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WHO WILL HAVE UNMET LONG-TERM CARE NEEDS AND HOW DOES MEDICAID HELP?

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Introduction

Many older Americans will need at least some long-term services and supports (LTSS) as they age. At the same time, a substantial number do not have sufficient resources to provide for LTSS care needs. The questions are whether those who cannot afford care are the same ones who need care; the extent to which Medicaid reduces any shortfalls; and the types of individuals that continue to fall short after Medicaid.

This *brief* is the final in a three-part series examining the need and resources for LTSS among retirees. The first *brief* looked at the likelihood of a 65-year-old developing minimal, moderate, or severe care needs, while the second examined the resources available to 65-year-olds to cover the different levels of care. This final *brief* combines the findings from the two earlier studies to determine the share of individuals projected to have inadequate resources for their specific care needs and explores the extent to which Medicaid makes up the difference.

The discussion proceeds as follows. The first section projects what share of older Americans may fall short of affording the care they need based on their private resources, which include both family members and the finanical means to cover paid caregivers. The second section explores the role of Medicaid and estimates the extent to which it reduces the share of individuals that fall short. The third section explores the disparities in unmet care needs across sociodemographic groups, taking account of both private resources and Medicaid. The final section concludes that while Medicaid covers a substantial share of the cost of long-term care and reduces disparities, a significant minority of retirees will still face varying degrees of unmet needs.

What Share of 65-Year-Olds Will Fall Short?

The first *brief* examined the odds of a 65-year-old developing minimal, moderate, and severe needs for LTSS, considering both the intensity and duration of the required care.[1] Lifetime needs are based on an individual's most severe experience.[2] The results show that roughly one-fifth of 65-year-olds never require

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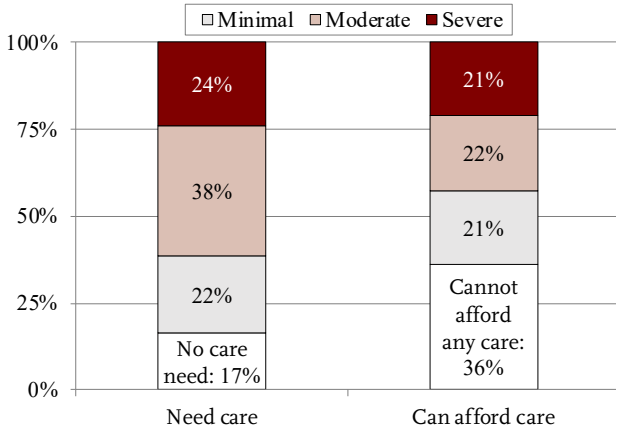
LTSS and about one-quarter will have severe needs with the rest falling somewhere in between (see first stacked bar in Figure 1).[3]

The second *brief* estimated the share of retirees who have the resources – either informal care from family or financial means – to cover any potential minimal, moderate, or severe care needs. The results determined that more than one-third of retirees will not have the resources for even the most minimal level of care, while one-fifth can afford care for severe needs if necessary (see second stacked bar in Figure 1).[4]

Figure 1. Percentage of 65-Year-Olds Who Will Need Care and Can Afford Care



Sources: Authors' calculations using data from the *Health and Retirement Study* (1998-2018), the *National Health and Aging Trends Study* (2011, 2015, 2017), and the *National Survey of Caregivers* (2011, 2015, 2017).

Table 1 combines these two results to determine the percentage of retirees that do not have enough to cover their individual care needs. The *left-hand column* shows the distribution of 65-year-olds by their predicted lifetime maximum level of care needs (Brief #1). The *top-most row* shows the distribution of 65-year-olds based on the highest level of care they can afford using their private resources (Brief #2). The last column shows the percentage of individuals with inadequate resources to cover their specific level of care – the sum of the shaded numbers in each row (Brief #3).

By definition, none of those with no care needs will fall short. In terms of individuals who will end up with minimal care needs, however, 9 percent will have no resources at all and therefore will fall short.

