

HOW MEDICAID HELPS OLDER AMERICANS

By STEVEN A. SASS*

Introduction

Medicaid is generally not the first program that comes to mind when discussing government health care for older Americans. Its counterpart, Medicare, is the primary health insurance program for seniors of all income levels, while Medicaid's beneficiaries span a broad age range and typically have low incomes. However, Medicaid does offer critical benefits to many retirees and those approaching retirement. For eligible retirees, Medicaid provides insurance directly or pays their Medicare premiums and co-pays. It is also the single largest source of long-term care support for the elderly, covering about half of total spending on these services. Finally, in states that adopted the Medicaid expansion under the Affordable Care Act, the program insures about one out of six Americans approaching retirement.¹

This *brief* offers a primer on the role of Medicaid for retirees and near-retirees. The discussion proceeds as follows. The first section reviews Medicaid benefits for the elderly, ages 65 and over. The second section reviews benefits for those approaching retirement, ages 50-64. The third section discusses how these groups, particularly those 65 and over, fit within the context of the larger Medicaid program. The final section concludes that the need for Medicaid benefits by older Americans will rise as the population ages and medical costs continue to increase faster than household incomes. Whether Medicaid meets this need depends on the outcome of the ongoing policy debate over the size and scope of the program.

Medicaid and Retirees

Medicaid is a means-tested medical insurance program jointly operated and funded by the federal and state governments. The federal government specifies mandatory and optional beneficiaries and services. The states operate individual Medicaid programs and decide which, if any, of the optional beneficiaries and services to cover. The federal government then matches state expenditures. The match is dollar-for-dollar for states with per-capita income at or above the national average, and up to three dollars-for-one in the poorest states. In 2016, the federal government covered an estimated 63 percent of total Medicaid expenditures.²

The federal government created Medicaid in 1965 as a complement to its existing welfare programs. Medicaid covered recipients of Aid to Families with Dependent Children, the cash benefit program for low-income children and their parents or caretakers. It also offered states federal money to insure recipients of what became Supplemental Security Income (SSI), the cash benefit program for disabled and elderly individuals with low incomes. Given rising medical costs and variability in the need for care, Medicaid coverage assured a basic level of well-being far more effectively than an increase in monthly cash benefits. Medicaid also absorbed an existing federal-state program – Medical Assistance to the Aged – that covered the health costs of “medically needy” elderly and disabled individuals, who would be impoverished if they had to pay those bills themselves.³

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In response to the continuing rise in health care costs since Medicaid's creation, Congress allowed the states to extend Medicaid benefits to a broader range of the population.⁴ Among the elderly, only SSI recipients get full Medicaid insurance coverage. But state Medicaid programs can cover certain Medicare out-of-pocket costs for two types of individuals: "qualified" and "qualifying" beneficiaries. For qualified beneficiaries, who have incomes up to the federal poverty level, Medicaid can pay their Part B premiums, co-pays, and most out-of-pocket drug costs. For qualifying beneficiaries, who have incomes up to 135 percent of the poverty level; Medicaid can pay their Part B premiums (see Table 1).⁵

TABLE 1. MONTHLY INCOME LIMITS FOR ELDERLY MEDICAID ELIGIBILITY BY TYPE OF BENEFIT, 2018

	Medicaid insurance (SSI)	Part B premiums & co-pays (Qualified)	Part B premiums (Qualifying)
Individual	\$750	\$1,032	\$1,386
Couple	1,125	1,392	1,872

Note: See endnote 6.

Sources: U.S. Social Security Administration (2017, 2018); and author's calculations from Centers for Medicare & Medicaid Services (CMS) (2017b).

Removing Medicare premiums and co-pays from the budgets of low-income households is a substantial benefit. For example, Medicare Part B premiums for most beneficiaries are \$134 a month in 2018. Even for households at the Medicaid eligibility ceiling, this amount represents 10-19 percent of their incomes (see Table 2). By eliminating co-pays and most out-of-pocket drug costs for households with incomes up

