



How Much Could Financing Reforms for Long-Term Services and Supports Reduce Medicaid Costs?

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Medicaid pays for nursing homes and other types of care for many older adults who develop health problems and need long-term services and supports (LTSS). Expanding access to long-term care insurance could reduce the number of people who turn to Medicaid for assistance, in turn lowering program costs and saving money for federal and state governments. Increasing the insured population can also give people more choice and flexibility in their LTSS. We analyze the effects of several new LTSS insurance programs on people age 65 and older and find these options can significantly reduce Medicaid costs. However, we also find significant differences in Medicaid savings among the alternatives we study.

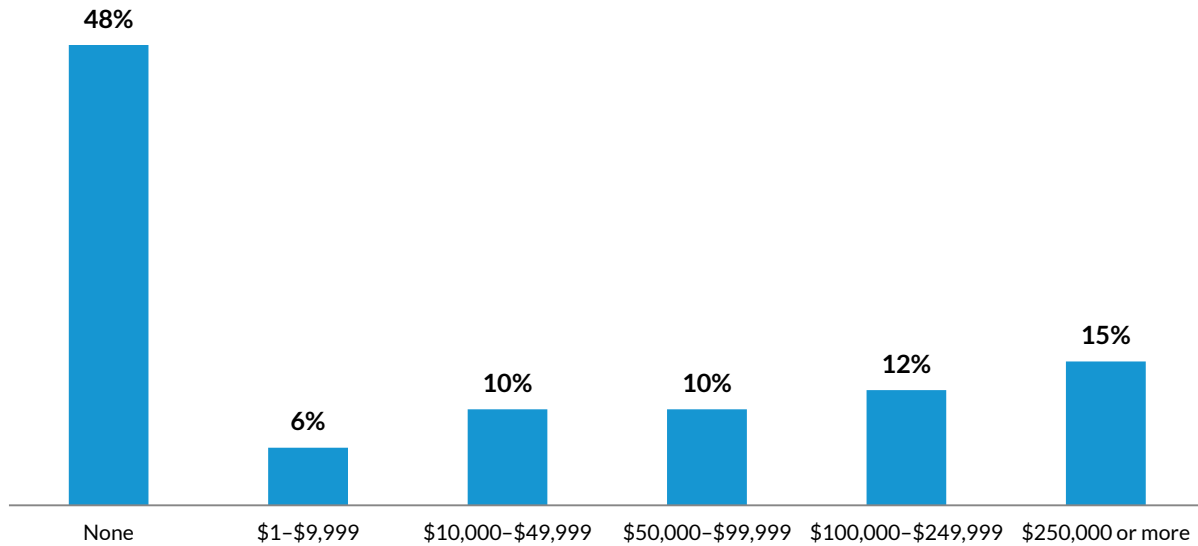
LTSS and Medicaid

About half of Americans will need high levels of LTSS after age 65 to help them with everyday activities (Favreault and Dey 2015). This care can be expensive: lifetime LTSS costs will average about \$138,000 (adjusted for inflation) for someone turning 65 today, and recipients could finance that cost by setting aside \$69,500 at age 65 (under the assumption that their investment earns average returns). But some people will incur much higher costs. For example, 15 percent of 65-year-olds will incur at least \$250,000 in future LTSS (figure 1).

FIGURE 1

Distribution of Future Long-Term Services and Supports Expenditures

Adults turning 65 between 2015 and 2019 (constant 2015 dollars)



Source: Favreault and Dey (2015).

Note: The figure shows the distribution of the sum of future expenditures, without adjusting for when costs are incurred. Expenditures do not sum to 100 percent because of rounding.

Few middle-income families can protect themselves from this financial risk. Traditional health insurance doesn't cover LTSS, and Medicare provides coverage only in special circumstances for a limited time. Only about 11 percent of Americans purchase private long-term care insurance (Johnson and Park 2011). Consequently, most families pay for LTSS out of pocket until their money runs out and then turn to Medicaid for support.