Table 1. Percentage of 65-Year-Olds with Private Resources Falling Short of Future Care Needs

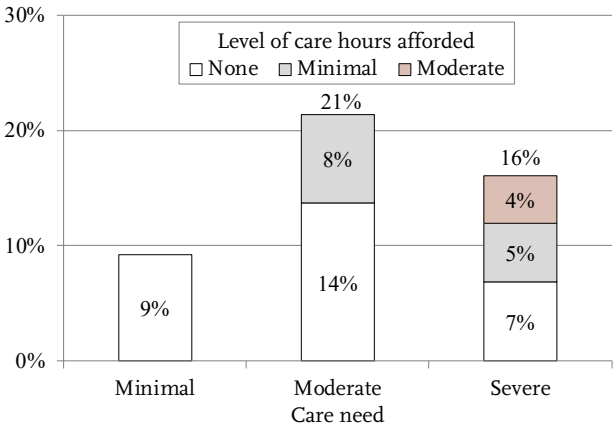
% with predicted care needs (Brief #1)		% with resources to cover care (Brief #2)				% that cannot afford *their* care needs (Brief #3)
		None	Minimal	Moderate	Severe	
	17%	*36%*	*21%*	*22%*	*21%*	
None	*17%*	6	4	5	2	*0%*
Minimal	*22*	9	5	5	2	*9*
Moderate	*38*	14	8	8	9	*21*
Severe	*24*	7	5	4	8	*16*

Note: Components may not sum to totals due to rounding.
Source: Authors' calculations.

For those needing moderate care, 14 percent will have no resources and 8 percent will have enough for only minimal care, so 21 percent will fall short. And for those with severe care needs, 7 percent will have no resources, 5 percent will have enough for only minimal care, and 4 percent will have enough for only moderate care, so 16 percent will fall short.

It is important to note that individuals fall short to varying degrees (see Figure 2). Among the 16 percent of older adults who will not be able to cover their severe care needs (2,292 hours annually for 5 years), 4 percent will have enough to provide for moderate

Figure 2. Percentage of 65-Year-Olds with Resources Falling Short, by Level of Care Covered by Private Resources



Note: Components may not sum to totals due to rounding.
Source: Authors' calculations.

care (1,272 hours annually for 3 years) and 5 percent will have enough only for minimal care (924 hours annually for 1 year).[5] Among the 21 percent of older adults with moderate care needs, 8 percent will have enough for minimal care hours. Only 30 percent (9 + 14 + 7) will not have any resources to provide for care.

The picture thus far, however, considers only private resources – either family or financial – available for future LTSS care needs. Fortunately, Medicaid offers some support for LTSS for those with limited resources.

How Does Medicaid Help Overall?

Medicaid is a joint federal-state program that covers about 20 percent of the nation's total LTSS care hours provided.[6] In order to qualify for Medicaid, retirees must have both a certain level of functional limitations and low levels of income and assets.

Functional Limitations to Qualify

People need a variety of assistance as they age – first with housework, or other instrumental activities of daily living (IADLs) like shopping or preparing meals, and then with more essential tasks, or activities of daily living (ADLs) like bathing, eating, and toileting. Medicaid provides support when people are unable to cope with these essential tasks.

Although Medicaid coverage requirements for LTSS vary from state to state, the program generally covers LTSS care in a nursing home setting. The most prevalent requirement for covering nursing home care is people who need help with 2+ ADLs, although many states have less stringent requirements.[7] In some states, Medicaid will also pay for home care, which can be cheaper than nursing home care and allows older Americans to maintain some autonomy.[8] Because Medicaid only covers LTSS care for those with serious functional limitations, those with minimal needs (e.g., shopping, housework, cooking, finances, medication) generally will not qualify.

