



**RESEARCH INSTITUTE  
DISCUSSION PAPER**

**SPEND-DOWN PATTERNS  
OF INDIVIDUALS ADMITTED TO  
NURSING HOMES IN CONNECTICUT**

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## **I. Executive Summary**

The Congressional Budget Office (1991) projects that the nursing home population will double by 2030, and triple by 2050. Aggregate expenditures for long term care are already sizable and are expected to increase exponentially in the coming decades. The total cost of long term care in the United States in 1996 was \$125.5 billion (\$38 billion for home health care, and \$87.5 billion for nursing homes); (Levit et al., 1997). A substantial number of individuals become poor after they enter a nursing home depleting their assets to meet their long term care bills, eventually “spending down” and qualifying for Medicaid.

This study describes the spend-down phenomena in Connecticut, using longitudinal data from the Connecticut Nursing Facility Registry on 8,781 individuals. The majority of individuals (60%) continued to pay privately throughout their stay; the remaining 40% relied on Medicaid for some portion of their stay. Though the group of persons spending-down was only one-quarter of the entire nursing home population, they accounted for 52% of total resident days. An individual’s risk of spending-down in paying for nursing home care was 31%. As might be expected, there was a strong positive relationship between length of stay and spend-down. The mean length of stay for those spending down was four times greater than those paying privately (4.6 years as compared with 1.2 years).

The policy interest in Medicaid spend-down reflects both individual and governmental concerns. Individuals fear exhausting all of their assets in paying for care, resulting in loss of financial independence and the stigma of welfare, as well as concerns about the quality of care provided for Medicaid residents. Policymakers on federal and state levels have considerable interest in estimating rates of spend-down as Medicaid financing for long term care continues to increase exponentially. The prevalence of spend-down directly affects the number of people eligible for Medicaid benefits for nursing home care. Spend-down estimates also offer some insight regarding affordability of nursing home care to the older population; high rates of spend-down are reflective of less affordable care (Wiener et al., 1996).

## II. Literature Review

### A. *Demographic Trends and Costs of Long Term Care*

Substantial attention has been devoted to the analysis of demographic trends and development of projections of demand for long term care services as the population ages. The trends are clear and the implications significant. By 2010, the year in which the first Baby Boomer reaches age 65, the absolute number of persons over age 65 is projected to be approximately 70 million, double the number in 1990 and 20% of the overall population (U.S. Bureau of the Census, 1996). Of particular importance is the fact that individuals aged 75 and older (who are more likely to be frail and in need of long term care services) will increase from 13 million in 1990 to 32 million in 2030, and those aged 85 and older will triple from 3 to 9 million (U.S. Bureau of the Census, 1996).

Long term care refers to a wide range of supportive services provided to persons who, as a result of chronic illness or frailty, are unable to function independently on a daily basis. Services may be provided in a variety of settings from personal residences to institutions such as traditional nursing homes; this range of services is known as the “continuum of care.” About 12.8 million Americans of all ages require long term care, only 2.4 million of whom live in nursing homes (National Academy on Aging, 1997). Over half (57%) of those individuals needing long term care are age 65 or older (GAO, 1994).

Demand for future use of long term care services is difficult to estimate, as assumptions about the relationship between age and disability vary (Manton et al., 1997; Schneider and Guralnik, 1990; Fries, 1989). It is clear, however, that rates of institutionalization increase markedly in later years. About 1% of Americans age 65 to 74 years reside in nursing homes, as compared with 6.1% of persons age 75 to 84, and 24% of persons age 85 and older (U.S. Bureau of the Census, 1993). The Congressional Budget Office (1991) projects that the nursing home population will increase 50% between 1990 and 2010, double by 2030, and triple by 2050. There is a substantial probability of using nursing home care during one’s lifetime; nearly 40% of all elderly will enter a nursing home at least once in their lifetime, and of those who do, about half will stay for 1 year (Kemper and Murtaugh, 1991).

Aggregate expenditures for long term care are already sizable and are expected to increase exponentially in the coming decades. The total cost of long term care in the United States in 1996 was \$125.5 billion (\$38 billion for home health care, and \$87.5 billion for nursing homes); (Levit et al., 1997). This cost was borne by individuals, insurers and federal, state and local governments as follows: a) federal, state and local governments, 61.5%, b) individuals, 36.5% (out-of-pocket, 31.5% and private insurance, 5%), and c) other private funds, 1.9% (Levit et al., 1997). The Medicare program paid for 11.4% of the total nursing home costs, as compared with Medicaid, which paid for 47.8% of total nursing home costs in 1996. Costs projected for 2005 are \$179.6 billion for nursing home care and \$68 billion for home care (Burner and Waldo, 1995). The Congressional Budget Office (1998) estimates that total costs of long term care will nearly triple by 2030, from \$123 billion to \$295 billion.

