The Importance of Federal Financing to the Nation's Long-Term Care Safety Net

Judy Feder and Harriet L. Komisar
Georgetown University

February 2012

This paper was supported by a grant from The SCAN Foundation. The SCAN Foundation is dedicated to creating a society in which seniors receive medical treatment and human services that are integrated in the setting most appropriate to their needs. For more information, please visit www.TheSCANFoundation.org.

Table of Contents

Exhibits

The Importance of Federal Financing to the Nation's Long-Term Care Safety Net

Judy Feder and Harriet L. Komisar*
Georgetown University

February 2012

I. Introduction

Long-term care is rarely mentioned in political discussions of deficit reduction. But the financing that supports it is most definitely on the table. Medicaid, along with Medicare and Social Security, is an "entitlement" targeted for "cuts", "swaps," or "caps" in numerous deficit-reduction proposals, both Republican and Democratic. And Medicaid—most often characterized as the federal-state health insurance program for low and modest income people—is, in fact, the nation's only safety net for people who need extensive long-term care services. A third of Medicaid spending goes toward that safety net, paying primarily for personal assistance in nursing homes and at home for people who need help with the basic tasks of daily life. Whether publicly recognized or not, deficit-reduction measures that aim to limit federal funding for Medicaid threaten the long-term care safety net.

But deficit pressures are not the only threat. Reliance on state-based financing—even when matched by federal funds—has produced a program with glaring inadequacies and inequities, which is poorly equipped to deal with future, let alone current, challenges in serving a growing elderly population. Policy "solutions" that would limit the federal commitment to long-term care financing without regard to the underlying challenge would increase, not decrease, these shortcomings. To equitably meet last-resort long-term care needs for people of all ages and incomes—across the nation—will inevitably require greater, not reduced, federal responsibility.

Accordingly, this brief reviews Medicaid's importance and limitations when it comes to long-term care and makes the case for strengthening Medicaid's safety net in one of two ways—assumption of full federal responsibility for Medicare beneficiaries who also rely on Medicaid (so-called "dual eligibles") or an enhanced federal match for Medicaid long-term care services. Each approach carries with it a federal commitment to bear the brunt of a growing elderly population—a burden that varies considerably across states. The difference between the two is whether to assure (the first approach) or to encourage (the second) greater equity and adequacy of services for low-income people across states. Either way, federal action is essential both to remedy current limitations and variations in Medicaid's long-term care safety net, and to assure its adequacy and equity into the future.

* Judy Feder, Ph.D., is a professor and former dean of the Georgetown Public Policy Institute, Georgetown University and a Fellow at the Urban Institute in Washington, D.C. Harriet L. Komisar, Ph.D., is a research professor in the Health Policy Institute and Georgetown Public Policy Institute at Georgetown University.

II. Medicaid's Long-Term Care Safety Net is Essential but Flawed

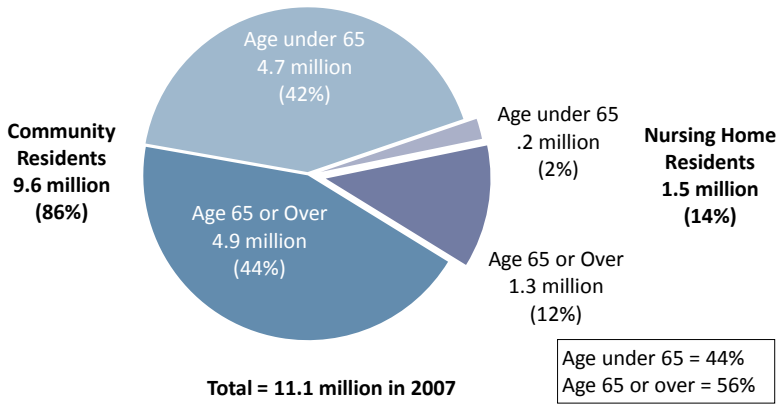
Why do people rely on Medicaid for long-term care? Simply put, because they lack the resources to manage on their own. Critics of Medicaid's safety net role argue that Medicaid reduces families' responsibility to save, purchase insurance, or provide for their own long-term care needs. But such arguments misjudge people's ability to plan for long-term care needs and the resources they have available if needs arise.

First, the need for long-term care is a risk, not a certainty. Although the risk of needing long-term care rises at older ages, people of all ages are at risk—and even at older ages, whether and the extent to which a person may need long-term care varies widely among individuals. Among people under the age of 65, less than two percent have long-term care needs,[1] but they constitute nearly 5 million of the 11 million people who need long-term care (**Figure 1**). Among people now turning age 65, an estimated three in ten will not need long-term care during the rest of their lives, while two in ten will need five or more years of long-term care (**Figure 2**).[2] Most people who need long-term care (over 80 percent of people with long-term care needs living at home) rely solely on family and friends to provide it and do not receive paid services.[3] But families cannot always provide the full amount, intensity, or type of care that is needed.

When paid care is necessary, its costs can far exceed most families' resources. In 2011, personal assistance at home averaged $20 an hour, or about $21,000 annually for 20 hour per

Figure 1

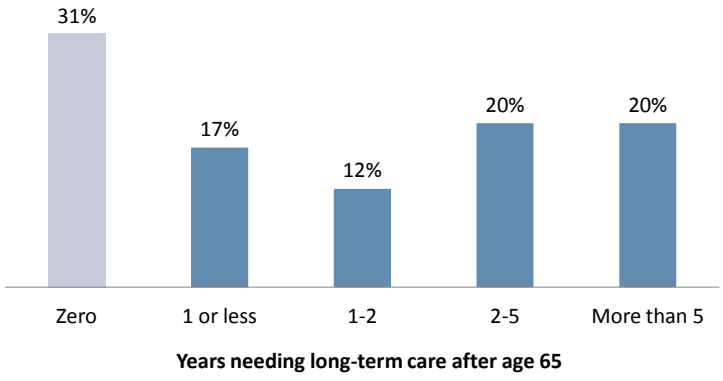
People with long-term care needs, 2007



Source: Authors' estimate based on Kaye, Harrington & LaPlante (2010) analysis of data from the 2007 National Health Interview Survey and the 2004 National Nursing Home Survey.