Medicaid is a combined state and federal program that serves two very different roles. It provides medical care for needy adults and children and LTSS for many older adults and people with disabilities. Although eligibility rules vary by state, people qualify for Medicaid LTSS only if they have a high need for personal assistance, limited income, and few financial assets (usually no more than \$2,000).¹ Although states have slowly expanded their home care programs under Medicaid, many frail older adults still receive benefits only if they live in a nursing home.

Currently, Medicaid spends more than \$100 billion a year on LTSS, accounting for about 60 percent of LTSS expenditures (O'Shaughnessy 2014).² Although about one-third of Medicaid spending currently goes to LTSS (Kaiser Family Foundation 2013), expenditures will likely rise as the population continues to age, increasing pressure on state and federal budgets. The Congressional Budget Office (2015) projects that between 2015 and 2040, total Medicaid spending as a share of gross domestic product will rise from 2.2 to 2.9 percent.

Increasing access to insurance could reduce Medicaid LTSS spending. Some people who otherwise would enroll in Medicaid would never need the program, because of their new insurance. For others, insurance would delay Medicaid enrollment or reduce Medicaid spending for their care. Additionally, insurance would give older adults more flexibility in the kind of care they receive, especially with a cash benefit. And those with insurance would be more likely to receive care at home rather than in a nursing facility.

What We Modeled

For decades, policymakers struggled to address the challenges of LTSS financing, with little success. To better understand new insurance-based alternatives, we analyze three new options: a front-end plan, a back-end (or catastrophic) plan, and a comprehensive plan. The front-end plan would begin paying a benefit after the first 90 days of need and continue coverage for up to two years. Under the back-end plan, insurance would be available only after two years. Consumers would be responsible for the first two years of expenses once they develop a need for a high level of care. After that waiting period, they would receive a benefit for the rest of their lives. The comprehensive plan combines the first two: Once triggering the benefit, a consumer would pay for the first 90 days of care. The program would then pay a daily benefit for life. Each plan would provide a cash benefit of \$100 a day with 3 percent annual increases.

For each alternative, we analyze both voluntary and mandatory insurance. The voluntary insurance programs would be financed with premiums, and the mandatory programs would be funded through dedicated payroll taxes. Because high earners would pay more taxes, our mandatory programs would provide indirect subsidies to workers with low earnings. For the voluntary programs, we model both a subsidized and an unsubsidized version. General tax revenues, not premiums, would fund the low-income subsidies in the voluntary plans. The mandatory programs would require enrollees to work and pay taxes for 10 years before qualifying for benefits, and the voluntary programs would require enrollees to pay premiums for 5 years before qualifying for benefits. We simulate the cost and impact of these options using DYNASIM, Urban Institute's projection tool.³ See Favreault, Gleckman, and Johnson (2015) and Favreault and Johnson (2015) for more details on the plans we model and how the model works.

