

Medicaid and an aging population

Medicaid is the major source of payment for long-term care, accounting for 47 percent of spending for nursing home and home care services in 2002.¹ Medicaid long-term care costs in 2002 were \$84.7 billion, or 34 percent of total Medicaid expenditures. About half of Medicaid long-term care spending is for the elderly; the rest goes for services to non-elderly disabled people, especially people with developmental disabilities.² There is wide variation in the resources states are currently devoting to long-term care. In coming years, different rates of population aging may shift the financial burdens among states. One result may be growing interest in reassessing the federal and state roles in Medicaid financing.

Current spending variation and possible future trends

States' spending for Medicaid long-term care per elderly person varies widely. In fiscal year 2001, estimated state spending (excluding federal matching funds) ranged from \$61 per elderly person in Louisiana to \$1,323 in New York (see Table 1). Some of this variation stems from differences in the federal share of Medicaid spending (which can mean that two states spending the same gross amount have different net state spending), prevalence of disability among the elderly, and other factors. However, state coverage and reimbursement policies are the most important factor. The disparities translate directly into different burdens on working-age adults, also shown in Table 1. With few exceptions, the states spending the least per elderly person are also spending the least per person aged 18 to 64.

Like other programs that serve the elderly, Medicaid is likely to face sharp spending increases as a result of population aging. While future costs might be affected by changes in disability rates, service innovations, or other trends, growth in the sheer number of elderly people is likely to mean a steadily rising burden. And the costs will be borne by fewer working people. The final columns of Table 1 show the projected change in the ratio of elderly people to working-age adults between 2001 and 2025. Nationally, this ratio grows by 66 percent; while there was one person over age 65 for every 5.2 people of working age in 2001, there will be one elderly person

Table 1. State Medicaid Long-Term Care Spending Per Working-Age Adult, 2001, and Changes in Ratio of Elderly to Working Age Adults, 2001-2025

State	Estimated state share of Medicaid long-term care spending for the elderly, 2001		Percent change in ratio of elderly to working-age adults, 2001-2025		
	Per elderly person (\$)	Per working age adult 18-64 (\$)	Rank (#)	(%)	Rank (#)
New York	1,323	253	1	47	42
Connecticut	1,047	235	2	36	46
Massachusetts	681	145	3	45	43
Ohio	639	127	4	72	25
Minnesota	654	125	5	82	18
Pennsylvania	538	125	6	58	38
Rhode Island	538	124	7	42	44
New Jersey	578	122	8	37	45
New Hampshire	620	117	9	71	29
Oregon	551	112	10	118	3
Washington	622	109	11	100	8
District of Columbia	609	107	12	32	48
Delaware	491	102	13	57	39
Hawaii	421	90	14	30	49
Missouri	412	90	15	62	34
Maryland	491	88	16	52	41
Vermont	438	87	17	75	22
West Virginia	355	87	18	81	19
Wisconsin	403	85	19	71	27
Nebraska	380	85	20	71	26
Maine	366	83	21	61	35
North Carolina	427	81	22	95	9
South Dakota	334	80	23	68	31
Florida	279	73	24	86	16
Indiana	363	72	25	66	32
Colorado	472	70	26	136	1
Alaska	757	70	27	92	10
Kentucky	348	68	28	87	14
North Dakota	277	67	29	75	21
Alabama	311	66	30	68	30
Arkansas	282	65	31	88	13
Texas	384	58	32	88	12
Montana	265	58	33	111	5
Georgia	380	57	34	90	11
Virginia	321	56	35	71	28
California	329	56	36	33	47
Illinois	317	56	37	62	33
Oklahoma	259	56	38	84	17

(continues)

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for every 3.1 people of working age in 2025. But the change in the ratio is much greater in some states than in others, from just 32 percent in the District of Columbia to 136 percent in Colorado.

Even with no change in Medicaid policies, some of the states that have been spending the least on long-term care will likely see the greatest increase in demand. These states may face difficult choices. To maintain the current level of services, they may need to increase the tax burden on active workers. Alternatively, they may adopt cost-cutting measures that could reduce access to care. This possibility is particularly troubling, because some of these states may already provide more limited access to long-term care than the typical state.