Figure 2

Percentage of people now age 65, by estimated years of needing long-term care after age 65



Source: P. Kemper, H. Komisar and L. Alecxih, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?" *Inquiry* 42(2) (Winter 2005/2006): 335-350.

week of assistance, and adult daycare center services cost an average of $70 per day, or about $19,000 on an annual basis for 5 days of services per week (**Table 1**). Assisted living services averaged about $42,000 for a basic package of services. For people who need the extensive assistance provided by nursing homes, the average annual cost is now $78,000 for a semi-private room, but varies widely among markets and averages over $100,000 in many of the country's most expensive areas.[4]

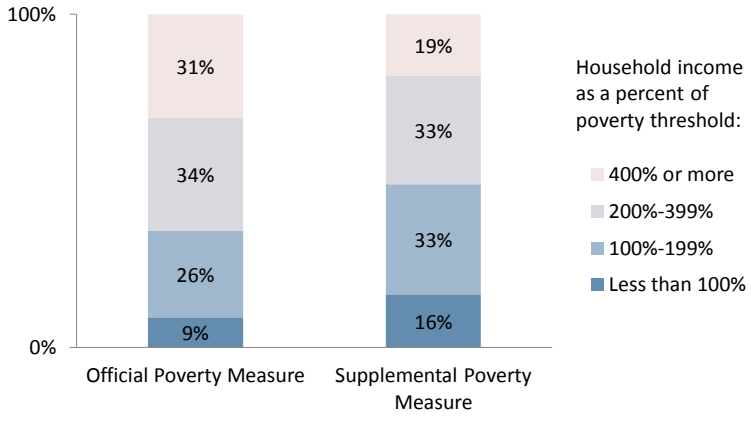
Table 1. Average national prices for long-term care services, by type of service, 2011

Nursing Home	$78,110 annually, semi-private room $87,235 annually, private room
Assisted Living	$41,724 annually for basic package
Home Care	$20 per hour 20 hours per week = $20,800 annually
Adult Day Services	$70 per day 5 days per week = $18,200 annually

Source: The MetLife Mature Market Institute, *Market Survey of Long-Term Care Costs: The 2011 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs*, October 2011.

The mismatch between the costs of these services and the resources of the people who need them is dramatic. Focusing on the older people who are most at risk of needing long term care, findings from the Census Bureau allow us to see this in two ways (**Figure 3**). Using the traditional or "official" measure of poverty, fewer than a third of people age 65 and over have incomes equal to or greater than four times the federal poverty level—or about $42,000 for an individual age 65 or older, or $53,000 for a senior couple.[5] Most people's incomes are clearly well below what is necessary to pay for institutional care and insufficient to make intensive care in the community affordable.[6] The new "supplemental poverty measure" indicates that even fewer older people have income sufficient to support care needs.[7] By this measure, which, along with other adjustments, takes out-of-pocket spending for medical care into account, the proportion of people with incomes greater than four times the poverty threshold falls from almost one in three to one in five.

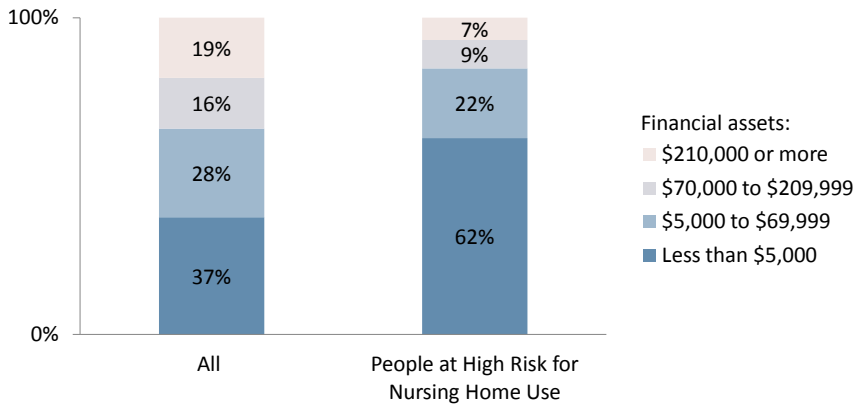
Figure 3
Distribution of people age 65 and over, by income relative to poverty threshold, 2010



Source: K. Short, *The Research Supplemental Poverty Measure: 2010,* U.S. Census Bureau, November 2011.

Although, in theory, savings can help fill the gap between income and service costs, in practice, savings are inadequate to the task. For people of working age who need long-term care, their disability often comes well before they have a chance to accumulate savings that might help pay for long-term care costs. Most older people also lack assets sufficient to finance extensive care needs. In 2005, only one in three seniors living in the community had savings of at least $70,000 (equivalent to the average cost of a year in a nursing home in 2005) (**Figure 4**). That proportion fell to 16 percent among seniors most likely to need nursing home care. Numerous seniors have low savings—more than one-third (37%) had less than $5,000 in savings in 2005.

Figure 4
Distribution of people age 65 and older living in the community, by financial assets, 2005



Source: B. Lyons, A. Schneider, and K. Desmond, *The Distribution of Assets of the Elderly Population Living in the Community*, Kaiser Commission on Medicaid and the Uninsured, 2005. People at high risk of nursing home use were defined as those age 85 or older, with no spouse, and who need assistance because of functional or cognitive limitations.

Given the unpredictability and catastrophic nature of extensive long-term care needs, heavy reliance on savings to finance them is never likely to work. Insurance is the best way to protect against the risk of unpredictable, potentially catastrophic expenses. But private insurance for long-term care has never really gotten off the ground. Only about 6 to 7 million people are estimated to currently hold any type of private long-term care insurance,[8] and most purchasers have relatively high incomes.[9] Unfortunately, many people in their 50s and early 60s are accumulating insufficient resources to cover basic living expenses in retirement**,** let alone to finance potential long-term care needs.[10] In addition, available long-term care insurance policies offer limited and uncertain benefits—raising questions about the wisdom of purchase. Policies limit benefits in dollar terms in order to keep premiums affordable, but therefore can leave policyholders with insufficient protection when they most need care; and policies have often lacked the premium stability that can assure purchasers of their ability to continue to pay in year after year, in order to receive benefits if and when the need arises.

Policies to promote or subsidize the purchase of private long-term care insurance (sometimes accompanied by consumer protection requirements) are intermittently proposed to encourage more people to purchase this type of insurance. But analysis shows that such subsidies are more likely to benefit people already able to purchase insurance on their own than to extend the market.[11] Further, without market reforms, these policy options are unlikely to create a dependable insurance marketplace. We need only look at experience in the non-group market for health insurance—plagued by risk selection, high marketing costs, benefit exclusions, and other problems— to recognize that reliance on that market for long-term care insurance will be grossly inadequate to assure most people sufficient protection.

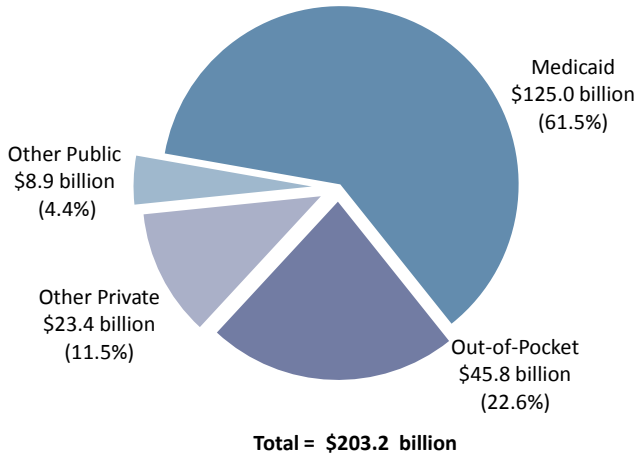
The Community Living Assistance Services and Supports (CLASS) Act—included in the Affordable Care Act—was intended to establish public, rather than private, long-term care insurance as a core means of protection against the risk of long-term care needs.[12] CLASS was designed to provide a limited daily cash benefit to people with functional impairments who make at least five years of payments beginning during their working years (and continue to pay premiums thereafter). CLASS relies on voluntary participation and is required, by law, to be fully premium financed. However, in October 2011, the Secretary of the Department of Health and Human Services suspended implementation of CLASS.[13] Although CLASS has not been repealed, its future as a basis for public long-term care insurance is tenuous, at best.

