The Big Medicaid Spend On The 65+ Population

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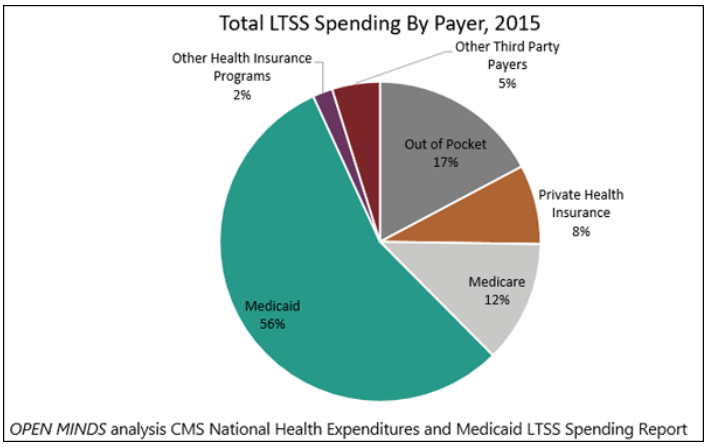
One interesting discovery we made in the discussion of the various health care reform proposals is that many consumers don't realize that a significant portion of Medicaid funds go to the 65+ population. While Medicare covers health care services for the 65+ population – hospitalizations, emergency rooms, pharmaceuticals, etc. – it is Medicaid that pays for long-term care for this population. That includes services for individuals with functional limitations needing assistance performing routine daily activities – as well as residential services including nursing homes, assisted living programs, and continuing retirement communities. I think this distinction is being lost in the current public debate.

Spending on long-term care is the U.S. in 2015 topped $282.9 billion. Medicaid is the primary payer for long-term services and supports (LTSS), at $158 billion, 56% of the total LTSS spending. Out-of-pocket spending by consumers accounts for the next largest proportion of spending at 17% or $48.9 billion, followed by Medicare at 12%, and private health insurance at 8%. For LTSS for the 65+ population, Medicaid spends an estimated $64 billion per year – 11.7% of total Medicaid spending.



Medicaid is the primary payer because Medicare does not cover these services. In fact, Medicare rules specifically prohibit payments for institutional care and for home-based services (although Medicare provides some limited therapeutic home

health services). And, most insurance, Medicare supplemental plans, and employer-sponsored insurance do not cover LTSS as part of their benefit package.

In 2012, Medicaid expenditures for the 2.1 million enrollees over age 65 receiving institutional services or HCBS was $57 billion, averaging out to about $27,000 per user. Medicaid programs nationally spent $41 billion per year for persons using institutional LTSS, such as nursing homes ($37,239 per user), $6 billion for other state plan LTSS ($10,970 per user), and $10 billion for persons receiving waiver HCBS ($17,296 per user).

There is long-term care insurance (LTCI) available, but for a price. In 2014, the total number of individuals with LTCI coverage was 7.2 million with annual premiums of $2,772 (see The State of Long-Term Care Insurance: The Market, Challenges and Future Innovations). And, only a small proportion of consumers can afford to pay privately for long-term care. In 2016, the national median annual cost of a home health aide was $46,332, an assisted living facility $43,539, and a semi-private room at a nursing home was $82,125 (see Compare Long Term Care Costs Across the United States).

As legislators and policymakers plan the future of Medicaid, it is important to consider that 28.9% of the Medicaid budget pays for long-term care – and that 10.4% of Medicaid spending is for LTSS for consumers age 65+ and above. Because the Medicare and Medicaid funding streams are linked for the 65+ population, reductions in Medicaid LTSS spending would result in increased Medicare costs as more 65+ consumers are hospitalized due to lack of suitable home-based support services (see AHCA Would Affect Medicare, Too). Those effects of availability of supported housing and social supports on health care costs are well-documented.

For more on LTSS, join Nancy Thaler, Deputy Secretary for the Office of Developmental Programs, Pennsylvania Department of Human Services on September 27 at The 2017 *OPEN MINDS* Executive Leadership Retreat where she will give the plenary session, “The Future Of Long-Term Services & Supports: A New Business Model For A Medicaid Managed Care Market.”