Medicaid Spend Down: Implications for Long-Term Services and Supports and Aging Policy

By Joshua M. Wiener, Wayne L. Anderson, Galina Khatutsky, Yevgeniya Kaganova, and Janet O'Keeffe (RTI International) and Anne Tumlinson, Eric Hammelman, and Elana Stair (Avalere Health)

This series summarizes current issues in financing long-term care and outlines policy options for increasing affordable access to services.

Introduction

Medicaid provides an important safety net for people who are poor or become poor, either because of the high costs of health and long-term care services or for other reasons. The transition from non-Medicaid to Medicaid status can be difficult, especially since it is generally associated with illness, disability, and declining income and assets. The high cost of long-term services and supports (LTSS) results in catastrophic out-of-pocket costs for many people needing services, some of whom spend down to Medicaid eligibility. For people who have been independent all of their lives, transitioning to Medicaid means depending on a means-tested welfare program for their health and long-term care services. Moreover, people transitioning to Medicaid are a substantial portion of state Medicaid expenditures. In an effort to avoid exhausting their resources and relying on Medicaid, others depend on unpaid family support or go without needed services.

Medicaid challenges and private long-term care insurance market deficiencies have led to a number of proposed policies to increase public or private insurance coverage for LTSS. Two major pathways exist to increase insurance coverage. The first pathway is to continue to develop policy options that would encourage individuals to enroll voluntarily in private or public insurance. Even if successful in increasing coverage among higher-income individuals, this pathway may not attract enough people or increase coverage among moderate- and lower-income individuals sufficiently to reduce reliance on the Medicaid program. A major challenge for voluntary long-term care insurance, whether public or private, is setting premiums in a manner that ensures the program will have sufficient funds to pay benefits, while keeping the premiums low enough to attract sufficient numbers of enrollees over whom to spread risk and ensure affordable premiums in the future.

An alternative to voluntary programs is mandatory enrollment that ensures a larger and healthier risk pool than a voluntary program. This strategy increases the number of people for whom the insurance would lengthen the spend-down period prior to Medicaid eligibility and for whom the insurance would replace some Medicaid spending after reaching eligibility.

This paper has two separate, but interrelated purposes. The first goal is to analyze the Medicaid spend-down experience, answering questions such as what proportion of the population spends down, what is the role of LTSS in spend down, and what are the characteristics of people who spend down. The second goal is to analyze the potential impact of various models of insurance for LTSS, focusing on the differential impact of voluntary programs, such as the recently repealed Community Living Assistance Services and Supports (CLASS) Act, and mandatory programs, such as those that

operate in Germany and Japan. A major focus is on the estimated premiums and on the impact on Medicaid expenditures and the number of people who spend down to Medicaid eligibility. This paper is a condensed version of two longer reports: "Medicaid Spend Down: New Estimates and Implications for Long-Term Services and Supports Financing Reform," by Joshua M. Wiener, Wayne L. Anderson, Galina Khatutsky, Yevgeniya Kaganova, and Janet O'Keeffe of RTI International[1] and "Insuring Americans for Long-Term Services and Supports: Challenges and Limitations of Voluntary Insurance," by Anne Tumlinson, Eric Hammelman, and Elana Stair of Avalere Health, and Joshua M. Wiener of RTI International.[2]

Data and Methods

This study uses two main sets of data. First, data from the 1996/1998 to 2008 Health and Retirement Study were merged with Medicare data on Medicare buy-in status to analyze Medicaid spend down. Since people often confuse Medicare and Medicaid, the Medicare data provide a more accurate designation of Medicaid eligibility than is possible from self-report survey data. Second, policy simulations were conducted using Avalere Health's Long-Term Care-Policy Simulation (LTC-PS) Model, which was modified with data from the Health and Retirement Study and Medicare to better estimate the impact of policy options on people who spend down to Medicaid and, thus, to better estimate the impact on Medicaid expenditures.