Income and Asset Limits to Qualify

In addition to being limited, typically, to people who need help with 2+ ADLs, Medicaid is also limited to those with few financial resources. The means tests vary by state, but most states follow the limits for the federal Supplemental Security Income (SSI) program for assets and set income equal to 300 percent of SSI.[9] Thus, the amounts in Table 2 are a common benchmark.[10] An individual's primary residence is often exempt from the asset test and, in some states, 401(k)/IRA assets are also exempt.[11]

Table 2. Baseline Medicaid Income and Asset Limits, 2021

	Individual	Married*
Monthly income	$2,382	$4,764
Assets	2,000	3,000

* Limits for married are for if both spouses are applying.
Source: American Council on Aging (2021).

Because the income and asset limits are so low, even with the allowable exemptions, it can be hard for individuals to qualify for Medicaid when they initially develop care needs. However, over time, some of those with extensive needs spend down their assets and do end qualifying. Therefore, to estimate the impact of Medicaid, it is necessary to consider both groups: those who qualify up front and those who are likely to qualify eventually by spending down.[12]

Predicting Who Will Spend Down

Estimates of those likely to spend down are based on the lifetime experience of older retirees.[13] Specifically, a regression shows that 65-year-olds with more functional limitations or worse self-reported health are more likely to spend down over their lifetime and those with more resources less likely (see Appendix Table A1). Individuals who are single at 65 are the most likely to end up on Medicaid, as are Black and Hispanic retirees.[14] These regression results are used to predict the likelihood that a 65-year-old will spend down.

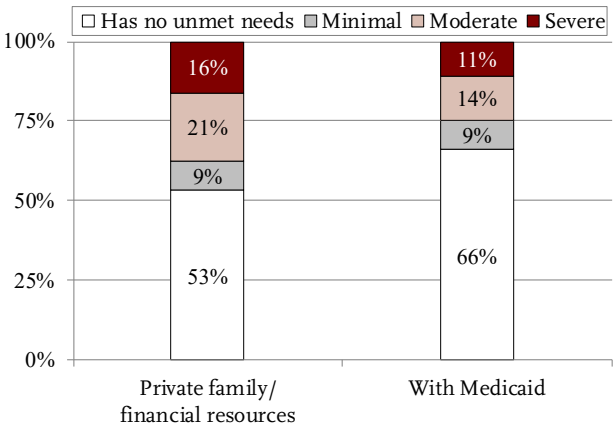
It is important to note that Medicaid does not necessarily provide the same quality of care as private resources might. In states that offer home care, the waitlist to get a Medicaid approved caregiver can be long.[15] Additionally, Medicaid covers semi-private rooms in nursing homes but not private, unless medically necessary.[16] Despite these differences, Medicaid plays a crucial role in covering LTSS costs.

Adding the hours that will be covered by Medicaid to those covered by family and financial resources provides a more accurate measure of any shortfall an individual may face in covering LTSS needs.

Medicaid's Impact

Without Medicaid, 16 percent of 65-year-olds will have severe care needs in the future that they will not be able to fully cover using private resources (see Figure 3). After accounting for Medicaid (for both those who qualify directly and those who spend down), this share declines to 11 percent. Similarly, 21 percent of 65-year-olds will have moderate care needs that they cannot fully afford; however, Medicaid reduces this share to 14 percent. The preponderance of people with unmet needs that do not spend down are middle-class married couples, who presumably are concerned about the welfare of the surviving spouse. Even though Medicaid does not provide support for minimal care needs, the program eliminates the LTSS care needs gap for 13 percent of older adults.

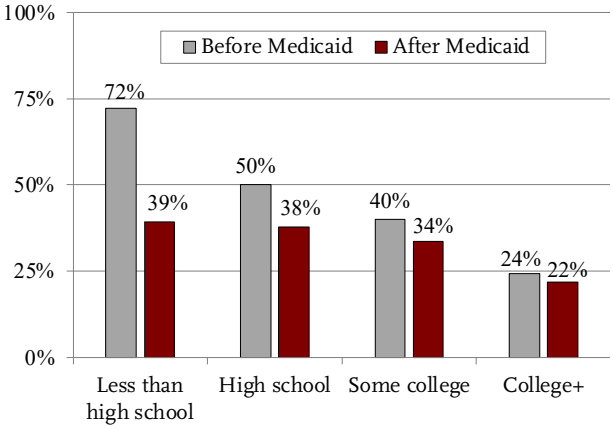
Figure 3. Percentage of 65-Year-Olds with Resources Falling Short of Future Care Needs Before and After Medicaid, by Needs Level



Source: Authors' calculations.