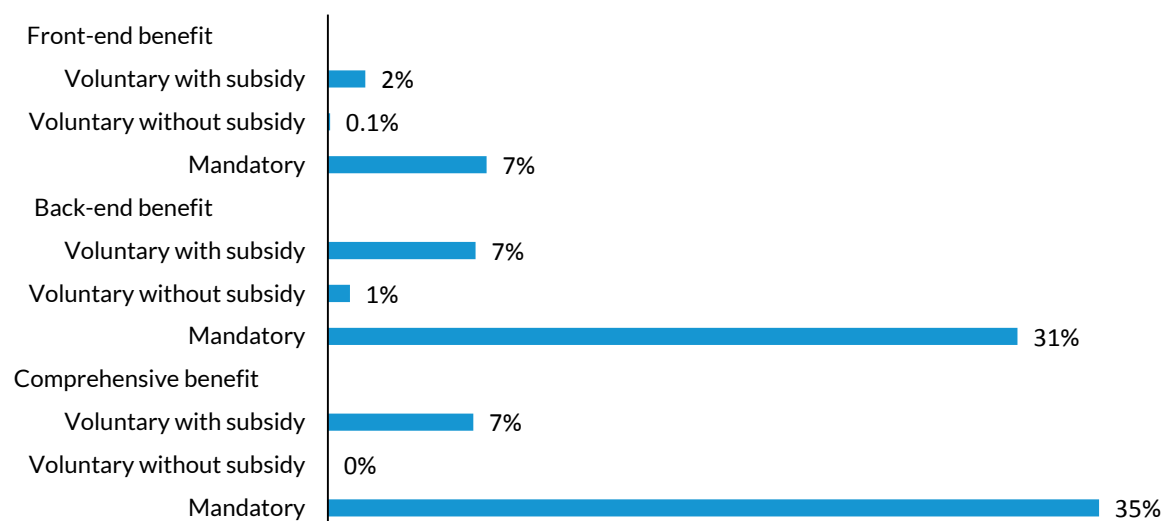
What We Found

Once fully phased in, the mandatory LTSS programs we model would substantially reduce Medicaid LTSS spending, the voluntary subsidized programs would modestly reduce Medicaid LTSS spending, and the voluntary programs without subsidies would have very little effect on Medicaid LTSS spending (figure 2). For example, we project that the mandatory comprehensive plan would reduce Medicaid LTSS spending 35 percent in 2070, while the voluntary subsidized comprehensive plan would reduce Medicaid LTSS spending 7 percent.

These differences reflect the number and characteristics of participants. Relatively high premiums would dampen enrollment in the voluntary programs: we estimate that no more than 20 percent of adults would participate in the voluntary subsidized programs and less than 5 percent would sign up for the voluntary unsubsidized programs. Most adults willing to pay relatively high premiums to enroll in the voluntary unsubsidized programs would have significant incomes and substantial wealth and thus would be unlikely to spend enough on LTSS to impoverish themselves and end up on Medicaid.

By contrast, almost all adults would enroll in the mandatory programs.⁴ Because these mandatory programs would be much larger than the voluntary alternatives and would include many more low-income people, they would offset much more Medicaid spending.

FIGURE 2
Reduction in Medicaid Long-Term Services and Supports Spending from Each New Financing Alternative, 2070



Source: Authors' estimates from DYNASIM.

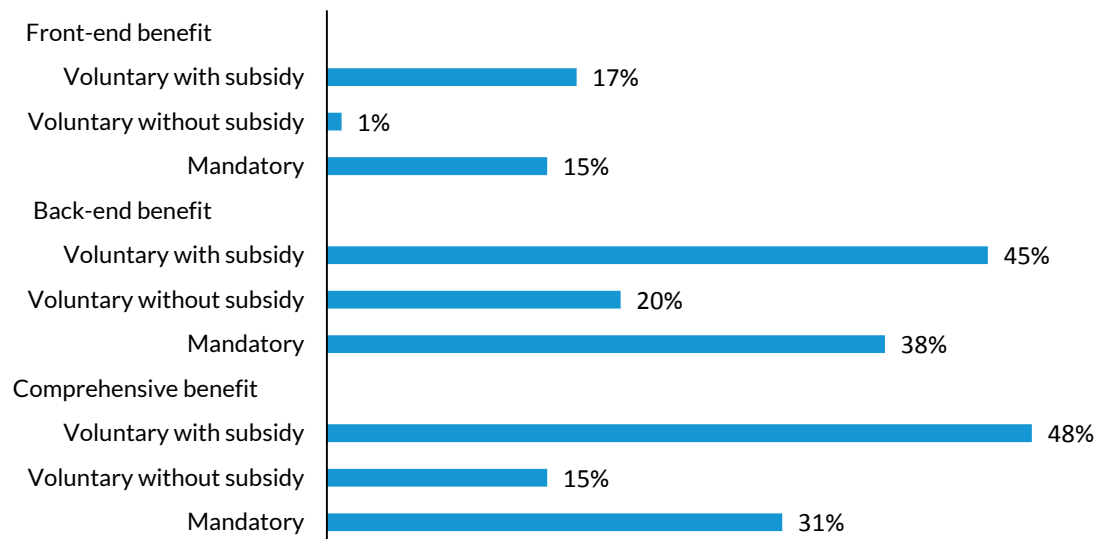
Plans that cover LTSS late in a disability spell, by providing comprehensive or back-end benefits, would offset more Medicaid spending than alternatives that cover only front-end costs. Most people qualify for Medicaid LTSS coverage only after they have incurred substantial out-of-pocket costs that deplete much of their wealth. Consequently, programs that provide only front-end benefits wouldn't reduce Medicaid LTSS spending much.