Results

The main findings of the studies are as follows:

Over the 1996/1998 to 2008 observation period, almost 10 percent of the previously non-Medicaid population aged 50 and over spent down to Medicaid eligibility. ***Table 1*** shows the rate of Medicaid spend down by age. Thus, Medicaid spend down is not a rare event. Moreover, among people who were Medicaid beneficiaries at any time during this time period, almost two-thirds became eligible after spending down to Medicaid eligibility. The spend-down population includes nondisabled people with low income and assets under age 65 who were initially ineligible for Medicaid and who became Medicaid eligible after age 65 because of different Medicaid eligibility requirements, but did not actually deplete their assets.

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About half of people who spent down to Medicaid eligibility did not use any LTSS. ***Table 2*** shows the rate of Medicaid spend down by use of LTSS. Fully 46 percent of people who spent down did not use any LTSS, 7 percent used only personal care, 33 percent used only nursing home care and about 14 percent used both personal care and nursing home care. The non-LTSS spend-down population may have become impoverished because of high out-of-pocket medical care costs, reductions in income due to pension limitations, or other factors related to everyday living (e.g., need to buy a new car or replace the furnace). Although the spend-down rate for people who do not use LTSS is much lower than it is for people who do use LTSS, there are many more people who do not use LTSS than do. Thus, a low prevalence rate of spend down for the people who do not use LTSS multiplied by a large number of people who do not use LTSS still yields a large number of people.

A significant minority of LTSS users who spent down to Medicaid eligibility resided in the community using personal care services. Among people using LTSS, most policy makers and researchers have focused on spend down in nursing homes. Although most people using LTSS who spent down to Medicaid eligibility used nursing home care, the analysis demonstrates that probably about one-fifth of people who both spend down and use LTSS do so in the community using personal care.

TABLE 1 Medicaid Spend Down, by Age

Spend-Down Measure	Percent (%)		
	<65 in 1996/1998	65+ in 1996/1998	Total
Non-Medicaid at Baseline (Cohort 1)	(N=10,885)	(N=9,398)	(N=20,283)
Spend down in age group	6.9	12.9	9.6
Spend down across age groups	38.5	61.8	100.3*
Medicaid at Some Time During Study Period (Cohort 2)	(N=1,366)	(N=2,107)	(N=3,473)
Spend down in age group	68.0	61.9	64.2
Spend down across age groups	41.7	58.6	100.3*
Total Population at Baseline (Cohort 3)	(N=11,427)	(N=10,426)	(N=21,853)
Spend down in age group	6.6	11.8	9.0
Spend down across age groups	38.4	62.0	100.4*

Source: RTI International analysis of Health and Retirement Study merged with Medicare data.
*Does not add to 100.0 percent due to rounding.

TABLE 2 Medicaid Spend Down, by Use of Long-Term Services and Supports during Study Period (1996/1998 to 2008)

Spend-Down Measure	Percent (%)				
	No LTSS	Only Personal Care	Only Nursing Home Care	Nursing Home & Personal Care	Total
Non-Medicaid at Baseline (Cohort 1)	(N=16,042)	(N=648)	(N=2,752)	(N=842)	(N=20,283)
Spend down within service use	5.6	21.2	23.4	31.7	9.6***
Total spend down population	46.1	7.1	33.1	13.7	100.0
Medicaid During Study Period (Cohort 2)	(N=1,696)	(N=392)	(N=936)	(N=449)	(N=3,473)
Spend down within service use	63.1	39.9	74.2	66.0	64.2***
Total spend down population	48.0	7.0	31.1	13.3	100.0
Total Population at Baseline (Cohort 3)	(N=16,863)	(N=912)	(N=3,057)	(N=1,021)	(N=21,853)
Spend down within service use	5.3	15.8	21.4	26.9	9.0***
Total spend down population	45.4	7.3	33.3	14.0	100.0

Source: RTI International analysis of Health and Retirement Study merged with Medicare data.
***p <.001