Not surprisingly, Medicaid helps those with fewer resources the most. For those with less than a high school education, Medicaid cuts the percentage falling short almost in half, while for those with college degrees – many of whom will not qualify for benefits – it has only a slight effect (see Figure 4). Thus, one would expect the pattern of falling short to have a much less steep gradient across socioeconomic characteristics once Medicaid is included in the mix.

Figure 4. Percentage of 65-Year-Olds with Resources Falling Short of Future Care Needs, Before and After Medicaid, by Education



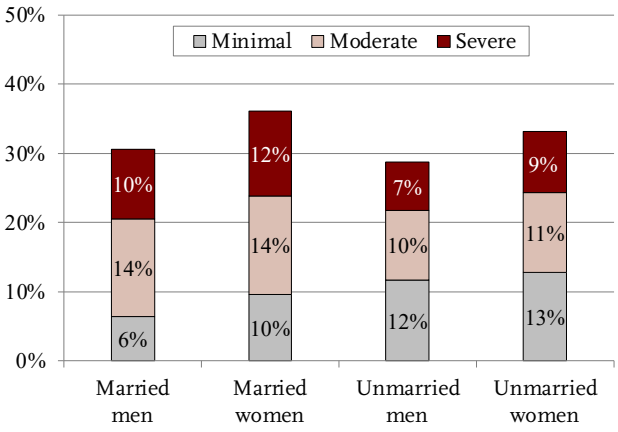
Source: Authors' calculations.

How Much Does Medicaid Help Vulnerable Groups?

Our two earlier *briefs* on LTSS, which focused only on private resources, suggested a serious mismatch between the need for services and the ability to pay for them. That is, single individuals, those without a high school diploma, Blacks and Hispanics, and those who report poor health were projected to need a lot of care, while the resources for long-term care rested with married individuals, those with college or more, whites, and the healthy. The following results show that including Medicaid in the discussion moderates the mismatch.

Marital Status. Once Medicaid is accounted for, the share falling short is relatively constant across marital groups – for example, the percentage of those who cannot cover severe care needs hovers around 10 percent for both married and single individuals (see Figure 5 on the next page).[17]

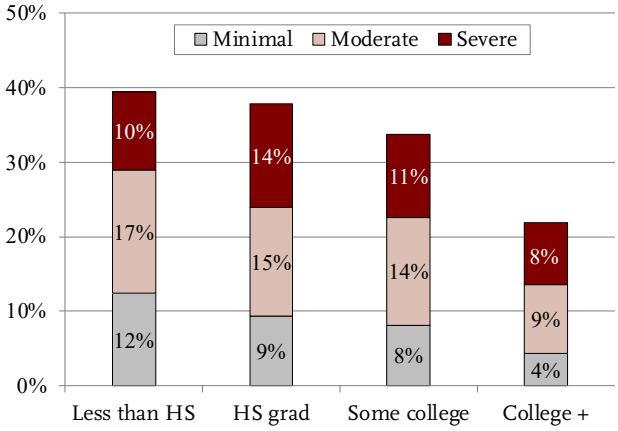
Figure 5. Percentage of 65-Year-Olds with Resources Falling Short of Future Care Needs After Medicaid, by Needs Level and Marital Status



Source: Authors' calculations.

Education. Similarly, once Medicaid is factored in, the trend by educational attainment is much less stark than the earlier *briefs* would suggest. Yes, those with a college degree or more have a significantly smaller share at risk, but the pattern across the other educational groups is much flatter (see Figure 6).

