.
- The need for long-term care is unpredictable and, when extensive service is required, financially catastrophic—best dealt with through insurance rather than personal savings. But the nation lacks a policy that ensures people of all ages access to quality long-term care when they need it, without risk of impoverishment.
- Private insurance for long-term care is expanding and will play a growing role in long-term care financing. However, even with improved standards and special "partnerships" with Medicaid, it does nothing for those currently in need, is not promoted as a means to serve the under-65 population and, in the future, will be affordable for only a portion of the older population—most likely, the better off.
- Medicaid is the nation's only safety net for those who require extensive long-term care. Rather than serving primarily as a deterrent to the purchase of private insurance, it serves overwhelmingly to ensure access to care for those least able to afford that insurance. But its invaluable services become available only when and if people become impoverished; its protections vary substantially across states; and, in most states, it fails to ensure access to quality care, especially in people's homes.
- Policy "solutions" that focus only on limiting public obligations for long-term care financing do our nation a disservice. Although individuals and families will always bear significant care-giving and financial responsibility, equitably meeting long-term care needs of people of all ages and incomes—throughout the nation—inevitably requires new federal policy and a significant investment of federal funds. Options include a core program of universal public insurance, extending Medicaid to provide a national "floor" of protection for low- and modest-income people, or—more modestly—broadening Medicaid coverage of home- and community-based care with more federal financing.

The Need for Long-Term Care

A significant and growing number of Americans need long-term care. Today, almost 10 million people of all ages need long-term care. Only 1.6 million are in nursing homes. Most people who need long-term care, especially younger people, live in the community. Among people not in nursing homes, fully three-quarters rely solely on family and friends to provide the assistance they require. The range of needs is considerable—with some people requiring only occasional assistance and others needing a great deal. Nationally, one in five people with long-term care needs who are not in nursing homes report “unmet” need, frequently resulting in significant consequences—falling, soiling oneself, or inability to bathe or eat.

The likelihood of needing long-term care is also unpredictable. Although the likelihood increases with age, close to 40 percent of people with long-term care needs are under the age of 65. And the need for care among the elderly varies considerably. Over a lifetime, projections for people currently turning age 65 indicate that about 31 percent are likely to die without ever needing long-term care; 17 percent are likely to need one year of care or less, and about 20 percent are likely to need care for more than five years.¹

Need for long-term care will grow in the not-so-distant future as a far larger proportion of the nation’s population will be over age 65 than are today. Experts disagree on whether disability rates among older people in the future will be the same as or lower than they are today. But even if the proportion of older people with disabilities declines, the larger number of older people will likely mean a larger number of people with long-term care needs in the future than today. The population aged 85 and older, who are most likely to have long-term care needs, is likely to double by 2030 and quadruple by 2050.

The Importance and Absence of Insurance

The cost of paid care exceeds most families’ ability to pay. In 2002, the average annual cost of nursing home care exceeded \$50,000, and of home care (four hours per day) was estimated at \$26,000. Clearly, the need for extensive, paid long-term care constitutes a catastrophic expense. Intensive family care-giving also comes at considerable cost—in employment, health status and quality of life—and may fail to meet care needs.

Because long-term care needs are unpredictable and may be financially catastrophic, insurance is the most appropriate financing strategy. Reliance on savings alone is inefficient and ineffective. People will either save too much or too little to cover expenses.

However, few people have adequate private or public long-term care insurance. Although sales of private long-term care insurance are growing (the number of policies ever sold more than tripled over the 1990s), only about 6 million people are estimated to currently hold any type of private long-term care insurance. Growing numbers of older people, especially of the segment

¹ Peter Kemper, Harriet Komisar, and Lisa Alecxih. Long-Term Care over an Uncertain Future: What Can Current Retirees Expect? Presentation at the annual meeting of the Gerontological Society of America, November 2004.

with significant resources, will create the potential for substantial expansion of that market. But private long-term care insurance policies remain a limited means to spread long-term care risk.

Private long-term care insurance:

- Is not available to people who already have long-term care needs;
- Is not designed to meet the needs of younger people who are also at risk of needing long-term care;
- Is not affordable to the substantial segment of older persons, now and in the future, with low and modest incomes;
- Limits benefits in dollar terms in order to keep premiums affordable, but therefore leaves policyholders with insufficient protection when they most need care; and
- Lacks the premium stability and benefit adequacy that can assure purchasers who pay premiums year after year that it will protect them against catastrophe.

We need only look at the experience in health insurance to recognize that reliance on individual-market long-term care insurance—plagued by risk selection, high marketing costs, benefit exclusions, and other problems—will result in care that is grossly inadequate to ensure sufficient protection for most people.