TABLE 2. MEDICARE PART B PREMIUMS AS A PERCENTAGE OF HOUSEHOLD INCOME FOR BENEFICIARIES AT THE INCOME LIMIT, 2018

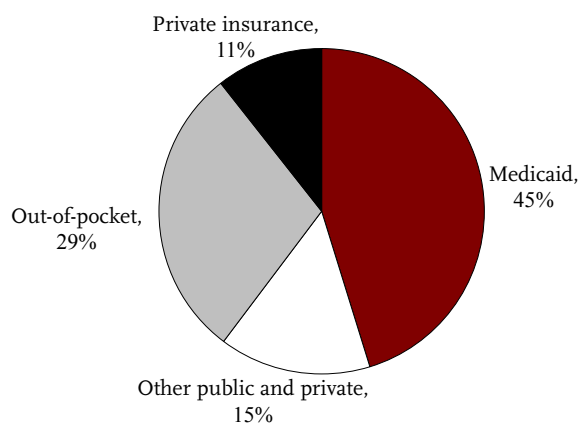
	Qualified beneficiary	Qualifying beneficiary
Individual	13%	10%
Couple	19	14

Sources: Author's calculations from CMS data (2017b, 2018).

to the poverty line, Medicare and Medicaid combined provide much the same benefits and income protection as full Medicaid coverage for SSI recipients.

By far Medicaid's largest expenditures for the elderly are on long-term care. Medicare essentially does not cover long-term care.⁷ But Medicaid does. Given the high cost of care – \$46,000 a year on average for home-based care and \$82,000 a year for a nursing home – many middle-income and even well-to-do elderly Americans exhaust their assets, become "medically needy," and rely on Medicaid to pay the bills.⁸ As a result, over 60 percent of all nursing home residents are Medicaid beneficiaries. With respect to all long-term care services for the elderly, Medicaid is also the dominant payer, covering close to half of total costs (see Figure 1).

FIGURE 1. MEDICAID'S ROLE IN THE PROVISION OF LONG-TERM CARE FOR INDIVIDUALS AGES 65+, 2012



Source: Author's calculations based on CMS (2012).

Medicaid and Near-Retirees

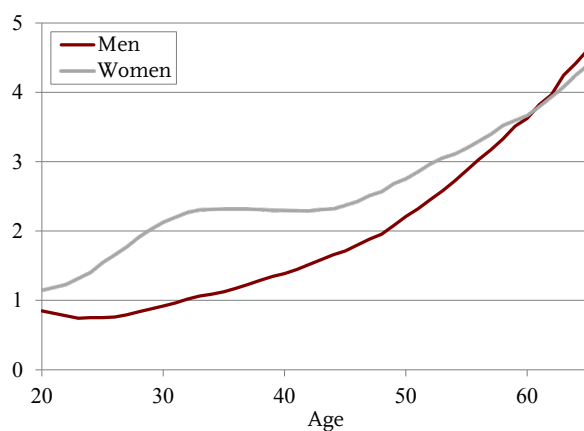
Before the Affordable Care Act (ACA) went into effect, in 2014, working-age adults were largely excluded from Medicaid, unless they were disabled. In most states, either Medicaid or the closely related Children's Health Insurance Program (CHIP) insured children in families with incomes up to 250 percent of the poverty line. But eligibility requirements for their parents remained quite stringent: the median income limit was 64 percent of the poverty line for working parents, or \$1,100 a month (in 2017 dollars) for a family of three.⁹

The aim of the ACA was universal coverage.¹⁰ The elderly and nearly all children were already insured.¹¹ But about one in five working-age adults lacked insurance, and the share was rising.¹² So the ACA aimed to cover working-age adults, using two distinct initiatives:

- *An expansion of Medicaid.* The expansion covers non-elderly adults with incomes up to 138 percent of poverty (similar to the income limits for qualifying Medicare beneficiaries in Table 1). The federal government covered the *entire* cost of these “newly eligible” Medicaid beneficiaries through 2016, with the federal contribution declining to 90 percent by 2020. The Supreme Court in 2012 ruled that the ACA Medicaid expansion is voluntary. But by the first quarter of 2017, 31 states and the District of Columbia had expanded their Medicaid programs to cover over 11 million newly eligible beneficiaries.¹³ In 2017, congressional proposals to repeal and replace the ACA would have significantly scaled back federal funds for the Medicaid expansion, but no such legislation was approved.
- *A restructuring of the insurance market.* The changes to the market include mandates, subsidies, regulations, outreach efforts, and an online marketplace for those with incomes above the Medicaid limits.¹⁴ Unlike the Medicaid expansion, the ACA’s insurance market reforms were introduced nationwide. The recent repeal of the ACA’s individual mandate and efforts to curtail insurer subsidies and regulations may affect the functioning of the ACA’s health insurance marketplaces going forward, but the impact at this point is uncertain.