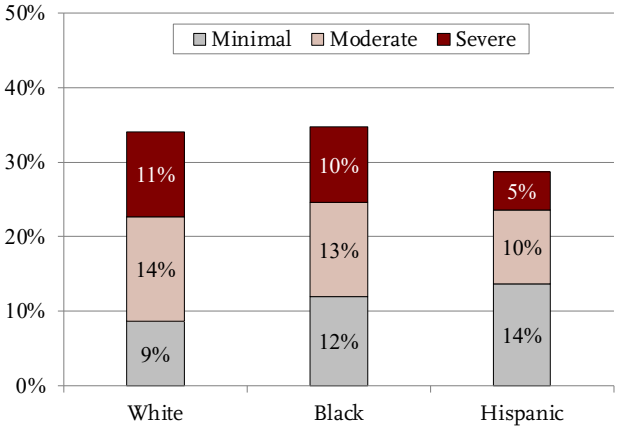
Figure 6. Percentage of 65-Year-Olds with Resources Falling Short of Future Care Needs After Medicaid, by Needs Level and Education



Source: Authors' calculations.

Race/Ethnicity. The equalizing effect of Medicaid is perhaps most obvious by race/ethnicity. Once Medicaid steps in, differences in unmet needs across these groups virtually disappear, with roughly one-third with care needs that still may not be met (see Figure 7).

Figure 7. Percentage of 65-Year-Olds with Resources Falling Short of Future Care Needs After Medicaid, by Needs Level and Race



Source: Authors' calculations.

Conclusion

If older Americans had to rely on family caregivers or financial resources for their care needs, 16 percent would not have enough to cover all of their severe needs and 21 percent would not have enough for all of their moderate needs. After accounting for Medicaid, however, the share of people falling short for severe and moderate care falls to 11 percent and 14 percent, respectively. Medicaid is especially helpful in filling the needs gap for those with limited resources, such as unmarried women, those without a college degree, and Black or Hispanic adults.

Headline numbers, however, tell only half the story. It is important to keep two things in mind. First, those who fall short do so to varying degrees. Over half of them will have at least some resources to provide for care. Second, falling short is a much more devastating problem for those with severe needs than for those with minimal needs, so just counting up all those with unmet needs does not provide a meaningful picture of LTSS shortfalls.

Endnotes

1 The focus is on estimating future care needs for 65-year-olds. Due to small sample sizes for this age group, the analysis augmented the sample by also incorporating data for individuals ages 66-69.

2 That is, a woman who breaks her leg requiring minimal care in her 60s, then has a bout of cancer in her 70s requiring more than a year of support, and then develops dementia in her 80s requiring more than three years of care would be counted once and classified as having "severe" LTSS needs.

3 For more details, see Belbase, Chen, and Munnell (2021a).

4 See Belbase, Chen, and Munnell (2021b).

5 See Belbase, Chen, and Munnell (2021b) for details on care hours.

6 Medicaid expenditures on LTSS, particularly on home and community-based services as opposed to residential care, have been increasing throughout the program's history. This trend indicates that Medicaid will tend to cover home care for individuals who qualify, and the usage of nursing homes for LTSS recipients covered by Medicaid has been in decline (Eiken et al. 2017).

7 For more discussion of ADL needs and Medicaid use, see Blewett and Hest (2020) and Thach and Wiener (2018).

8 In many cases, to qualify for Medicaid LTSS support, individuals must undergo a clinical and/or functional examination.

9 Most individuals ages 65+ who are on Medicaid are covered by either Institutional Medicaid or Home and Community-Based Services Waivers. Functionally, states have different Medicaid categories for the elderly with different eligibility requirements. These programs allow the elderly to receive care through Medicaid, particularly for long-term care.