Current public policy falls far short of ensuring insurance protection. Medicare, which provides health insurance to many who need long-term care, covers very little long-term care. Its financing for nursing home care and home care is closely tied to the need for acute care and is available for personal care only if skilled services—like nursing and rehabilitation therapy—are also required. Medicaid plays a critical role in financing the long-term care that people could otherwise not afford. But it finances care only after people have exhausted virtually all their own resources. Unlike what we think of as “insurance,” Medicaid does not protect people against financial catastrophe; it finances services only after catastrophe strikes.

The Medicaid Safety Net

It is Medicaid that provides the nation’s long-term care safety net. In 2002, Medicaid paid for close to half of long-term care expenditures, and—despite the fact the vast majority of Medicaid beneficiaries are low-income adults and children not needing such services—long-term care accounted for about a third of Medicaid spending.²

Most nursing home users who qualify for Medicaid have such limited resources that they satisfy Medicaid’s income and asset eligibility requirements on admission. About 16 percent of elderly nursing home users begin their nursing home stays using their own resources and then become eligible for Medicaid as their assets are exhausted. Because the costs of long-term care are so high relative to most people’s income and resources, the opportunity to “spend down” to eligibility—spending virtually all income and assets in order to qualify—is essential to ensure access to care.

² Ellen O’Brien and Risa Elias. *Medicaid and Long-Term Care*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2004.

Despite Medicaid's essential role, however, it has significant limitations. Medicaid's services fall far short of meeting the needs and preferences of people who need care. Medicaid's benefits focus overwhelmingly on nursing home care—an important service for some, but not the home care services preferred by people of all ages. In the last decade, Medicaid home care spending has increased from 14 percent to 29 percent of Medicaid's total long-term care spending. But nursing homes still absorb the lion's share of Medicaid's support for long-term care. Further, most states have expanded home- and community-based care through programs that “waive” some statutory Medicaid requirements—specifically, the entitlement to service for people who qualify due to need for care. The ability of states to limit, through waiver programs, the number of people who can receive assistance—to create waiting lists—leaves large numbers in need of assistance without service.

Medicaid protection also varies considerably from state to state. As a federal-state matching program, Medicaid gives states the primary role in defining the scope of both eligibility and benefits. An analysis by the Urban Institute³ emphasized that the resulting state variation in service availability is a source of both inequity and inadequacy in our financing system. In an examination of 1998 spending in 13 states, long-term care dollars per aged, blind, or disabled enrollee in the highest-spending states (New York and Minnesota) were about four times greater than in the lowest (Alabama, Mississippi)—a differential even greater than that found for Medicaid's health insurance spending for low-income people.

Both Georgetown's research and that conducted by the Government Accountability Office⁴ tell us that differences in state policies have enormous consequences for people who need long-term care. Research reveals that the same person found financially eligible or sufficiently impaired to receive Medicaid services in one state might not be eligible for Medicaid in another—and, if found eligible, might receive a very different mix or frequency of service. And a comparison of use of paid services by elderly Medicare-Medicaid dual eligibles in six states documents substantially greater unmet need in the state with the smallest share of people likely to receive paid services as in the state with the largest.⁵

This variation—as well as ups and downs in the availability of benefits over time—undoubtedly reflects variation in states' willingness and ability to finance costly long-term care services. The recent recession demonstrated the impact on states of changes in their economies and the vulnerability of Medicaid recipients to states' reactions. In 2001, Medicaid accounted for 15 percent of state spending, with long-term care responsible for 35 percent of the total. Virtually all states were cutting their Medicaid spending as budget pressures struck, endangering access either for low-income people needing health insurance, older or disabled people needing long-term care, or both. If current policies persist, pressure to make difficult tradeoffs will only get stronger. In the future, states with bigger increases in the elderly-to-worker ratio will face the greatest pressure. And, since many of the states with above-average growth in need currently

³ John Holahan. Variation in Health Insurance Coverage and Medical Expenditures: How Much Is Too Much? Chapter 6 in John Holahan, Alan Weil, and Joshua M. Wiener, *Federalism and Health Policy*, The Urban Institute Press, 2003.

⁴ *Long-term Care, Availability of Medicaid Home and Community Services for Elderly Individuals Varies Considerably*. Washington, DC: U.S. GAO, 2003

⁵ Komisar, Harriet L., Judith Feder, and Judith D. Kasper. Unmet Long-Term Care Needs: An Analysis of Medicare-Medicaid Dual Eligibles. *Inquiry* (forthcoming Summer 2005).

spend relatively little per worker on Medicaid long-term care, there is a strong likelihood that, in the future, long-term care financing will be even less equitable and less adequate across the nation than it is today.