Medicaid pays for most long-term care expenditures but its protections are limited and vary across states

Given long-term care costs and the absence of insurance, it is not surprising that when people need extensive care, they often rely on Medicaid to help pay for it. In 2009, Medicaid financed 61.5 percent of national long-term care spending ($203 billion) **(Figure 5)**.[14] Medicaid paid in part or in full the costs of about two-thirds of the nation's 1.5 million nursing home residents.[15] An estimated 2.3 million people received Medicaid-financed home and community-based services during 2007.[16] Spending on long-term care services accounts for a full third of all Medicaid spending,[17] and for 70 percent of Medicaid spending on the 9 million people who are "dual-eligibles" (that is, beneficiaries of both the Medicare and Medicaid programs).[18]

Figure 5

National expenditures for long-term care, by source, 2009



Source: C. O'Shaughnessy, *The Basics: National Spending for Long-Term Services and Supports,* National Health Policy Forum, March 2011.

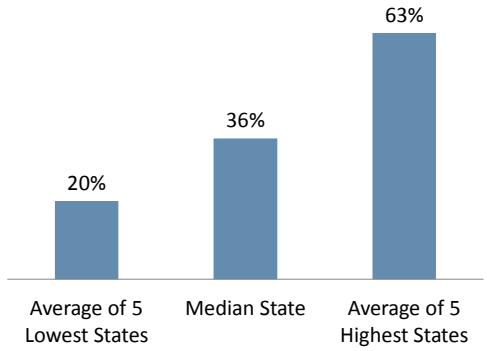
To qualify for Medicaid protection, individuals must have low income and savings to begin with, or exhaust the resources they have in purchasing medical and long-term care.[19] Given how high service costs can be, the opportunity to qualify for Medicaid when the costs exceed an individual's income and savings is essential to assure that people have access to care. Most nursing home users age 65 and older who qualify for Medicaid satisfy Medicaid's income and asset eligibility requirements on admission.[20] But about 14 percent of nursing home users age 65 and older begin their nursing home stays by spending only their own resources and then become eligible for Medicaid when their financial resources are exhausted.[21] Medicaid recipients in nursing homes are required to spend all of their income on their nursing home care (subject to limits for people with spouses at home), except for a small "personal needs allowance" of $30 to $60 in most states.[22]

Some argue that people "transfer" their assets in order to qualify for Medicaid rather than exhaust their assets before they qualify, allowing even well-to-do people to qualify for Medicaid benefits. But evidence shows the following realities: 1) few older adults have the income or wealth that would warrant such transfer; 2) people in poor health are more likely to conserve than to exhaust assets; 3) for the elderly population as a whole, transfers that occur are typically modest (less than $2000); and 4) transfers associated with establishing eligibility are not significant contributors to Medicaid costs.[23]

Despite Medicaid's importance, its protections vary considerably from state to state and, in most if not all states, fall short of meeting people's needs. Variation takes multiple forms. The first variation is in the breadth or narrowness of its eligibility requirements and the share of people in need of care each state's program serves. To estimate the "reach" of states' Medicaid long-term care programs, a recent study by the AARP measured the ratio of the number of people receiving Medicaid long-term care services in each state to the state's number of low-income adults with difficulties in activities of daily

living (an estimate of the number of people with long-term care needs).[24] This ratio provides an approximate measure of the proportion of low-income adults with long-term care needs who receive Medicaid long-term care services. The states with the most extensive coverage are estimated to reach about two thirds of low-income adults with long-term care needs—about three times the share in the states with the least extensive programs (**Figure 6**). Half the states reach only about a third of this population.

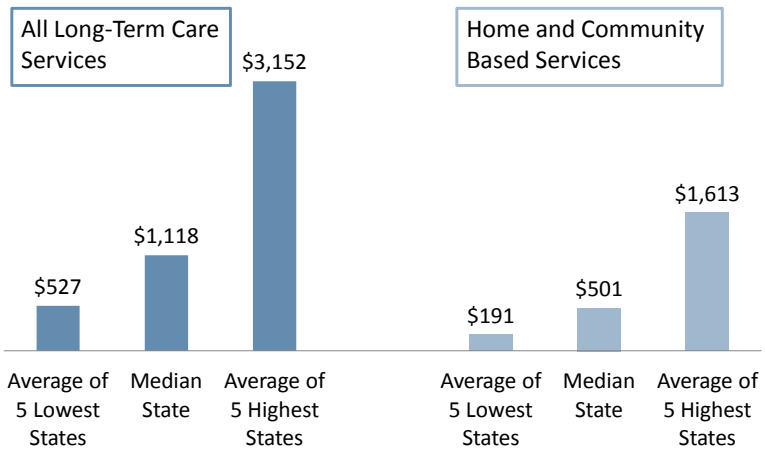
Figure 6
Estimated percentage of low-income adults with long-term care needs who receive Medicaid long-term care services, 2007



Note: Estimated in each state as the ratio of the approximate number of people receiving Medicaid long-term services and supports to adults age 21 or older who reside in a nursing home or who reside in the community with income at or below 250% of the federal poverty level and have difficulty with bathing or dressing.
Source: S. Reinhard et al., *Raising Expectations: A State Scorecard on Long-Term Care Services and Supports for Older Adults, Adults with Physical Disabilities, and Family Caregivers*, AARP Public Policy Institute, 2011.

Even greater variation among state programs is apparent when comparing states' Medicaid long-term care spending per low-income state resident. This measure reflects the combined effect of a state's breadth of eligibility with the generosity of services it provides (**Figure 7**). Medicaid long-term care spending per low-income state resident in the highest spending states (averaging $3,000 in federal fiscal year 2009 in the 5 highest states) is about six times the amount of the lowest spending states (averaging $500 in the 5 lowest states). The range is still larger—from about $1600 to about $200, or eight to one—for Medicaid's non-institutional long-term care services for people in the community, the setting where most people with long-term care needs reside.

Figure 7
Medicaid long-term care spending per state resident with income below 200% of poverty level, 2009



Source: Authors' estimates based on: S. Eiken et al., *Medicaid Expenditures for Long-Term Services and Supports: 2011 Update,* Thomson Reuters, October 31, 2011, for Medicaid expenditures in federal fiscal year 2009; and U.S. Census Bureau, "POV46: Poverty Status by State: 2010", last revised September 13, 2011, for number of state residents with income below 200% of the federal poverty level in 2010.

