

Medicare and Long-Term Care

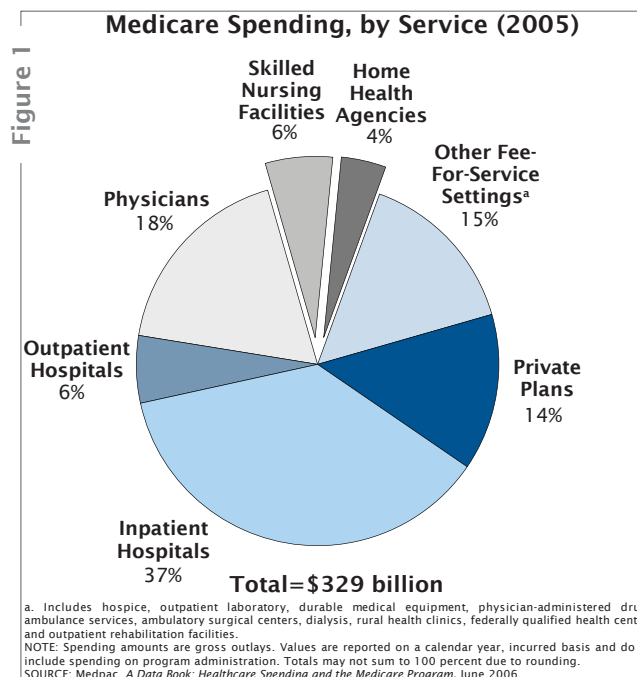
Medicare has contributed substantially to the wellbeing of the nation's elderly and people with disabilities. Over the past four decades, Medicare has helped to improve the health of its beneficiaries and assure their financial wellbeing. But Medicare also has significant gaps. Key among them is the fact that Medicare does not pay for long-term care. Medicare pays for nursing home and home care services, but Medicare is designed to pay for the treatment of acute, short-term illness. These services are available only to beneficiaries who need skilled nursing care or therapies, and are often time-limited.

At the same time, nearly a third of the Medicare population has some physical or cognitive limitation that makes it difficult for them to perform certain activities of daily living, such as getting dressed, moving around the home, and using the bathroom.¹ Medicaid is available to provide assistance to some Medicare beneficiaries who are poor, or who cannot afford the high cost of long-term care services, but most long-term care is a family responsibility. Individuals and families provide a substantial amount of unpaid care and pay for care out of personal resources. Long-term care accounts for the single largest out-of-pocket expense of Medicare beneficiaries.²

Medicare's Coverage of Post-Acute Services

Medicare pays for most of the medical care costs of people who need long-term care, and it makes sizable payments to long-term care service providers—home health agencies and nursing homes. Medicare spent \$32.8 billion on home health care and skilled nursing facility (SNF) services in 2005, accounting for 10% of program spending (see Figure 1).³ However, Medicare's coverage of home care and nursing home care is very limited. Medicare pays for 100 days of nursing home care for beneficiaries with a prior hospital stay who need skilled nursing care or rehabilitative therapy. Medicare pays the full costs of care for the first 20 days of a nursing home stay; after that, beneficiaries make a substantial copayment of \$124 per day in 2007. As a result of these limits, SNF stays tend to be short, lasting an average of 25 days.⁴

Similarly, Medicare covers home health care, but limits services to people with skilled care needs. To be eligible for home health services, beneficiaries must be "homebound," need "intermittent" skilled nursing or therapy services, and be under the care of a physician who prescribes their plan of



care. Home health aide services (assistance with dressing, transferring, toileting, and other activities of daily living) are provided, but people who have no skilled care needs—who require assistance with daily activities only—are not eligible to receive home health care.

Medicare's home health benefit is more open-ended than its SNF benefit: eligibility for home care is not tied to a recent hospitalization, there is no limit on the number of days of care or the number of home care visits a beneficiary may receive, nor is there any beneficiary cost-sharing. About 6 percent of Medicare beneficiaries used home health services in 2004, receiving, on average, 31 home health visits.⁵

Ups and Downs in Medicare's Home Health Benefit

Medicare spending on home health care has been marked by significant ups and downs in recent years. The benefit provided increasing levels of service to people with chronic conditions for several years in the early 1990s before being cut back in the latter part of the decade.

In 1989, a U.S. Supreme Court decision led to a reinterpretation of the eligibility guidelines for Medicare home health care, and contributed to rapid growth in the number of beneficiaries receiving home health and the amount of service each beneficiary received. Between 1989 and 1997, the proportion of beneficiaries receiving home health care more than doubled, rising from 5.1% to 10.8%, and the number of visits increased from an average of 31 visits per user in 1989 to 79 visits per user in 1997.⁶ A substantial amount of the growth was attributable to people receiving more than 200 visits per year. Expenditures over this period grew at a 25% average annual rate.