In sum, under current policy, neither public nor private insurance protects people against the risks associated with long-term care. Despite Medicaid's important role as a safety net, the overall result for people who need care is catastrophic expenses, limited access to service, and care needs going unmet.

Myths and the Current Policy Debate

In 2005, there has been long-overdue attention to long-term care. Several congressional hearings have been held, and policy makers increasingly recognize long-term care as an issue in both retirement and health security policy. However, the focus has been overwhelmingly budget driven—aimed more at simply reducing federal spending than at equitably distributing long-term care costs. Further, flawed assumptions about people's resources and the role of public and private insurance underlie policy proposals that, in reality, would redistribute resources in favor of the better off and away from the neediest rather than improve equity and security in long-term care financing.

Questionable claims that are commonly made are...

...that Medicaid's nursing home coverage serves primarily as an asset shelter for the wealthy. To receive Medicaid support for nursing home care, beneficiaries must have limited assets and must contribute virtually all their income to the cost of care. Critics have labeled this spend-down requirement a "fallacy," arguing that the bulk of Medicaid resources go to finance nursing home care for people who could afford to pay for themselves. However, the evidence shows that few of the elderly have the income or wealth that would warrant such transfer; that people in poor health are more likely to conserve than to exhaust assets; that, for the elderly population as a whole, transfers that occur are typically modest (less than \$2,000); and that transfers that are associated with establishing eligibility are not significant contributors to Medicaid costs.⁶

...that availability of Medicaid discourages the purchase of private insurance.⁷ A 2004 Congressional Budget Office (CBO) report⁸ put forward the proposal that Medicaid be made "meaner"—more restrictive in its eligibility—in order to promote the purchase of private long-term care insurance. Empirical analysis of people's actual insurance purchases, however, challenges the idea that Medicaid's availability significantly deters purchase—finding, specifically, that Medicaid had no impact on long-term care insurance purchase decisions among workers age 51 to 61 and only a slight impact on the decisions of potential purchasers over age

⁶ Ellen O'Brien. Medicaid's Coverage of Nursing Home Costs: Asset Shelter for the Wealthy or Essential Safety Net? Georgetown University Long-Term Care Financing Project, May 2005. <http://ltc.georgetown.edu>.

⁷ Ellen O'Brien

⁸ *Financing Long-term Care for the Elderly*. Washington, DC: Congressional Budget Office, April 2004

70. This is too small an effect to explain the very low proportion of elderly holding policies.⁹ More restrictive Medicaid policies might therefore have little impact on purchases and, as CBO recognized, would leave even many of those who purchase insurance with benefits too limited to cover the costs of care.

...that improving and subsidizing private long-term care insurance will reduce public spending. As a strategy to reduce pressure on Medicaid, CBO also explored proposals to make private long-term care insurance more attractive.¹⁰ One strategy would be regulation to standardize policies and their protections. Standardizing long-term care insurance policies might facilitate consumers' ability to make choices in the marketplace and improve the adequacy of private long-term care insurance. But, as CBO notes, standards that improve policies would likely increase insurance premiums. While the outcome might be better protection for those who can afford private insurance—a worthy goal—higher premiums would likely reduce rather than increase the numbers of people willing or able to buy insurance.

Another strategy would expand the “partnerships for long-term care”—state programs which allow benefits paid by private insurance to offset (or protect) assets for Medicaid users who purchase approved private long-term care insurance policies. These partnerships have been advocated as a means to save Medicaid money by preventing “spend-down” and asset transfers. The hope is that providing asset protection through Medicaid to enhance or subsidize private insurance policies' limited benefits will encourage modest-income people to purchase private long-term care insurance. Experience with these policies in four states has produced only limited purchases, primarily among higher income people, and has affected too few people for too short a period to assess its impact on Medicaid spending.¹¹ The partnership has contributed to improved standards for long-term care insurance policies and more partnership policies are being sold to more modest-income people as the standards that apply to them are also applied to the broader market. However, if these policies simply substitute for policies individuals would otherwise have purchased, they may increase rather than decrease Medicaid expenditures.