Low spending on community-based care relative to institutional care reflects Medicaid's historical emphasis on nursing homes as the primary locus of long-term care support. Over the past two decades, states have moved toward greater balance. In 2009, 44 percent of Medicaid long-term care spending nationwide was for home and community-based services, up from 18 percent in 1995.[25] But this overall trend obscures disparate treatment within the Medicaid population, as well as across states. Home and community-based services constitute a significantly larger share of spending on long-term care services for people with developmental disabilities (66 percent nationwide) than for older adults and people with physical disabilities (36 percent nationwide). One source of this difference is that community-based long-term care services for people with developmental disabilities are more likely to consist of 24 hours per day of support (for example, provided by group homes). For older people and people with physical disabilities, nursing home and other institutional services continue to dominate spending in most states, with substantial variation across the nation (**Table 2**). Half the states direct more than 70 percent of their long-term care spending on this population to nursing home and other institutional services. But the community-based services' share of long-term care spending in the most community-oriented states was almost six-fold the share in the states that were most institution-oriented (63 percent on average in the five highest states compared with 11 percent on average in the five lowest).

Table 2. Percentage of Medicaid long-term care spending on services for older adults and people with physical disabilities that is for non-institutional services, 2009

Lowest state	4%
Average of 5 lowest states	11%
Median state	28%
Average of 5 highest states	63%
Highest state	79%

Source: Authors' calculations based on data from S. Eiken et al., *Medicaid Expenditures for Long-Term Services and Supports: 2011 Update,* Thomson Reuters, October 31, 2011. Amounts are for federal fiscal year 2009.

This variation in the availability of home and community-based care services across states, particularly for older people and people with physical disabilities, has enormous consequences in terms of access to adequate care. Unlike most Medicaid services, which the law requires be made available to all people eligible, home- and community-based care is subject to enrollment caps. Most states have limits on enrollment and establish waiting lists for care at home.[26] Most people who have long-term care needs are, in fact, at home—and dependent primarily on family for the services they need. But surveys have shown that many people living at home are receiving insufficient care and, as a result, are at heightened risk of negative consequences—like falling, soiling themselves, or going without bathing or eating. Analysis indicates that the prevalence of unmet needs for long-term care, though significant across the country, is lower in states with greater availability of services at home.[27]

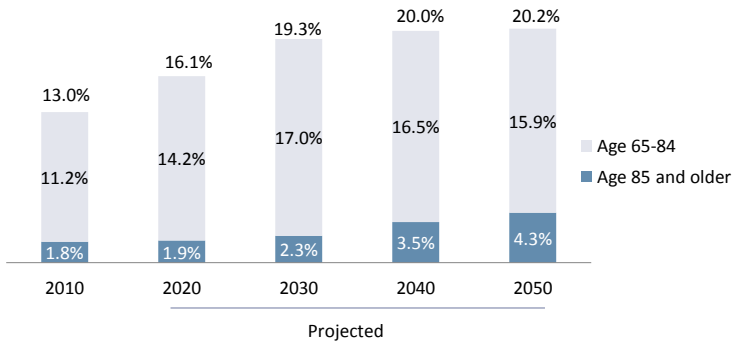
III. Challenges and Choices for the Future

Medicaid's challenges in meeting the needs of its eligible population are not limited to long-term care. The deep and extended economic recession is seriously squeezing Medicaid resources at the same time it increases the demand for services—particularly among low-income families. The availability of an enhanced federal match from 2009-2011 alleviated some of this financial burden. But the extra match ended in June 2011, and the squeeze continues—affecting all Medicaid beneficiaries, whether or not they need long-term care.

The threat to Medicaid's ability to address long-term care needs goes beyond the business cycle. The aging of the population affects Medicaid just as it affects Medicare and Social Security. Having more older adults—especially very elderly people—will increase the need for long-term care. The percentage of the population aged 85 and older is expected to increase by more than one-quarter by 2030 (from 1.8 percent in 2010 to 2.3 percent in 2030) and to more than double by 2050 (to 4.3 percent) (**Figure 8**). It is among this population that the need for long-term care is most substantial. Nearly 3 in 10 people age 85 years or older have moderate to severe long-term care needs—three times the proportion among 75-84 year-olds (**Figure 9**). As the baby boom generation ages, more people will need more long-term care.

Figure 8

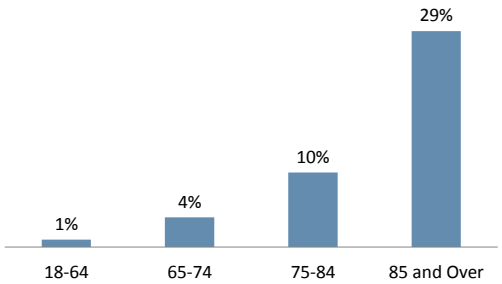
Percentage of the population that is age 65 and older, 2010 to 2050



Sources: 2010 from C. Werner, *The Older Population: 2010*, U.S. Census Bureau, November 2011. Projections for 2020-2050 from U.S. Census Bureau, "Table 3. Percent Distribution of the Projected Population by Selected Age Groups and Sex for the United States: 2010 to 2050," August 14, 2008.

Figure 9

Percentage of people in each age group who have moderate to severe long-term care needs, 2005

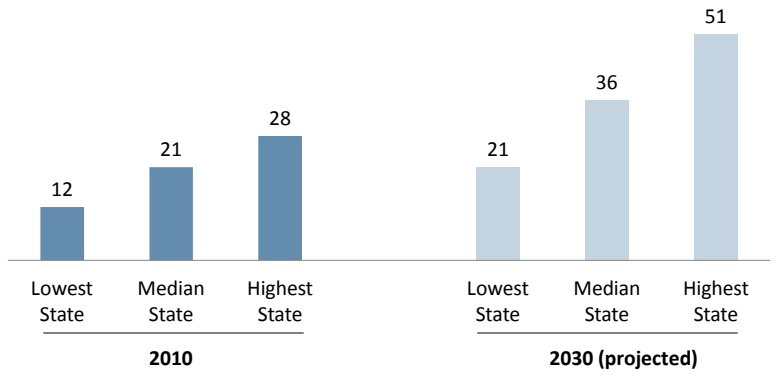


Note: Based on community residents needing assistance with activities of daily living and nursing home residents.
Source: Authors' estimate based on data from: Centers for Disease Control and Prevention, Health Data Interactive, www.cdc.gov/nchs/hdi.htm; and Centers for Disease Control and Prevention, National Nursing Home Survey, 2004 Current Resident Tables, June 2008, http://www.cdc.gov/nchs/nnhs/resident_tables.htm.