10 These states have higher asset limits: Maine, Maryland, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New York, North Dakota, Rhode Island, and the District of Columbia. Connecticut is the only state with a lower asset limit ($1,600). These states have lower income limits: California, Delaware, Hawaii, Illinois, Kansas, Massachusetts, Minnesota, Missouri, Montana, Nebraska, New York, North Dakota, North Carolina, and Utah (American Council on Aging 2021).

11 The primary residence is exempt as long it serves as the main home for an individual or their spouse or certain close relatives. In the case of a single person moving into a nursing home facility, the home is exempt if there is an intent to return home, which may be evaluated by the state. If the person moves permanently into a facility with no intent to return, the home may become a countable asset or the state may require the equity value be used to pay for health care costs or to reimburse the state when the individual dies. Further, Medicaid implements a five-year look-back period that ensures any finances transferred out of ownership in the last five years were not improperly liquidated in order to meet the limits (American Council on Aging 2021).

Some states also exempt the pension income of the spouse who does not plan to receive Medicaid. See De Nardi et al. (2011) for a discussion of how the elderly may qualify for Medicaid.

12 It is worth noting that some individuals may consciously choose not to spend down – even if it means forgoing needed services – in order to preserve their nest egg as a bequest for their children.

13 Adapting Borella, De Nardi and French (2017), we estimate current retirees' probability of ending up on Medicaid based on different sociodemographic and health characteristics using an OLS regression. Individuals from the AHEAD, CODA, and HRS cohorts for years 1998-2018 are used to calculate the percentage of retirees who end up receiving Medicaid.

14 Public expenditures on medical care are higher for Hispanic seniors than for white seniors, and Latino individuals accounted for nearly one-third of all Medicaid enrollees in 2018 (Escarce and Kapur 2006 and Gelrud Shiro and Reeves 2020). Further, Medicaid covers roughly three times the share of the overall Black population than the white population, and Black individuals also account for roughly one-fifth of enrollees (Kaiser Commission on Medicaid Facts 2011). Borella, De Nardi, and French (2017) find a positive but small effect of the number of children on the likelihood of Medicaid recipiency, which Wiener et al. (2013) posit could be due to the fact that individuals may transfer their assets to children in order to meet spend-down requirements.

15 Kaiser Family Foundation (2018).

16 Centers for Medicare & Medicaid Services (2021).

17 Guner, Kulikova, and Lllull (2014) find that marriage promotes good health into old age, and therefore married couples are less likely to develop care needs that would occasion a spend-down of resources. Wiener et al. (2013) also find that married couples spend down to Medicaid less frequently.

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APPENDIX

Table A1. Effect of Health and Sociodemographic Characteristics on Probability of Medicaid Spend-down for 65-Year-Olds

	Spend-down likelihood
Intensity at 65: 1	0.0348***
	(0.00448)
Intensity at 65: 2	0.0416***
	(0.00680)
Intensity at 65: 3	0.117***
	(0.00705)
Cannot cover minimal	0.0256***
	(0.00317)
Cannot cover moderate	0.0129***
	(0.00234)
Cannot cover severe	7.93e-05
	(0.00149)
Single women	0.0104
	(0.00752)
Married men	-0.0407***
	(0.00592)
Married women	-0.0337***
	(0.00599)
Black	0.0681***
	(0.00484)
Hispanic	0.164***
	(0.00634)
Other race	0.0568***
	(0.00850)
Health at 65: Good	-0.00188
	(0.00172)
Health at 65: Fair/poor	0.0301***
	(0.00259)
Education: High school	-0.0624***
	(0.00319)
Education: Some college	-0.0733***
	(0.00331)
Education: College+	-0.0651***
	(0.00325)
Middle income tercile	-0.0547***
	(0.00255)
Top income tercile	-0.0567***
	(0.00220)
Homeowner	-0.182***
	(0.00715)
Number of children	0.00688***
	(0.000522)
Constant	0.290***
	(0.00946)
Observations	69,628
R-squared	0.203

Notes: Robust standard errors in parentheses. *** p<0.01.
Source: Authors' calculations from HRS (1998-2018).

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