Before the ACA went into effect, 15 percent of adults ages 50-64 were uninsured. This percentage was less than the share of prime-age and younger adults without coverage.¹⁵ But insurance is especially valuable for those approaching retirement as the need for care, and the cost of insurance, rise sharply after age 50 (see Figure 2). Most uninsured adults ages 50-64 had low incomes and could not afford insurance.¹⁶ Many had health impairments. And all were at risk of incurring unaffordable medical bills or forgoing needed treatment. Not receiving needed medical care can limit the ability to work and perhaps lead to premature retirement. It also allows impairments to become more serious and more costly to treat when these individuals become eligible for Medicare at 65.

FIGURE 2. MEDICAL INSURANCE COST INDEX BY AGE AND GENDER, 2010



Note: Cost at age 20 = 1.

Source: Yamamoto (2013).

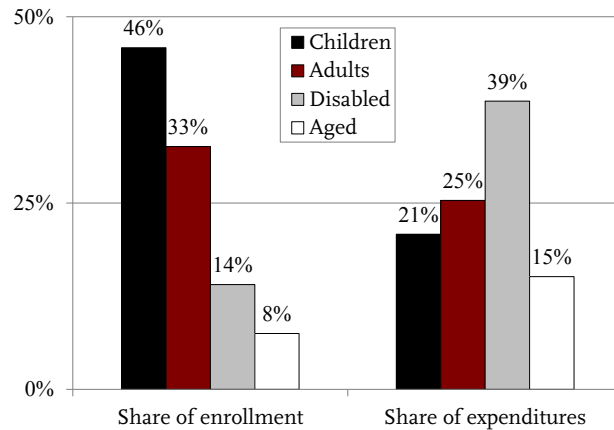
The share of Americans ages 50-64 without insurance fell by 6.4 percentage points between 2012 (pre-ACA) and 2016 – from 15.5 percent to 9.1 percent – due at least in part to increased Medicaid enrollment in the expansion states.¹⁷ Early evidence indicates that Medicaid expansion has led to greater use of preventive services, more treatment for chronic conditions, and improvements in self-reported health.¹⁸ However, most experts agree that it is too early to identify long-term effects on health or medical costs.¹⁹

The Bigger Picture

As discussed above, Medicaid provides critical services to many older Americans. Older Americans are nevertheless a small component of a much larger Medicaid program. Of Medicaid’s four main groups of beneficiaries, the aged is the smallest in both enrollment and expenditures (see Figure 3, on the next page). The aged group covers those 65 and over, so it does not include adults approaching retirement who benefited from the Medicaid expansion. Expenditures on the aged could start to rise sharply when the first Boomers reach their 80s starting in 2026. Nevertheless, children and younger adults will likely remain by far Medicaid’s largest beneficiary groups, and the disabled by far the largest recipients of Medicaid expenditures.

The Medicaid program has grown dramatically since 1965. It was created because medical care was expensive and beyond the reach of low-income households. Medical care has since gotten increas-

FIGURE 3. MEDICAID/CHIP ENROLLMENT AND EXPENDITURES BY MEDICAID ENROLLMENT GROUP, 2015



Note: Enrollment in person-year equivalents.

Sources: CMS (2016, 2017c).

ingly expensive and beyond the reach of an increasingly large share of the population. Medicaid now provides benefits to roughly one in four Americans, at a cost of about 3 percent of GDP.²⁰ Since Medicaid is a means-tested program, its expenditures are redistributive transfers from high- and middle-income households to households with incomes below the Medicaid eligibility thresholds. And unlike Medicare, which is funded to a significant degree by earmarked payroll taxes and beneficiary premiums, Medicaid is funded by general government revenues at the federal and state levels.

Medicaid's cost and fiscal burden have made the size and scope of the program a critical policy concern. As underscored by recent debates, policymakers could decide that the resources Medicaid spends to provide specific services to specific beneficiaries have better uses; or that the resources could be spent more efficiently or raised more equitably; or that there are limits to the redistribution of resources from higher- to lower-income households. Such decisions could reduce the resources that Medicaid uses to insure low-income children, adults, and elderly and disabled SSI recipients; to cover the premiums and co-pays of low-income elderly and disabled Medicare beneficiaries; or to provide long-term care for elderly and disabled individuals who cannot afford it. The outcome will clearly affect the well-being of older Americans.