## *B. Current Strategies to Reduce Long Term Care Costs*

### Public programs

A number of proposals to substantially expand public financing of nursing home care have emerged since the early 1990s (Norton and Newhouse, 1994; U.S. Bipartisan Commission on Comprehensive Health Care, 1990). The three primary models include: a) "front end" coverage for the first 3 or 6 months of a stay, b) "back end" benefits with waiting periods of one or two years, and c) coverage of all nursing home days with or without substantial income-related cost sharing. One study simulated effects of such proposals on public expenditures using 1987 National Medical Expenditure Survey data, and found that the short front end benefit (the least expensive option for public expenditures) would have increased public payments by \$1 to \$2 billion in 1987. Comprehensive coverage of all stays, with variable cost-sharing arrangements, increased public costs by an additional \$9 to \$10 billion (Short and Kemper, 1994).

Broad-based public sector expansion was examined by the U.S. Bipartisan Commission on Comprehensive Health Care ("The Pepper Commission") in 1990. Potential approaches included expansion of coverage for nonmedical home care, increases in income and asset limits, and increases in reimbursement rates. None of these proposals were ultimately deemed viable, with critics arguing that the fundamental design of Medicaid as a welfare program severely constrains any potential for successful reliance on this program for long term care (Wiener et al., 1994).

Finally, the notion of social insurance has been explored in policy discussions around long term care reform, using non-means tested, universal programs such as Social Security and Medicare as models. This basic approach would allow (or require) individuals to pool their risks in an insurance program, paying premiums or taxes into a federal fund and receiving benefits as needed (Wiener et al., 1994). The primary advantages of social insurance are that it would provide individuals and families protection against catastrophic costs and offer universal coverage. The main disadvantage is cost; the Pepper Commission's comparatively modest proposal for social insurance was estimated to cost \$43 billion a year in new federal spending (U.S. Bipartisan Commission on Comprehensive Health Care, 1990).

It is essential to note that, contemporaneous with debates regarding expansion of long term care benefits, policymakers have directed significant attention toward identifying strategies for reducing Medicaid expenditures. During 1995 and 1996, Congress debated a number of proposals designed to: a) bring more private resources into the long term care system, b) reform the delivery system to increase efficiency, and c) reduce eligibility, reimbursement and service coverage. Opponents of such actions argued that substantial savings cannot be realized without negative impact on access to and quality of care (Wiener, 1996).

### Public/private demonstrations and models

**Capitated financing approaches.** A number of models to manage long term care costs through capitated financing systems have been developed and tested since the 1980s. These programs provide a single integrated system of payment and delivery of acute and long term care services. The most well established models include the Program of All-inclusive Care for the Elderly (PACE) model (Eng, 1997), the Social Health Maintenance (SHMO) demonstrations

(Greenberg et al., 1988) and the Arizona Long Term Care System (ALTCS) (McCall and Korb, 1994). These models have been evaluated with respect to enrollment, satisfaction, quality of care, utilization and costs (Branch et al., 1995; Kane et al., 1992; Irvin et al., 1997; Mukamel et al., 1998). Although they represent very different approaches, some common themes have emerged from evaluation studies. Evidence suggests high consumer satisfaction among enrollees. However, voluntary enrollment has been limited and caution has been expressed as to the programs' long term viability (Branch, 1995; Kane et al., 1992). Studies of the impact on quality of care in capitated, integrated programs have produced mixed results (Wiener, 1996). Similarly, the data on cost effectiveness and utilization are inconclusive and vary by model (Brown, 1993; Weissert et al., 1997). Some studies have shown that acute care utilization may be reduced in capitated care settings, but it is unclear whether integration of acute and long term care services generates additional savings (Brown et al., 1993).