TABLE 3 **Spend-Down Population Income and Assets by Use of Long-Term Services and Supports, by Quartiles—Total Assets Less IRAs Quartiles**

Income Quartiles	No LTSS Use					LTSS Use					Total				
	$0–38,899	$38,900–111,999	$112,000–251,999	$252,000+	Total	$0–38,899	$38,900–111,999	$112,000–251,999	$252,000+	Total	$0–38,899	$38,900–111,999	$112,000–251,999	$252,000+	Total
Ns	660	282	95	40	1,077	567	329	140	61	1,097	1,227	611	235	101	2,174
$0–15,939	40.1%	12.1%	2.1%	0.6%	54.9%	39.0%	17.9%	4.8%	0.7%	62.4%	39.6%	15.0%	3.5%	0.6%	58.7%
$15,940–31,908	16.2%	8.8%	3.4%	1.0%	29.5%	9.8%	9.0%	6.2%	2.2%	27.3%	13.0%	8.9%	4.8%	1.6%	28.4%
$31,909–60,999	4.5%	4.2%	2.3%	0.6%	11.6%	2.5%	2.6%	1.5%	1.6%	8.1%	3.4%	3.4%	1.9%	1.1%	9.8%
$61,000+	0.5%	1.1%	0.9%	1.5%	4.0%	0.4%	0.5%	0.3%	1.0%	2.2%	0.4%	0.8%	0.6%	1.2%	3.1%
Total	61.3%	26.2%	8.8%	3.7%	100.0%	51.7%	30.0%	12.8%	5.6%	100.0%	56.4%	28.1%	10.8%	4.6%	100.0%

Source: RTI International analysis of Health and Retirement Study merged with Medicare data.
*p <.05, **p <.01, ***p <.001.
Quartile classes are determined by the income and assets of the total population at baseline.

People who spend down to Medicaid eligibility are disproportionately lower income and have substantially fewer assets than people who do not spend down. ***Table 3*** presents the income and assets of people who spend down and those who do not spend down. People who spend down are disproportionately black, Hispanic, unmarried, and have lower levels of education, all characteristics associated with lower levels of income and assets. This finding of lower income and assets is inconsistent with the common assumption that the income and assets of people who spend down are typical of the population as a whole and that people who spend down are predominantly middle class. The financial status and trajectory over time of people who spend down is very different and much more limited than for people who do not spend down. While the income and assets of people who do not spend down increase over time, the income and assets of people who spend down decline or are, at best, stable over time. Moreover, among people who spend down, few are asset rich and income poor.

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Policy solutions promoting voluntary enrollment into private or public insurance are unlikely to attract enough people to reduce the nation's dependence on Medicaid for LTSS financing. Mandatory insurance options are more likely to have lower premiums, cover more people, pay for a higher proportion of LTSS spending, and reduce the number of people who spend down and Medicaid spending. ***Table 4*** shows the results for a voluntary insurance program with parameters similar to the former CLASS Act but with a five-year rather than lifetime benefits, a stronger work requirement, and an assumed participation rate of about five percent. Enrollment in the fifteenth year of the program would be around 8 million people. By that year, about 159,000 people would receive

benefits and about 3,000 people would have delayed Medicaid participation in that year. For a 5-year benefit, the 15-year estimated Medicaid savings is $5.6 billion.

