McKnights Long-Term Care News

GUEST COLUMNS

Oops!: How the collapse of out-of-pocket long-term care spending hurts senior care

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Everyone has heard about someone who lost their life's savings to the high cost of long-term care. The media is full of such stories. *KFF Health News* and the *New York Times* highlighted many in their *Dying Broke* series.

Nevertheless, I'd like to ask senior care operators and investors these questions. How often do you see catastrophic LTC spend down occur among your clientele? Is that outcome widespread or only anecdotal? Have you ever seen hard evidence that LTC spending down into impoverishment is commonplace?

I've followed the literature on Medicaid financial eligibility and LTC spend down for decades. Over the years, many scholars of fine repute have published extremely high estimates of personal out-of-pocket LTC spending. A few examples follow. Let's consider whether they are valid.

Kemper, Komisar, and Alecxih claimed in 2005 that 45% of LTC expenditures were "uninsured private expense." Favreault and Dey said in 2016: "Families will pay about half of the costs themselves out-of-pocket." In 2021, Favreault and Johnson concluded that "out-of-pocket payments" were 57% of "total LTSS expenditures."

Do those estimates comport with your revenue projections? In 2023,

NIC-MAP reported national nursing home revenue as 55% Medicaid, 22% Medicare, and 12% managed care, but only 7% private. The evidence for out-of-pocket spending in other LTC venues is not much higher, as you can see in the following table.

LTC spending realities

I recently compiled a summary of actual out-of-pocket LTC spending by year for nursing homes, home healthcare, and other (health, residential and personal care) based on National Health Expenditure (NHE) data.

The "other" category includes spending for Medicaid home and community-based waivers and care provided in residential care facilities such as assisted living. For additional tables showing a breakout of all the sources of LTC funding (Medicare, Medicaid, private insurance, out-of-pocket, and other payers), see LTC Bullet: OOPS! The Collapse of Out-of-Pocket Long-Term Care Spending and Its Consequences.

Out-of-Pocket LTC Spending by Year by Venue

	NH & CCRC	Home Health	Other*	Overall
1970	50%	0%	9%	40%
1980	40	17	4	26
1990	40	18	4	26
2000	32	19	5	20
2010	26	8	4	14
2020	23	10	3	12
2023	26%	12%	3%	13%

* CMS provides "Quick Definitions for National Health Expenditure Accounts (NHEA) Categories" here.

As you can see from the table, actual OOPs have collapsed from 40% in 1970 and are only about one-fourth (13%) of the estimates published by scholars (approximately half) over the years. Further, nuances in the data imply that OOPS may be even smaller. For example, in 2013 CMS lumped CCRCs in with nursing homes.

But CCRCs are mostly private-pay as they include independent and assisted living and cover room and board, not primarily LTC, as nursing homes do. This makes OOPS look higher artificially. Also, half of the 13% overall OOPS figure is income, mostly Social Security benefits, that people already on Medicaid are required to contribute to offset Medicaid's cost for their care. Only 6% or 7% of OOPs, about one dollar out of 15, could come from asset spend down that would deplete savings.

What accounts for the radical difference between the very high estimates of out-of-pocket LTC spending cited above (45%, half, and 57%) and the actual NHE data reported in the table? Scholars arrived at those out-sized OOPS estimates using "micro-simulation," specifically the Urban Institute's "Dynamic Simulation of Income Model (DYNASIM)."

They use a two-step process. First, they assume no one qualifies for Medicaid LTC benefits until they spend down their income to $967 per month and their assets to $2,000 paying privately for care. Next, they ask DYNASIM to estimate OOPS based on available economic and demographic data. Voila! Americans must be spending down into near-total impoverishment in catastrophically high numbers.

Medicaid methodology

What is wrong with this method? First, Medicaid's draconian income and asset limits do crush poor people financially very quickly. But they do not impact middle-class and affluent people in the same way.

High-income individuals qualify for Medicaid LTC benefits because most states subtract private healthcare costs from their income before applying a low-income standard. Other states cap income but

allow special income diversion trusts to achieve the same purpose. Either way, people with high incomes who have commensurately high private health and LTC expenses qualify for Medicaid LTC benefits.

Likewise, high assets do not interfere with Medicaid LTC eligibility because most large assets seniors own are exempt, including most home equity, IRAs, a side business, an auto of any value, prepaid funeral expenses, all personal belongings and home furnishings, and others listed online or available from Medicaid planners. Any countable assets are easily removed by using them to purchase a home improvement, a nicer car, or any other exempt resource.

This method to qualify for Medicaid LTC while preserving wealth is explained in "Medicaid's $100+ Billion Leak." It works because, unlike income spend down that must be for documented health or LTC expenses, asset spend down can be to purchase anything, including exempt resources, for which the purchaser receives fair market value.

Bottom line, if what you read in the popular and academic media about the crushing cost of LTC spending that is supposedly impoverishing millions of aging Americans does not ring true compared to your Medicaid census and private pay revenue, this is why. For a full diagnosis of the problem and for proposed solutions, see "Long-Term Care: The Problem," "Long-Term Care: The Solution," and "Better Long-Term Care for Billions Less."

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