From the budgetary perspective, advocacy of reliance on Medicaid to essentially subsidize private long-term care insurance alongside promotion of budget legislation to curtail federal Medicaid contributions seems both disingenuous and risky. The administration itself assumes no budget savings, and CBO suggests that there is a risk that it could increase Medicaid costs if people who would have purchased private insurance anyway avail themselves of asset protection. From the broader equity perspective, targeting private long-term care insurance to modest-income people seems questionable, at best. The purchase of a limited long-term care insurance policy could easily absorb close to 10 percent of median income for a couple aged 60—a substantial expenditure for a cohort acknowledged as woefully unprepared to meet the basic income needs of retirement.

⁹ Frank A. Sloan and Edward C. Norton. Adverse Selection, Bequests, Crowding Out and Private Demand for Insurance: Evidence from the Long-Term Care Insurance Market, *Journal of Risk and Uncertainty* 15, no.3 (1997): 201-219.

¹⁰ CBO, April 2004.

¹¹ Alexis Ahlstrom, Emily Clements, Anne Tumlinson and Jeanne Lambrew. The Long-Term Care Partnership Program: Issues and Options. Pew Charitable Trusts' Retirement Security Project, George Washington University and The Brookings Institution, December 2004.

Even more questionable are proposed tax preferences for the purchase of private long-term care insurance. The tax deductions that were included in the president's budget last year cost \$6 billion over five years and would disproportionately benefit higher-income purchasers of such coverage—the population that needs subsidization the least. Experience in health insurance also suggests that the population likely to benefit is the group most likely to have purchased insurance even in the absence of credits—substituting public for private dollars. As currently proposed, these tax benefits are not even designed to reach the substantial portion of older and younger Americans with low and modest incomes. To propose cuts in Medicaid while providing subsidies to better off Americans would not only fail to decrease total public spending, but would make its distribution less equitable.

Effective Strategies for Long-Term Care Financing

Consideration of budgetary limitations is an important part of any policy development process. But allowing budgetary constraints to drive that process distorts the nation's policy choices. Developing better long-term care policy requires an assessment of how to finance affordable access to long-term care, while distributing costs equitably between individuals who need care and their families, on the one hand, and the rest of federal and state taxpayers on the others. Achieving that goal requires recognition of the need for an increase, not a decrease, in the commitment of public resources—and, to be adequate and effective in all states—federal resources.

Expanded public financing for long-term care could take a variety of forms and would, by no means, eliminate private contributions. Options include:

Core public insurance, supplemented by private insurance and private resources. Analysis by the Organization for Economic Cooperation and Development (OECD) of long-term care policy in 19 OECD countries¹² found that the number of countries with universal public protection for long-term care (Germany, Japan and others) is growing. Public protection, they report, does not imply either the absence of private obligations (cost sharing and out-of-pocket spending) or unlimited service use and exploding costs. Rather, in general, it reflects a “fairer” balance between public and private financing—relating personal contributions to one's ability to pay and targeting benefits to the population in greatest need. Many of these nations have substantially larger proportions of elderly than does the U.S. and therefore can be instructive to us as we adjust to an aging society.

One approach to future long-term care in the U.S. is social insurance—in which everybody contributes to financing the system and resources are allocated based on need. Modeled on Social Security, a social insurance approach would provide everyone access to a “core” or “basic” long-term care benefit, which could be supplemented by private insurance purchases by the better off and enhanced public protection for the low-income population. The basic benefit

¹² Manfred Huber and Patrick Hennessy, OECD, Directorate for Employment, Labour and Social Affairs, “Financing Long-term Care: International Comparisons,” presented at Academy Health 2004 Research Meeting, San Diego, CA.

could be a Medicare benefit or a new social insurance program for services at home as well as in nursing homes. The supplemental coverage offered by private insurers would provide additional security, similar to private pensions for Social Security. Low-income populations would qualify for a federally-funded program (like SSI) that would ensure that cost does not limit their access to needed long-term care.

A floor of protection against impoverishment. Another option would be establishment of a public “floor” of protection—a national program ensuring everyone access to affordable quality long-term care, at home as well as in the nursing home, without having to give up all their life savings as Medicaid requires today. The asset floor could be set to allow people who worked hard all their lives to keep their homes and modest assets, while allowing the better off to purchase private long-term care insurance to protect greater assets. To provide a uniform federal floor would require a significant expansion of existing Medicaid eligibility, which, along with current spending below the floor, would be financed with federal funds. This new federal funding for long-term care would provide substantial relief to states to focus on health insurance, education and other pressing needs—relief that governors have explicitly requested by calling on the federal government to bear the costs of Medicare-Medicaid “dual eligibles.”