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TABLE 4 **Estimated Premiums and Other Outcomes for Voluntary Enrollment Programs**

Benefit Parameters				
Length of benefit	Lifetime	5 years	3 years	1 year
Eligible population	Working	Working	Working	Working
Income threshold	$12,000	$12,000	$12,000	$12,000
Vesting period	5 years	5 years	5 years	5 years
Pay premiums while on benefit	Yes	Yes	Yes	Yes
Daily benefit amount	$50	$50	$50	$50
Participation rate assumption	2%	5%	7%	20%
Insurance Program Enrollment and Benefit Payments				
Y1 average monthly premium	$142.96	$48.58	$34.48	$15.07
Total lives enrolled, Y15	3,928,150	8,387,072	11,250,812	27,917,000
Receiving benefits, Y15	251,263	158,780	137,260	152,249
Total disabled population, Y15	10,759,580	10,759,580	10,759,580	10,759,580
Percent of total disabled population receiving benefits, Y15	2.3%	1.5%	1.3%	1.4%
Premiums collected, Y1-Y15 (millions)	$85,760	$60,847	$57,976	$66,451
Benefits paid, Y1-Y15 (millions)	$47,787	$40,893	$38,264	$40,525
Premiums collected, Y15 (millions)	$7,112	$4,890	$4,649	$5,249
Benefits paid, Y15 (millions)	$6,468	$4,099	$3,557	$3,947
Medicaid Federal and State ($)				
Medicaid enrollment, Y15 w/out program	62,021	46,653	45,945	74,901
Medicaid enrollment, Y15 w/program	60,652	43,674	41,906	64,307
Delayed Medicaid enrollment, Y15	1,369	2,979	4,039	10,593
Medicaid savings, Y1-Y15 (millions)	$5,643	$5,638	$5,815	$8,764
Medicaid savings, Y15 (millions)	$768	$632	$655	$1,191

Source: Avalere Health analysis of the Long-Term Care-Policy Simulation Model.

Table 5 shows that a mandatory long-term care insurance program with a 5-year benefit length covering the same working population that is eligible for the voluntary program produces about 11 times the enrollment (86 million compared to 8 million) by the 15th year of the program and six times the population receiving benefits (979,394 compared to 158,780). Of those

TABLE 5 **Mandatory Programs, Comparisons by Benefit Designs (1, 3, and 5 Years)**

Benefit Parameters						
Length of benefit	1 year	1 year	3 years	3 years	5 years	5 years
Eligible population	Working	All ages	Working	All ages	Working	All ages
Vesting period	0 years	0 years	0 years	0 years	0 years	0 years
Pay premiums while on benefit	Yes	Yes	Yes	Yes	Yes	Yes
Daily benefit amount	$50	$50	$50	$50	$50	$50
Insurance Program Enrollment and Benefit Payments						
Y1 average monthly premium	$14.16	$43.36	$26.39	$71.99	$35.26	$89.03
Total lives enrolled, Y15	86,726,046	165,359,420	86,726,046	165,359,420	86,726,046	165,359,420
Receiving benefits, Y15	377,115	1,075,728	709,227	2,073,350	979,394	2,873,292
Total disabled population, Y15	10,759,580	10,759,580	10,759,580	10,759,580	10,759,580	10,759,580
Percent of total disabled population receiving benefits, Y15	3.5%	10.0%	6.6%	19.3%	9.1%	26.7%
Premiums collected, Y1-Y15 (millions)	$215,240	$706,303	$405,688	$1,330,267	$547,726	$1,770,811
Benefits paid, Y1-Y15 (millions)	$121,383	$515,853	$217,913	$964,221	$286,935	$1,272,855
Premiums collected, Y15 (millions)	$15,664	$41,317	$29,548	$76,846	$40,007	$102,507
Benefits paid, Y15 (millions)	$11,241	$31,969	$21,147	$61,536	$29,180	$85,156
Medicaid Federal and State ($)						
Medicaid enrollment, Y15 w/ out program	256,137	802,588	328,359	1,055,576	386,955	1,256,725
Medicaid enrollment, Y15 w/ program	220,274	693,094	292,495	946,081	351,091	1,147,230
Delayed Medicaid enrollment, Y15	35,863	109,495	35,863	109,495	35,863	109,495
Medicaid savings, Y1-Y15 (millions)	$34,135	$169,635	$42,967	$234,129	$49,193	$275,654
Medicaid savings, Y15 (millions)	$4,019	$13,210	$4,852	$16,398	$5,527	$18,932

Source: Avalere Health analysis of the Long-Term Care-Policy Simulation Model.

receiving benefits, the mandatory program for the working population delays spend down to Medicaid for 35,863 people in the fifteenth year of the program compared to about 3,000 people for the voluntary program. The 15-year Medicaid savings for the mandatory program is estimated to be $49 billion compared to about $6 billion for the voluntary program.