Conclusion

Medicaid covers medical services for older Americans on a means-tested basis. The need for such benefits will rise as the population ages, especially with medical costs rising faster than the incomes of older households. The extent to which Medicaid will continue to fill this need depends on the outcome of the ongoing debate over the size and scope of the program.

Endnotes

- 1 U.S. Census Bureau, *Current Population Survey* (2017).
- 2 Centers for Medicare & Medicaid Services (CMS) (2016). The federal government generally covered about 59 percent of Medicaid expenditures prior to the Affordable Care Act Medicaid expansion (Snyder and Rudowitz, 2015).
- 3 For more on the origins and expansion of Medicaid, see Cohen and Ball (1965), Klemm (2000), and Moore and Smith (2005).
- 4 Provost and Hughes (2000) and Klemm (2000).
- 5 CMS (2016, 2017a, and 2017b). Medicaid monthly income eligibility thresholds are \$20 above the poverty line percentage amounts. Eligibility also includes an asset test – having financial assets (bank deposits, stocks, bonds, or 401(k)/IRA balances) of less than \$2,000 for individuals and \$3,000 for couples for SSI eligibility; and \$7,390 for individuals and \$11,090 for couples for Medicare premium and co-pay support. Eligibility for individuals with incomes greater than 120 percent of poverty, plus \$20, is subject to the availability of funds. For more on eligibility for Medicaid benefits, see Schneider, Elias, and Garfield (2003).
- 6 Income limits vary by state. Income limits can be higher if some income is from work. Financial asset limits for SSI: \$2,000 for individuals and \$3,000 for couples (in 2018); for Medicare supports: \$7,390 for individuals and \$11,090 for couples (in 2017). Benefits for qualifying beneficiaries are provided if sufficient funds are available.
- 7 Medicare covers up to 100 days of skilled nursing home care, but only after a hospital stay. It also provides some coverage for certain home health services.
- 8 Kaiser Family Foundation (2017a). Access to Medicaid long-term care benefits varies widely from state to state. In general, “medically needy” beneficiaries must have: 1) financial assets below the SSI thresholds of \$2,000 for individuals and \$3,000 for couples; and 2) incomes net of the cost of care below specified thresholds, with all income above a “personal needs allowance” required to contribute to the cost of care, with the median state allowance for those in a nursing home of \$50 a month, and \$1,962 a month for those receiving community-based care in 2015 (Kaiser Commission on Medicaid and the Uninsured 2016a).
- 9 Kaiser Commission on Medicaid and the Uninsured (2013).
- 10 Gruber (2011).
- 11 Medicare (and Medicaid) covered the elderly. Due largely to the expansion of Medicaid and CHIP, which covered nearly 40 percent of U.S. children, only about 5 percent of children then lacked insurance. See Rosenbaum and Kenney (2014) and Hayes et al. (2017).
- 12 Kaiser Family Foundation (2017b).
- 13 Kaiser Family Foundation (2017c) and Kaiser Commission on Medicaid and the Uninsured (2016b).
- 14 These reforms removed a major impediment to the Medicaid expansion: by allowing individuals with incomes somewhat above the Medicaid limits to purchase similar insurance at very low cost, it removed a powerful work disincentive for Medicaid recipients, who would lose Medicaid coverage if they earned too much.
- 15 The uninsured share was 20 percent for adults ages 35-49 and 26 percent for adults ages 19-34 (Courtemanche et al. 2017).
- 16 Smolka, Multack, and Figueiredo (2013).
- 17 Author’s calculations from the U.S. Census Bureau’s *Current Population Survey* (2013, 2017).
- 18 Sommers et al. (2016) and Simon, Soni, and Cawley (2017).
- 19 For a review of the literature, see Antonisse et al. (2016) and Kaestner et al. (2017).
- 20 The share of the U.S. population covered by Medicaid uses CMS (2017c) for Medicaid enrollees and U.S. Census data for total U.S. population. Medicaid spending as a share of GDP uses total Medicaid spending (federal and state) from CMS (2017c) and GDP from the Federal Reserve Bank of St. Louis.

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