States are aging at different rates and the adequacy of their resources varies considerably

Figure 10

Range among states in the number of people age 65 and older per 100 people ages 18-64 (2010 and 2030)

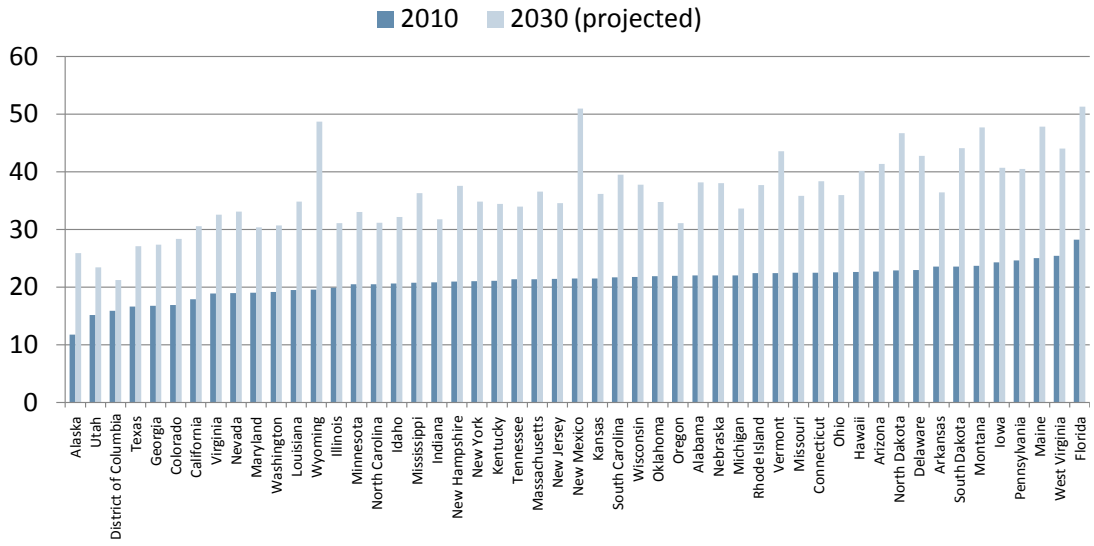


Source: Authors' tabulations of data from: L. Howden and J. Meyer, *Age and Sex Composition: 2010,* U.S. Census Bureau, 2010 Census Briefs, May 2010; and U.S. Census Bureau, "File 2. Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex: July 1, 2004 to 2030," 2005.

The population is aging in every state. But the effects—and the burdens—of an aging population will be larger in some states than others. Key to the adequacy of public resources to support the needs of older people will be the availability of working people to generate resources—measured as the ratio of one age group to the other. In 2010, the number of people aged 65 per 100 people aged 18-64 ranged from 12 in the "youngest" state to 28 in the oldest state (**Figure 10**). By 2030, this ratio is projected to grow in all states and the range to expand from 21 in the youngest states to 51 in the oldest. In 2030, more than half of the states will have a ratio greater than the highest state has today. On the whole, the "oldest" states today will continue to be among the "oldest" in 2030 (**Figure 11**).

Figure 11

Number of people age 65 and older per 100 people ages 18-64, by state (2010 and 2030)



Source: Authors' tabulations of data from: L. Howden and J. Meyer, *Age and Sex Composition: 2010,* U.S. Census Bureau, 2010 Census Briefs, May 2010; and U.S. Census Bureau, "File 2. Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex: July 1, 2004 to 2030," 2005.

It is uncertain whether any state has the capacity to deal with the needs of an aging population.[28] What is certain is that the greater the imbalance between the older population and the working age population, the greater challenge states will face in sustaining, let alone improving, the adequacy of long-term care services**.** As a result, the inadequacy and inequity that already characterizes Medicaid long-term care services across the states is likely to grow substantially worse in the years to come. To address today's insufficiencies and to build a better and more equitable system for the future, a change in financing is required.

Medicaid's current matching approach leaves inequities and inadequacies in place for the future

Medicaid's inadequacies and inequities at least partially reflect the influence of its financing mechanism—an open-ended federal match of state spending. The federal match varies, from a minimum of 50 percent to a high of 74 percent, based on a formula that provides a larger federal share to states with lower per capita incomes.[29] The purpose of the formula is to facilitate spending in poorer states and, in general, to encourage spending.

In practice, however, providing lower-income states' greater incentives to spend has not offset variations in state incomes in shaping Medicaid spending. A 2001 Urban Institute analysis of thirteen states found that a 1 percent increase in per capita income was associated with about a 2 percent increase in state Medicaid spending per low-income person.[30] For example, a state with 10 percent higher average income than another state would spend 20 percent more per low-income resident. As a result, even with higher Medicaid matching rates for low-income states, low-income states had total (federal and state) Medicaid spending per low-income resident that was substantially less than in higher-income states.

The aging of the population is only likely to exacerbate this variation—as the share of the population likely to need services grows relative to the working-age population needed to support them.[31] As the population ages, only an expansion of federal responsibility for financing long-term care services is likely to prevent or reverse growing inadequacy and inequity in the availability of Medicaid support for long-term care**.**

Enhanced federal support is needed for an equitable and sustainable long-term care safety net

At least two approaches of enhanced federal support are worthy of exploration. First is the full federal financing of a federally-defined long-term care benefit for dual eligibles (that is, low-income seniors and people with disabilities who are eligible for both Medicare and Medicaid)—which from its inception, assures greater equity in service availability across states, as well as absorbing from the states responsibility for financing care to a growing elderly population. Second is a substantially enhanced federal match for Medicaid long-term care, tied to the aging of the state's population, which encourages rather than assures greater equity but, like the first option, largely shifts the financial burden of aging to the federal level.[32]

Full federal financing of long-term care for dual eligibles

The first—and the most straightforward approach to promoting both equity and adequacy—is replacement of the federal-state matching formula with full absorption of financing for a standard package of long-term care services for dual eligibles at the federal level. This option would establish nationally-uniform standards for eligibility and long-term care benefits for low-income Medicare beneficiaries of all ages (that is, seniors and younger people eligible for Medicare because of disabilities). This option could be designed as a uniform long-term care benefit incorporated into the Medicare program. Alternatively, as a program targeted to low-income people, it could be achieved by establishing a nationally-uniform minimum benefit with federal financing that states could enhance with federal matching funds. Because we are focusing on the safety net rather than a universal program (like Medicare, providing coverage to all who qualify without regard to income), we explore the latter approach here. Implementation of the benefit would be handled at the state level, enabling the program to benefit from state initiatives in service delivery and care coordination that are now being promoted.[33] Federalizing long-term care financing for dual eligibles in this way would resemble the establishment of the Supplemental Security Income program for low-income older adults and people with disabilities in 1972, which replaced federal matching grants to states with a federally-financed, federal-state administered, "floor" of income protection.[34]

A new federally-financed long-term care program for dual eligibles would set a nationally-uniform benefit standard for dual eligibles, designed to fall somewhere in the middle of the range of state long-term care programs today. To achieve equity and control spending growth, the benefit would be nationally defined—with specific benefits assigned based on an individual's needs, as determined by a standardized assessment process. In addition, payment rates to providers would be federally defined and adjusted for geographic variation in input costs, like Medicare payment rates. States would have the option of providing additional services to supplement the federal benefit, and could receive federal matching funds for those services.