Particularly important in this regard would be expanded protection for home and community-based care. Although many states have taken advantage of the flexibility within Medicaid to expand access to long-term care at home, states have often done this through home and community-based services (HCBS) waiver programs which permit states to cap enrollment and maintain waiting lists for services. Waiting lists, in many states, are both large and long. For example, Texas has nearly 75,000 people on its waiting list for community living services and the average wait time is two years to receive services.¹³ States have historically been reluctant to provide home and community-based care to all who qualify, for fear that the numbers and costs will exceed their willingness to pay. Establishing a uniform, federally-funded program that would protect against impoverishment, while expanding the range of options for people who need long-term care, would be a considerable advance in long-term care insurance protection.

A federally funded home-care Medicaid benefit, with uniform eligibility across the states. Because Medicaid serves the neediest population and, in the current budgetary environment, is at risk, the highest priority for expenditure of the next federal dollar should be to provide states some fiscal relief, while improving Medicaid protection for the lowest-income population in need of care. Federalizing home-care for low-income people who need long-term care is a logical “next step” in long-term care financing.

Creating the opportunity for individuals to receive long-term services and supports in the community—irrespective of where they live—would improve the quality of life for beneficiaries and for their family caregivers, even if eligibility levels remain relatively low.

To achieve this goal, the federal government could fully fund a “community support services” benefit for all individuals with income below a specified eligibility level—uniform across states (similar to the fully federally funded income floor provided by Supplemental Security Income).

¹³ Kaiser Commission on Medicaid and the Uninsured. *Medicaid: Issues in Restructuring Federal Financing*. Washington, DC., Henry J. Kaiser Family Foundation, January 2004.

States that wanted to expand enrollment above this level could do so. However, the new program would create a nationwide safety net to ensure a minimum level of protection for people in need.

In any of these initiatives—as well as within the current Medicaid program—policy attention should also be paid to improving the quality of long-term care. Both regulation and provider payment policy can affect providers’ investment in patient care—particularly in supporting adequate staffing. Payment policies vary across states, and some reward quality-related investment far more than others. Promotion of policies that reward such investment (not only in Medicaid, but in Medicare where rewards are lacking) is likely to result in better care.¹⁴

Conclusion

Some will undoubtedly characterize proposals like these as “unaffordable” given the fiscal demands of Medicare and Social Security and the current federal budget deficit. But that deficit reflects policy choices—favoring tax cuts over the use of our collective resources to pursue common social goals. Along with other revenues, the estate tax is especially appropriate for long-term care financing since it would mean taxing everyone’s estate at certain levels to provide reasonable estate protection for those unlucky enough to need long-term care.

Indeed, focusing on the budget and avoiding taxation ignores the public responsibility to address for all Americans what should be our fundamental policy choice: do we want to live in a society in which we ensure affordable access to long-term care for people who need it or in a society in which we leave people in need to manage as best they can on their own? If we are to be the caring society we wish ourselves to be, we, like other nations, should move in the direction of greater risk-sharing and equity in long-term care financing by adopting the national policy and committing the federal resources which that will require.

¹⁴ For a review of literature and proposals, see Debra J. Lipson, “Linking Payment to Long-term Care Quality: Can Direct Care Staffing Measures Build the Foundation,” Better Jobs Better Care, Institute for the Future of Aging Services, American Association of Homes and Services for the Aging, April 2005.

Judy Feder is Professor and Dean of the Georgetown Public Policy Institute. She is one of the nation's leaders in health policy. Her expertise on the uninsured, Medicare, Medicaid, and long-term care is regularly drawn upon by members of Congress, Executive officials, and the national media. Feder has also held leadership policy positions, both in the Congress and in the Executive Branch. As Staff Director of the congressional Pepper Commission (chaired by Senator John D. Rockefeller IV), Feder is widely credited with setting the stage for the health reform debate of the 1990s. She became a key actor in that debate, as a senior official in the Clinton Administration. In her three years as Principal Deputy Assistant Secretary at Health and Human Services, Feder helped shape the Administration's health care policy, working intensively with members of Congress and with the national media to promote the expansion of health care coverage. Feder today pursues her policy leadership at Georgetown's Public Policy Institute. She continues her research as Co-Director (with Sheila Burke) of the Georgetown University Long-term Care Financing Project and as Senior Advisor to the Kaiser Family Foundation's Commission on Medicaid and the Uninsured and a member of the Commonwealth Task Force on the Uninsured. She is also a member of the board of the American Progress Action Fund. Feder is a political scientist, with a B.A. from Brandeis University and a master's and Ph.D. from Harvard University.

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1333 H Street, N.W., 10th Floor
Washington, D.C. 20005
(202) 682-1611
www.americanprogress.org**