Implications for program financing

If demographic trends lead to a redistribution of the long-term care burden among states, there may be a need to reassess the federal and state roles in financing Medicaid long-term care. States' burdens could be eased through a general increase in the federal share or a new federal long-term care program. A more modest step would be to redesign the formula for computing the federal share of Medicaid spending. The U.S. Government Accountability Office (GAO), formerly the General Accounting Office, has studied the option of replacing the current formula, based on states' per capita income, with one that uses age, poverty rates, health care costs, and states' revenue-raising capacity.³ While GAO found that the new formula reduced differences in states' abilities to fund adequate services, it is hard to develop a consensus in support of proposals that would reallocate federal funds among the states.

Some Medicaid reform proposals would actually lock current spending differences in place. For example, in 2003 the Bush Administration proposed replacing the current open-ended federal financing of Medicaid with two fixed federal grants to each state, one for acute and one for long-term care.⁴ The grants would have been based on each state's past spending, with fixed annual increases. This plan would have made no allowance for changes in states' populations over time. States with a faster-growing elderly population would have been left to finance excess cost growth on their own.

Notes

1. H. Komisar and L. Thompson, *Who Pays for Long-Term Care?* (Washington, DC: Georgetown University Long-Term Care Financing Project, updated July 2004, fact sheet).
2. U.S. Congressional Budget Office, *The Long-Term Budget Outlook* (Washington, DC: CBO, December 2003).
3. U.S. General Accounting Office, *Medicaid Formula: Differences in*

Table 1. (continued)

State	Estimated state share of Medicaid long-term care spending for the elderly, 2001			Percent change in ratio of elderly to working-age adults, 2001-2025	
	Per elderly person (\$)	Per working age adult 18-64		Rank (%)	Rank (#)
		(\$)	Rank (#)		
Michigan	279	55	39	58	37
Mississippi	277	55	40	74	23
Kansas	246	53	41	60	36
South Carolina	253	49	42	87	15
Idaho	253	47	43	114	4
Wyoming	243	46	44	103	7
New Mexico	216	42	45	55	40
Tennessee	189	37	46	78	20
Utah	232	33	47	123	2
Nevada	185	33	48	106	6
Louisiana	61	11	49	72	24
Total	464	89		66	

NOTE: Working age is defined as 18 to 64. Years are federal fiscal years. Table excludes Arizona and Iowa. Arizona is omitted because it capitates health plans for most long-term care services and does not break out this spending in its annual CMS-64 report. Iowa had no net state expenditure for long-term care after adjustment for estimated excess federal matching for nursing facility payments under its upper payment limit program.

SOURCE: Author's estimates based on U.S. Bureau of the Census, "Population Estimates—State Population Datasets," http://eire.census.gov/popest/estimates_dataset.php (accessed July 2004) and U.S. Bureau of the Census, "State Population Projections," Table 2. Projections of the Population, By Age and Sex: 1995 to 2025, <http://www.census.gov/population/projections/state/stpjage.txt> (accessed July 2004); and Medicaid spending for nursing facility, personal care, home health care, PACE, home and community-based services (HCBS) waivers and non-waiver community services from Centers for Medicare and Medicaid (CMS), "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Programs (CMS-64)," <http://www.cms.hhs.gov/medicaid/mbes/ofs-64.asp> (accessed July 2004). Elderly share of spending estimated using states' most recent available Medicaid Statistical Information System reports and, for HCBS waivers, M. Kitchener and C. Harrington, "Medicaid 1915(c) Home and Community Based Waivers: Program Data, 1992-1999," http://www.hcbs.org/files/6/259/kaiser_final.pdf (accessed February 18, 2004). When a single waiver program served both the elderly and the non-elderly disabled, all spending is included. Nursing facility spending is net of state recoveries of excess federal matching funds through upper payment limit programs, based on estimates in T. Coughlin, B. Bruen, and J. King, *States' Use of Medicaid UPL and DSH Financing Mechanisms in 2001* (Washington, DC: Urban Institute, 2003).

Funding Ability among States Often Are Widened (Washington, DC: GAO, July 2003).

4. K. Finegold, L. Wherry, and S. Schardin, *Block Grants: Details of the Bush Proposals*, Assessing the New Federalism Policy Brief A-64 (Washington, DC: Urban Institute, April 2004).



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About the Project

The *Georgetown University Long-Term Care Financing Project* pursues analysis designed to stimulate public policy discussion about current long-term care financing and ways to improve it. The project is supported by a grant from the Robert Wood Johnson Foundation. Mark Merlis wrote this *Fact Sheet*.