States would be required to contribute toward the costs of the new federal benefit, as they currently are to the Medicare prescription drug benefit[35]—specifically, states would be required to pay the federal government an amount initially equivalent to either their current long-term care spending on dual eligibles or, for state's whose current programs are "more generous" than the federal standard, an amount equivalent to what it would cost them to offer the uniform federally-defined benefit. The state payment amount would be increased annually by an index measuring inflation (as measured by wage growth or the consumer price index, for example) and growth in the state's population. The population adjustment increases the state's contribution as its revenue capacity increase. The index holds states "harmless" for disproportionate growth in the dually-eligible population in need of service (that is, for growth in the dually-eligible population that exceeds the rate of growth of the overall population). The result is that as states get older, they would pay less than under current arrangements to maintain the same level of service. The federal government, on the other hand, would pick up the costs of expansion to the federally-defined benefit level in states now below it, and most of the costs of a growing number of dual eligibles in all states. Federal matching funds would continue to be available to states providing additional benefits beyond the federally-defined standard.

By establishing and sustaining a nationally-uniform benefit floor across all states, this proposal has the potential to "uplift" a substantial portion of the population to a higher level of service—enhancing both adequacy and equity into the future. Arguments for this proposal include the fact that the federal government is already financing roughly 80 percent of dual eligibles' acute and long-term care—financing nearly all their acute care, through Medicare, and more than half their Medicaid long-term

care services.[36] Were the federal government to pick up the rest, it would bring an end to current incentives to shift responsibilities and costs from one program to the other and, if well managed, encourage federal coordination of services across the full spectrum of an individual's care needs.

Aging-based enhancement of federal match for long-term care services

A different approach to strengthening the long-term care safety net would be a substantial increase in federal financing through an enhanced matching rate, tied to the proportion of a state's population who are low-income seniors. Such an approach would resemble the recent enhancement of state matching rates to reflect states' unemployment levels,[37] that is, increasing federal responsibility for a national challenge—in this case, the aging of the population. However, it would differ from the unemployment approach in its permanence and its design to have the federal government bear most of the burden of an aging population over time. Unlike the previous approach, the enhanced match would leave it to states to determine benefits and payment, much as they do today. Further, this approach would affect all Medicaid recipients of long-term care, rather than applying only to dual eligibles.

Under this approach, the federal government could adopt a range of matching enhancements for long-term care spending depending on the "age" of the state; for example, the enhancements could initially range from perhaps an addition of 5 percentage points to the current federal share for states that are now the "youngest" to an addition of 10 or 15 percentage points for states that are now the "oldest." A state's "age" would be measured based on the ratio of its population age 75 or over with incomes below 300 percent of the federal poverty level (the population most likely to need Medicaid long-term care services) to its working aged population (the population providing the bulk of the financial resources in the state).

Some might advocate that the enhanced match apply only, or differentially, to home and community-based services, in order to encourage "rebalancing" away from institutional care. But aging will challenge states' capacity to deliver both institutional and non-institutional services. Focusing enhanced federal support only on community services could put adequacy of institutional care at risk. An enhanced match applying to all long-term care services will facilitate the increased emphasis on community-based services that is already occurring.

To assure that enhancements expand service and eligibility levels—rather than replace state funds—states would be required to spend enhancement dollars on long-term care and to sustain at least their current eligibility and benefit standards (or initial spending levels). Over time, the enhanced matching rates would partially relieve the states of the burden of an aging population with increasing long-term care needs. A state's "age" would be periodically recalculated and the federal enhancement would increase with the increase in a state's "age" (that is, ratio of people age 75 or older with income below 300 percent of poverty to the working age population). The relationship between the ratio and the enhancement would be fixed, so as states age, the maximum enhancement would also rise (as ratios increase in all states), subject to a maximum enhancement of 20 or 25 percent.

Unlike the previous option, which targeted federal financing to the least generous states, this second option would initially focus enhanced federal financing on states with the largest shares of residents likely to need help paying for long-term care services. This option's different approach to targeting, along with the absence of the previous option's nationally-defined benefit and payment schedule, will likely mean continued wide variation in service availability across the states. Tying the availability of federal financing to the share of a state's population that is older and unable to afford services will likely enhance the adequacy of the safety net in all states.

IV. Conclusion

Forty years ago, Congress enacted the Supplemental Security Income program to promote greater adequacy and equity in income support for low-income older people and people with disabilities. The Supplemental Security Income program replaced federal matching grants to states with full federal financing of basic income support. Now is the time to take a similar step with respect to long-term care financing in Medicaid.

The current Medicaid long-term care safety net, though invaluable to people who rely on it, leaves too many people who need services without them and makes the adequacy of services a function of where people live. Today, variations in adequacy are considerable. Half the states reach only about a third of the low-income population with long-term care needs, and the least generous states achieve only about a third the reach of the most generous. Long-term care spending per low income person in the state—which reflects not only who gets served but how much service they get—varies even more: six-fold from the most generous to the least generous states for all long-term care services and eight-fold for services at home or in the community. Limited service is associated with reports of greater "unmet need"—or going without—among people who rely on others for help dressing, toileting, eating and performing other basic tasks of daily life.

Over the next two decades, the aging of the population will double the share of the population that is over age 85, the age group most likely to need long-term care. All states will experience the increase, but some states will face greater challenges than others—measured by the growth in the ratio of the older population to the working age population. States already strapped in their ability to provide long-term care services will find themselves more strapped over time, and both inadequacy and inequity of service across the nation will likely increase.

Neither the inequity nor the inadequacy of Medicaid long-term care services across states is a problem likely to be solved with greater "flexibility" in states' use of existing resources and admonitions to pursue greater efficiency. Although long-term care at home has the potential to serve more people at lower cost than current reliance on nursing homes for the bulk of care to older adults in need, currently low levels of service resources mean that greater resources will be essential to meet the needs of a growing elderly population.

The fundamental problem is not inefficiency; rather it is basic demographics and distribution of resources. With a growing older population dispersed unevenly across states, deficit reduction proposals that would take the federal government out of the financing picture or reduce its role would clearly worsen, rather than improve, current long-term care financing deficiencies. Block grants or other financing mechanisms to arbitrarily limit growth in federal financing will lock inadequacy and inequity in place and worsen it over time. Even Medicaid's open-ended federal matching grants, designed to provide greater assistance to more hard-pressed states, will increasingly fall short in establishing a decent floor of long-term care protection across the nation.