Although the mandatory programs offset much more Medicaid LTSS spending than the smaller voluntary programs, voluntary subsidized programs better direct their benefits toward reducing Medicaid LTSS expenditures. In effect, they provide more value in Medicaid savings but less savings overall. We project that in 2070, 48 cents of each dollar spent by the voluntary subsidized comprehensive plan would reduce Medicaid LTSS spending (figure 3). Some of the remaining 52 cents would fund new paid services by filling unmet needs or easing burdens on unpaid family caregivers. The rest would offset existing spending by families or private long-term care insurance.

Only 31 percent of outlays by the mandatory comprehensive plan and 15 percent of outlays by the voluntary unsubsidized comprehensive plan would go to reducing Medicaid LTSS spending. Also, among both voluntary and mandatory programs, a much larger share of outlays by back-end plans than front-end plans would offset Medicaid spending.

FIGURE 3

Share of Program Outlays That Offset Medicare Long-Term Services and Supports Spending for Each New Program, 2070



Source: Authors' estimates from DYNASIM.

Conclusions

Because Medicaid now pays the lion's share of LTSS costs, new financing options could significantly reduce Medicaid spending. Dedicated premiums or taxes would prefund at least some LTSS expenditures and limit the current reliance on Medicaid, which is financed through general tax revenues and strains federal and state budgets. New insurance programs could also provide older adults with more flexibility in how they receive LTSS and enable more people to receive services at home rather than in nursing facilities.

The structure and design of the LTSS insurance program matter. The relationship between the various insurance options and Medicaid depends on who receives LTSS and for how long, who is likely to obtain insurance, and what type of coverage that insurance provides. In general, those with low incomes and little wealth are far more likely to receive Medicaid LTSS than higher-income people (Johnson 2013). Not only do those with low incomes and little wealth have fewer resources to pay for LTSS but also they are more likely to need high levels of care and for a longer period.

However, low-income people are unlikely to buy voluntary insurance unless it is subsidized. Similarly, few middle-income people would purchase voluntary insurance, largely because policies would cost more than they are willing or able to pay. Higher-income people are the most likely to purchase voluntary insurance, but they are least likely to require Medicaid. Consequently, although the voluntary programs we analyze would increase insurance enrollment, they would cut Medicaid spending relatively little.

Mandatory insurance, however, would enroll more than 95 percent of Americans at age 65, including nearly all those with low and moderate incomes. Because so many low- and middle-income people would be insured, mandatory programs would significantly reduce Medicaid spending for LTSS.

We modeled only a few options, and alternative designs could have different effects on Medicaid. For example, new insurance programs could provide larger daily benefits, which would offset more Medicaid spending. Or new programs could require enrollees to wait longer before the programs pay benefits, which would offset less Medicaid spending. The way these programs are structured would also determine whether they better protect families than Medicaid. Programs that kick in only after many families have impoverished themselves, for instance, would not provide much more financial protection than Medicaid. Our research is only the first step in the analysis required to design new LTSS financing programs, but it illustrates the potential power of our simulation tool in demonstrating how new options can interact with existing programs.