By extending the eligible population to include everyone, notably non-working older adults, the enrolled population jumps to 165 million people in the fifteenth year of the program, with 2.9 million receiving benefits and 109,495 people delaying Medicaid spend down in that year. The proportion of the population receiving benefits that are delaying spend down in this program model is the highest of all the program variations because people over age 65 are represented in much larger numbers than in the program where enrollment is restricted to people who work. The resulting Medicaid savings are $275 billion over the first 15 years of the program.

Conclusions

The data in this report suggest that many conventional assumptions in LTSS and aging policy, more generally, need to be rethought. First, current policy initiatives in LTSS focus on rebalancing the delivery system, largely ignoring the financing system that assures that catastrophic out-of-pocket expenses that force people onto welfare are routine events for people who use services. These issues have recently received major attention in Australia and the United Kingdom, where the respective governments have proposed major new initiatives that cap out-of-pocket expenses for people using LTSS.[3,4] The results of this study demonstrate that Medicaid spend down is something that happens to a significant number of people as they age. It is not a rare circumstance that only a few people experience.

Second, Medicaid spend down is part of a larger issue concerning the inadequacies of our retirement security system and is not just an issue of LTSS. The large proportion of people who spend down and who do not use LTSS deserve additional analysis, but is likely the result of inadequate protection against out-of-pocket health care costs, pensions that are not indexed for inflation, and low Social Security benefits. Within the LTSS population, spend down is not solely an issue of use of nursing homes, as is commonly assumed and also includes people who use home care services. Preventing Medicaid spend down will require addressing more than the high costs of nursing home care.

Third, it has long been a strategy of many policy makers to promote private long-term care insurance with the expectation that savings to Medicaid would follow. However, the income and assets of people who spend down are considerably lower than commonly assumed, casting doubt about whether the spend down population could be expected to purchase private long-term care insurance. Thus, promoting private sector long-term care insurance without very deep subsidies is unlikely to have more than a marginal impact on Medicaid expenditures for LTSS. The Medicaid spend down population and the population who can afford private long-term care insurance have little overlap.

Fourth, the choice for policy makers is whether to pay for the nation's growing need for LTSS through increased taxes to fund Medicaid or through an alternative insurance mechanism. Our research shows that a voluntary approach to insurance is unlikely to attract a sizable enough number of people who would otherwise spend down to Medicaid because of their need for LTSS. When Congress established

the CLASS Act, a public insurance program for LTSS authorized by the Affordable Care Act, it did not require individuals to enroll but instead left program participation optional. The actuarial concerns about adverse selection that led Congress to enact an individual mandate for health insurance did not prevail with respect to long-term care insurance, and the Obama Administration discontinued implementation of the program because of concerns about actuarial soundness and sustainability. The American Taxpayer Relief Act of 2012, signed into law by President Obama on January 3, 2013, repealed the CLASS Act and established a new Long-Term Care Commission to examine financing options.

A mandatory long-term care insurance program can shift the LTSS financing burden more effectively from Medicaid to insurance financing for two main reasons. First, there will be far more people enrolled in a mandatory program than a voluntary program. In a voluntary program, only a small fraction of people eligible for the program enroll, so far fewer people receive benefits, delay Medicaid spend down, and replace Medicaid funding with insurance funding. Second, as the participation rate drops in a voluntary program, so does the proportion of the population receiving benefits that would have spent down to Medicaid in the absence of the insurance. That is, there are fewer people relative to those receiving benefits whose coverage is delaying spend down to Medicaid.

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