Achieving an equitable, adequate, and viable long-term care safety net clearly requires greater, not lesser federal financial involvement is required. To that end, we have proposed two options. Full federal financing of long-term care for dual eligibles would, like enactment of the Supplemental Security Income program, replace federal matching grants to the states with a new uniform standard of eligibility and benefits. States would continue to share in benefit costs but would be "held harmless" from the burden of an aging population—which would be absorbed by the federal government. The second option, similar to the recent enhancement of the federal match to help states cope with severe unemployment,

would retain federal matching rates but increase the federal share as the state's "age" increases (as measured by the ratio of low-income older people to people of working age in the state).

An enhanced match for long-term care services would leave in place more variation and inequity across states (at lower federal cost) than full federal financing of long-term care for dual eligibles. But by "cushioning" states from the costs of providing services for a growing older population, enhanced federal matching rates would sustain greater adequacy of long-term care services in all states.

Achieving greater equity and adequacy of long-term care service—along with state fiscal relief—will carry a significant price in increased federal spending. It is hard to be optimistic that the nation will be willing to pay this price, given political battles around financing even current service commitments. But this brief documents that a failure to adequately finance a long-term care safety net also carries a price: the inevitable deterioration in care for growing numbers of people unable to care for themselves. Whether this is a price the nation can tolerate is a question yet to be squarely addressed.

Acknowledgements

The preparation of this paper was supported by a grant from The SCAN Foundation. We wish to thank Gretchen Alkema, Bruce Chernof, Kali Peterson, and their colleagues at The SCAN Foundation for their support of this work and for their thoughtful contributions to this paper. We are also grateful to John Holahan and Tim Waidmann for their advice and expertise, to Carol O'Shaughnessy and Bill Scanlon for reviewing and providing comments on an earlier draft, and to Nicole Cafarella for excellent research support. The views put forward here are those of the authors and do not necessarily represent those of the people we have mentioned or of The SCAN Foundation's directors, board, or staff.

Notes

[1] Authors' estimate based on data from: H. Stephen Kaye, Charlene Harrington, and Mitchell P. LaPlante, "Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much?" *Health Affairs* 29(1) (January 2010): 11-21; and U.S. Census Bureau, "Table 1. Population by Age and Sex: 2007," May 2009, http://www.census.gov/population/www/socdemo/age/age_sex_2007.html.

[2] Peter Kemper, Harriet L. Komisar, and Lisa Alecxih, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?" *Inquiry* 42 (2) (Winter 2005/2006): 335-350.

[3] H. Stephen Kaye, Charlene Harrington, and Mitchell P. LaPlante, "Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much?" *Health Affairs* 29(1) (January 2010): 11-21.

[4] The MetLife Mature Market Institute, *Market Survey of Long-Term Care Costs: The 2011 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs*, October 2011, http://www.metlife.com/assets/cao/mmi/publications/studies/2011/mmi-market-survey-nursing-home-assisted-living-adult-day-services-costs.pdf.

[5] Poverty thresholds from: C. DeNavas, B. Proctor, and J. Smith, *Income Poverty, and Health Insurance Coverage in the United States: 2010*, Current Population Reports, P60-239, U.S. Census Bureau, September 2011.

[6] When calculated specifically for people in the community who need long-term care, only a quarter had income as high as three times the federal poverty level in 2005 and the percentage with income below the federal poverty level was almost three times as large as for all community residents (26% versus 11%). Judy Feder, Harriet L. Komisar, and Robert B. Friedland, *Long-*

Term Care Financing: Policy Options for the Future, Georgetown University Long-Term Care Financing Project, 2007, Figures 16 and 17, http://ltc.georgetown.edu/forum/ltcfinalpaper061107.pdf.

[7] Kathleen Short, *The Research Supplemental Poverty Measure: 2010,* Current Population Reports P60-241, U.S. Census Bureau, November 2011, http://www.census.gov/hhes/povmeas/methodology/supplemental/research/Short_ResearchSPM2010.pdf

[8] Carol O'Shaughnessy, *The Basics: National Spending for Long-Term Services and Supports (LTSS*), National Health Policy Forum, March 2011, http://www.nhpf.org/library/details.cfm/2783 (citing Marc A. Cohen, "Long-Term Care Insurance: Are Consumers Protected for the Long-Term?" testimony before the U.S. House Committee on Energy and Commerce, Subcommittee on Oversight and Investigation, July 24, 2008, http://democrats.energycommerce.house.gov/images/stories/Documents/Hearings/PDF/Testimony/OI/110-oi-hrg.072408.Cohen-Testimony.pdf).

[9] Lifeplans, W*ho Buys Long-Term Care Insurance? A 15-Year Study of Buyers and Non-Buyers, 1990-2005*, prepared for America's Health Insurance Plans, April 2007, www.ahipresearch.org/PDFs/LTC_Buyers_Guide.pdf. Richard W. Johnson and Janice S. Park, "Who Purchases Long-Term Care Insurance?" Urban Institute, March 2011, http://www.urban.org/events/upload/Older-Americans-Economic-Security-27.pdf.

[10] Paul Fronstin, Dallas Salisbury, and Jack VanDerhei, *Funding Savings Needed for Health Expenses for Persons Eligible for Medicare*, EBRI Issue Brief, December 2010, http://www.ebri.org/pdf/briefspdf/EBRI_IB_12-2010_No351_Savings.pdf. Jack VanDerhei and Craig Copeland, *The EBRI Retirement Readiness Rating: Retirement Income Preparation and Future Prospects,* EBRI Issue Brief, July 2010, http://www.ebri.org/pdf/briefspdf/EBRI_IB_07-2010_No344_RRR-RSPM.pdf. Barbara A. Butrica, Karen E. Smith, and Howard M. Iams, "This is Not Your Parent's Retirement: Comparing Retirement Income Across Generations," *Social Security Bulletin* 72(1)(2012): 37-58, http://www.ssa.gov/policy/docs/ssb/v72n1/v72n1p37.pdf.

[11] Judith Feder, Harriet L. Komisar, and Robert B. Friedland, *Long-Term Care Financing: Policy Options for the Future.* Georgetown University Long-Term Care Financing Project, 2007, http://ltc.georgetown.edu/forum/ltcfinalpaper061107.pdf.

[12] Carol V. O'Shaughnessy, *The Basics: The Community Living Assistance Services and Supports (CLASS) Act: Major Legislative Provisions*, National Health Policy Forum, June 9, 2010 (with December 20, 2011 update), http://www.nhpf.org/library/details.cfm/2790.

[13] U.S. Department of Health and Human Services, "Secretary Sebelius' letter to Congress about CLASS," October 14, 2011, http://www.hhs.gov/secretary/letter10142011.html.

[14] Carol O'Shaughnessy, *The Basics: National Spending for Long-Term Services and Supports (LTSS*). National Health Policy Forum, March 2011, http://www.nhpf.org/library/details.cfm/2783.