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With increasing concern that Medicare's home health benefit had evolved into a long-term, personal care benefit, several policy changes were made in the 1997 Balanced Budget Act to rein in this growth. Changes in both eligibility criteria and payment method led to a sharp reduction in home health care use and spending. The share of Medicare beneficiaries receiving home health care services dropped to 7.1% in 2001, with sharp declines in the proportion of beneficiaries using home health care for extended periods of time. Between 1997 and 2001, mean visits per home health care user declined from 79 to 32 visits per year, and expenditures fell by half, dropping from \$17.9 billion to \$8.7 billion. Spending has increased somewhat since 2001, rising to \$11.2 billion in 2004.⁷

Medicare and National Spending on Long-Term Care

Medicare spending represents a significant share of all spending on long-term care. According to one recent estimate, Medicare spent \$42.2 billion on home care and nursing home care, representing roughly 20 percent of national spending on long-term care in 2005 (see Figure 2). Individuals and families contributed a roughly comparable amount (\$37.4 billion), while Medicaid spending accounted for nearly half of what the nation spent on long-term care, with expenditures of \$101.1 billion.⁸ Medicare spending accounted for more than a quarter of spending on home care, and about 17 percent of all nursing home spending. [Figure 2]

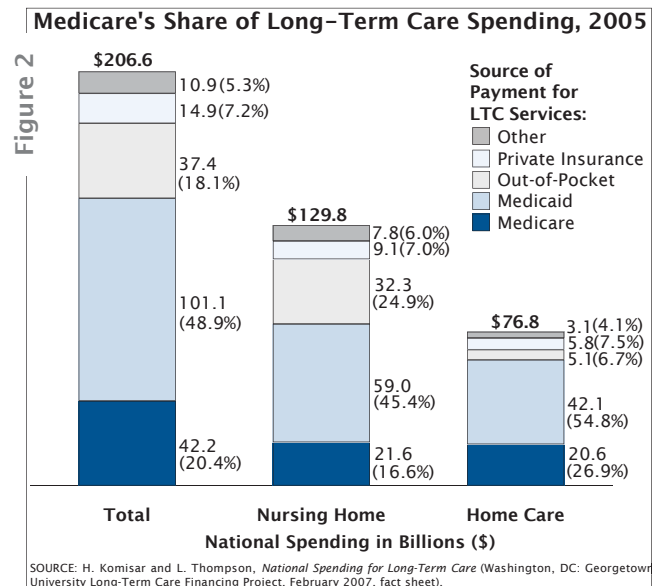
Medicaid's Role as a Supplement to Medicare

Some low-income Medicare beneficiaries receive assistance with long-term care costs through the means-tested Medicaid program. About 7.2 million Medicare beneficiaries are also enrolled in Medicaid (dual eligibles), though not all of them receive assistance with long-term care. In 2002, Medicaid spent more than \$66 billion on long-term care services for nearly 2.3 million dual eligibles. Most of that spending (\$50 billion) was for care provided in nursing homes and other facilities; roughly \$16 billion was for home and community-based care. Medicare beneficiaries who use long-term care services are a high-cost population in Medicaid, representing just 4 percent of the Medicaid population, but accounting for 30 percent of Medicaid spending.⁹

Options to Broaden the Role of Medicare in Long-Term Care

Medicare could be modified to play a larger role in financing long-term care. Options include federalizing long-term care costs for dual eligibles and adding a personal care benefit to Medicare.

- **Federalizing long-term care costs for dual eligibles.** One option for expanding Medicare's role, and relieving burdens on states, would be for the federal government to pay the full cost of Medicaid long-term care services for Medicare beneficiaries. Long-term care assistance would remain means-tested, but the federal government would pay the



full cost rather than the current federal matching rate (which varies across states from 50% to 77%). Along with full federal financing, uniform eligibility and coverage rules would eliminate much of the variation in access to services that characterizes Medicaid today.

- **Adding a personal care benefit to Medicare.** Other policy reforms could be designed to deliver modest benefits to a broader population. For example, Medicare's home care benefit could be expanded to include a modest personal care benefit, designed to provide assistance to individuals who need help with daily activities but who do not have skilled care needs and are thus ineligible for Medicare's current home health benefit. Adding a new benefit to Medicare (or revising the home health benefit) would increase costs, but eligibility criteria could be designed to limit services to beneficiaries with significant needs for assistance.

Notes

- Centers for Medicare and Medicaid Services, *Program Information on Medicare, Medicaid, and SCHIP*, June 2002 edition, Section III.B.2, p. 4. (http://www.cms.hhs.gov/TheChartSeries/downloads/sec3b_p.pdf).
- In 1999, spending on long-term care accounted for 41% of direct out-of-pocket spending, spending on prescription drugs for 21%. Medicare cost sharing accounted for 27%. See CMS, *Program Information on Medicare, Medicaid, and SCHIP*, June 2002 edition, Section III.B.5, p. 8. (http://www.cms.hhs.gov/TheChartSeries/downloads/sec3b_p.pdf).
- MedPAC, *Data Book*, June 2006, Section 1, p. 9. (http://medpac.gov/publications/congressional_reports/Jun06DataBookSec1.pdf).
- MedPAC, *Data Book: Healthcare spending and the Medicare Programs*, June 2005, p. 156.
- Medicare Utilization Statistics for Part A are available at: (http://www.cms.hhs.gov/MedicareFeeForSvcPartsAB/02_MedicareUtilizationforPartA.asp#TopOfPage).
- CMS Data Compendium*. November 2003. Medicare Use of Selected Types of Long-Term Care, 1982-2001. (http://www.cms.hhs.gov/DataCompendium/02_2003_Data_Compendium.asp#TopOfPage).
- MedPAC, *Data Book*, June 2006, p. 134. (http://medpac.gov/publications/congressional_reports/Jun06DataBookSec9.pdf).
- Harriet L. Komisar and Lee Shirey Thompson, *National Spending for Long-Term Care*, Fact Sheet, Georgetown University Long-Term Care Financing Project, February 2007.
- Anna Sommers, Mindy Cohen and Molly O'Malley, *Medicaid's Long-Term Care Beneficiaries: An Analysis of Spending Patterns*, Kaiser Commission on Medicaid and the Uninsured, November 2006. (<http://kff.org/medicaid/upload/7576.pdf>).