Notes

1. For a description of Medicaid eligibility rules, see, for example, O’Keeffe et al. (2010).
2. These estimates are sensitive to the type of expenses included in LTSS spending. Defining LTSS differently than O’Shaughnessy (2014), the Congressional Budget Office (2013) concludes that Medicaid plays a smaller role in LTSS financing.
3. Milliman provided us with premium and participation estimates for the voluntary options (Giese and Schmitz 2015). For more information on DYNASIM, see “DYNASIM: Projecting Older Americans’ Future Well-Being,” Urban Institute, accessed January 26, 2016, <http://www.urban.org/policy-centers/cross-center-initiatives/program-retirement-policy/projects/dynasim-projecting-older-americans-future-well-being>.
4. We estimate that 96 percent of all adults would enroll in the mandatory programs; these programs would exclude only those who fail to satisfy the 10-year lifetime work requirement.

References

- Congressional Budget Office. 2013. *Rising Demand for Long-Term Services and Supports for Elderly People*. Washington, DC: Congressional Budget Office. <https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44363-LTC.pdf>.
- . 2015. *The 2015 Long-Term Budget Outlook*. Washington, DC: Congressional Budget Office. <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50250-LongTermBudgetOutlook-4.pdf>.
- Favreault, Melissa, and Judith Dey. 2015. “Long-Term Services and Supports for Older Americans: Risks and Financing.” Washington, DC: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. <http://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>.

- Favreault, Melissa M., and Richard W. Johnson. 2015. *Microsimulation Analysis of Financing Options for Long-Term Services and Supports*. Washington, DC: Urban Institute.
http://www.thescanfoundation.org/sites/default/files/nov_20_revised_final_microsimulation_analysis_of_ltss_report.pdf.
- Favreault, Melissa M., Howard Gleckman, and Richard W. Johnson. 2015. "Financing Long-Term Services and Supports: Options Reflect Trade-Offs for Older Americans and Federal Spending." *Health Affairs* 34 (12): 2181-91.
- Giese, Christopher J., and Allen J. Schmitz. 2015. *Premium Estimates for Policy Options to Finance Long-Term Services and Supports*. Brookfield, WI: Milliman.
http://www.thescanfoundation.org/sites/default/files/milliman_report_-_premium_estimates_for_policy_options_to_finance_ltss.pdf.
- Johnson, Richard W. 2013. "Income and Wealth of Older Adults Needing Long-Term Services and Supports." Testimony to the Commission on Long-Term Care, August 1. Washington, DC: Urban Institute.
<http://www.urban.org/research/publication/income-and-wealth-older-adults-needing-long-term-services-and-supports>.
- Johnson, Richard W., and Janice S. Park. 2011. "Who Purchases Long-Term Care Insurance?" Washington, DC: Urban Institute. <http://www.urban.org/research/publication/who-purchases-long-term-care-insurance>.
- Kaiser Family Foundation. 2013. *Medicaid and its Role in State/Federal Budgets and Health Reform*. Menlo Park, CA: Kaiser Family Foundation. <https://kaiserfamilyfoundation.files.wordpress.com/2013/04/8162-03.pdf>.
- O'Keefe, Janet, Paul Saucier, Beth Jackson, Robin Cooper, Ernest McKenney, Suzanne Crisp, and Charles Moseley. 2010. *Understanding Medicaid Home and Community Services: A Primer: 2010 Edition*. Washington, DC: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.
<http://aspe.hhs.gov/pdf-report/understanding-medicaid-home-and-community-services-primer-2010-edition>.
- O'Shaughnessy, Carol V. 2014. "National Spending for Long-Term Services and Supports (LTSS), 2012." Washington, DC: National Health Policy Forum. http://www.nhpf.org/library/the-basics/Basics_LTSS_03-27-14.pdf.

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