[15] H. Stephen Kaye, Charlene Harrington, and Mitchell P. LaPlante, "Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much?" *Health Affairs* 29(1) (2010): 11-21.

[16] Molly O'Malley Watts, Emily Lawton, and Katherine Young, *Medicaid's Long-Term Care Users: Spending Patterns Across Institutional and Community-based Settings,* Kaiser Commission on Medicaid and the Uninsured, October 2011, http://www.kff.org/medicaid/7576.cfm.

[17] Steve Eiken et al., *Medicaid Expenditures for Long-Term Services and Supports: 2011 Update,* Thomson Reuters, October 31, 2011, http://www.hcbs.org/moreInfo.php/doc/3661.

[18] David Rousseau et al., *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007*, Kaiser Commission on Medicaid and the Uninsured, December 2010, http://www.kff.org/medicaid/upload/7846-02.pdf.

[19] Julie Stone, *Medicaid Eligibility for Persons Age 65+ and Individuals with Disabilities: 2009 State Profiles*, Congressional Research Service, June 28, 2011.

[20] Brenda C. Spillman and Peter Kemper, "Lifetime Patterns of Payment for Nursing Home Care," *Medical Care* 33(3) (1995): 280-96.

[21] Ibid.

[22] Lina Walker and Jean Accius, *Access to Long-Term Services and Supports: A 50-State Survey of Medicaid Financial Eligibility Standards*, AARP Public Policy Institute, September 2010, http://assets.aarp.org/rgcenter/ppi/ltc/i44-access-ltss_revised.pdf.

[23] 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/pdfs/nursinghomecosts.pdf. Timothy Waidmann and Korbin Liu, *Asset Transfer and Nursing Home Use: Empirical Evidence and Policy Significance*, Kaiser Commission on Medicaid and the Uninsured, April 2006, http://www.kff.org/medicaid/upload/7487.pdf. U.S. Government Accountability

Office, *Medicaid Long-Term Care: Few Transferred Assets before Applying for Nursing Home Coverage; Impact of Deficit Reduction Act of Eligibility Is Uncertain*, March 2007, http://www.gao.gov/new.items/d07280.pdf.

[24] Susan C. Reinhard, Enid Kassner, Ari Houser, and Robert Mollica, *Raising Expectations: A State Scorecard on Long-Term Care Services and Supports for Older Adults, Adults with Physical Disabilities, and Family Caregivers*, AARP Public Policy Institute, September 2011, http://www.aarp.org/relationships/caregiving/info-09-2011/ltss-scorecard.html. The ratio's denominator is the number of adults age 21 or older who reside in a nursing home or who reside in the community with income at or below 250% of the federal poverty level reporting difficulty in activities of daily living (specifically, bathing or dressing). Other research has found that the overwhelming majority of people who have "difficulty" in activities of daily living have long-term care needs—that is, need assistance with activities of daily living or instrumental activities of daily living (H. Stephen Kaye, Charlene Harrington, and Mitchell P. LaPlante, "Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much?" *Health Affairs* 29(1) (2010): 11-21).

[25] Steve Eiken et al., *Medicaid Expenditures for Long-Term Services and Supports: 2011 Update,* Thomson Reuters, October 31, 2011, http://www.hcbs.org/moreInfo.php/doc/3661.

[26] Jhamirah Howard, Terence Ng, and Charlene Harrington, *Medicaid Home and Community-Based Services Programs: Data Update*, Kaiser Commission on Medicaid and the Uninsured, December 2011, http://www.kff.org/medicaid/upload/7720-05.pdf.

[27] Harriet L. Komisar, Judith Feder, and Judith D. Kasper, "Unmet Long-Term Care Needs: An Analysis of Medicare-Medicaid Dual Eligibles," *Inquiry* 42(2) (2005): 171-182.

[28] U.S. Government Accountability Office, *State and Local Governments' Fiscal Outlook: 2011 Update*, April 2011, http://www.gao.gov/new.items/d11495sp.pdf.

[29] Kaiser Family Foundation, statehealthfacts.org, "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," citing data source: *Federal Register*, November 10, 2010 (vol. 75, no. 217), pp. 69082-69084, http://www.statehealthfacts.org/comparetable.jsp?typ=2&ind=184&cat=4&sub=47. Vic Miller, *An Overview of Changes in the Federal Medical Assistance Percentages (FMAPs) for Medicaid*, Kaiser Commission on Medicaid and the Uninsured, July 2011, http://www.kff.org/medicaid/8210.cfm.

[30] John Holahan, "Variation in Health Insurance Coverage and Medical Expenditures: How Much Is Too Much?" in John Holahan, Alan Weil, and Joshua M. Wiener, eds., *Federalism and Health Policy***,** Washington, D.C.: The Urban Institute Press, 2003.

[31] The U.S. General Accounting Office has pointed out that a state's average income per person (which is used to determine its federal matching rate) is not a good proxy for differences states face in the cost of providing health care services that are related to the ages of the populations served. U.S. General Accounting Office, *Medicaid Formula: Differences in Funding Ability among States Often Are Widened*, July 2003, http://www.gao.gov/new.items/d03620.pdf.

[32] In an analysis of broad Medicaid financing reform options, Holahan and Weil, include options along the lines of what we propose. John Holahan and Alan Weil, "Toward Real Medicaid Reform," *Health Affairs* 26(2) (2007): w254-w270.

[33] Centers for Medicare & Medicaid Services, "State Demonstrations to Integrate Care for Dual Eligible Individuals—Design Contracts," https://www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp#TopOfPage; and Centers for Medicare & Medicaid Services, letter to state Medicaid directors, "Re: Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees," July 8, 2011, https://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

[34] Social Security Administration, *Annual Report of the Supplemental Security Income Program*, May 2011, http://www.ssa.gov/oact/ssir/SSI11/index.html.

[35] A state's current payment for the prescription drug benefit is based on its drug spending per dual eligible in the base year (2003), increased for national growth in prescription drug spending, and multiplied by the current number of dual eligibles in the state and a "phase-down percentage" (scheduled to decrease from a start of 90% in 2006 to 75% in and after 2015). Andy Schneider, *The "Clawback": State Financing of Medicare Drug Coverage*, Kaiser Commission on Medicaid and the Uninsured, June 2004, http://www.kff.org/medicaid/upload/The-Clawback-State-Financing-of-Medicare-Drug-Coverage.pdf.

[36] Judy Feder et al., *Refocusing Responsibility for Dual Eligibles: Why Medicare Should Take the Lead*, Urban Institute, October 2011, http://www.rwjf.org/files/research/72868qs68dualeligiblesfull20110930.pdf.

[37] Kaiser Family Foundation, *American Recovery and Reinvestment Act (ARRA): Medicaid and Health Care Provisions*, Medicaid Facts, Kaiser Commission on Medicaid and the Uninsured, March 2009, http://www.kff.org/medicaid/upload/7872.pdf.