**Public/private partnerships.** There are a number of models of public/private partnerships involving private long term care insurance designed to induce greater numbers of individuals to purchase policies through either lower premiums or guaranteed publicly funded coverage. The most commonly discussed mechanism for encouraging the purchase of long term care insurance is providing tax subsidies to employers or tax deductions to individuals. These strategies were included in the Health Insurance Portability and Accountability Act of 1996 (the Kassebaum-Kennedy bill). Such incentives have been criticized as benefiting individuals who would have purchased policies anyway, therefore representing a costly and potentially inefficient means of promoting insurance (Wiener, 1998). Proponents maintain that these models demonstrate important public endorsement of the need to plan ahead for long term care and the value of long term care insurance (Meiners, 1998). The impact of long term care insurance on Medicaid is unclear, although evidence suggests the savings may not be substantial (Rice et al., 1991). Estimates suggest that 29%-38% of purchasers who use nursing home services would qualify for Medicaid payments if they did not own a policy. Owning a policy, however, would reduce spend-down rates among policyholders by 39%, although the ultimate impact on Medicaid is reduced since many policyholders voluntarily let their policies lapse before entering nursing homes (Cohen et al., 1994).

A different approach linking Medicaid to long term care insurance is currently being tested as a multistate program. The model (the Partnership for Long Term Care) combines the public Medicaid program with private long term care insurance in financing the costs of long term care (Meiners, 1998). Partially supported by the Robert Wood Johnson Foundation, this program has been implemented in four states (California, Connecticut, Indiana, New York). While the specific elements of the model vary across states, the basic concept is that individuals purchase a state-certified Partnership long term care insurance policy from a private long term care insurer. This policy allows for protection of personal assets in determining eligibility for Medicaid once benefits under the policy are utilized. A primary goal of this model is to constrain the growth in Medicaid long term care expenditures through education around the importance of planning ahead for long term care and by offering high-quality, private long term care insurance. While the experiment is too young to determine potential cost savings to the state, the states expect to ultimately benefit if the number of policyholders can be expanded to include those at risk of spending-down their resources to the point where Medicaid must pay.

### *C. Medicaid Estate Planning*

Qualifying for nursing home coverage under Medicaid is extremely complex, with varying rules from state to state. In Connecticut, a single individual must spend-down his or her assets to \$1,600 to qualify for Medicaid. This asset level includes cash, bank accounts, stocks and bonds. Items excluded from the asset limit include a car, a burial plot up to \$5,400 (in 1999), life insurance of any amount if it has no cash surrender value, and the cash surrender value of life insurance if the face value of all the life insurance policies is less than \$1,500. A house is not counted as an asset if the individual applying for Medicaid is expected to have a short nursing home stay and return home, or if any of the following people lives in it: spouse, a child under 21, a disabled adult child, or a sibling who is also part owner and has lived in the home at least one year prior to the application to Medicaid. If none of the housing criteria are met, the value of the house will be counted as an asset in the Medicaid eligibility determination if it is determined the applicant will not be returning home.

Community-dwelling spouses are protected by special rules and regulations, subject to income and asset limits. A community-based spouse may retain at least one-half of total assets up to a maximum of \$81,960 (in 1999). In addition, the community spouse may retain one car, certain burial arrangements, and the home. It is important to note that the majority of individuals applying for Medicaid coverage for nursing home coverage are single, and, therefore, community spousal protections are not applicable. The nursing home resident, except for a few deductions such as a personal needs allowance, and a community spousal allowance, must contribute all of his or her income toward the cost of nursing home care.

Current Federal and State laws prohibit the transfer of property or financial assets with the intention of accessing Medicaid (such divestiture cannot occur within thirty-six months preceding the application for Medicaid or sixty months when a trust or certain annuities are involved). In recent years, policymakers, researchers and consumers have become interested in asset divestiture (the process of transferring, sheltering, and underreporting of assets for the purpose of satisfying financial criteria for Medicaid). This process is also known as Medicaid Estate Planning (MEP).

There is wide variation in the level and nature of MEP activities across states, which may be attributed to legal, socioeconomic and health service factors (Burwell and Crown, 1996). The most frequently cited study on MEP was conducted by the Government Accounting Office in Massachusetts (GAO, 1993). A review of applications for Medicaid found that over one half (54%) of applicants had converted countable assets to non-countable assets (thereby excluding them from consideration in determining Medicaid eligibility). Another 13% transferred assets to others. However, 52% of these applications were ultimately denied, making the impact on Medicaid expenditures unclear.

To date, Brian Burwell and colleagues have published three studies on MEP (Burwell, 1991; Burwell, 1993; Burwell and Crown, 1995). The latter of the three studies focused on case studies from four purposefully selected states: Massachusetts, California, New York and Florida. The findings indicated most eligibility workers estimate that between 5% to 10% of single applicants purposefully divert assets prior to applying for Medicaid and 20% to 25% of married applicants do so. A three-phase study was conducted in Connecticut, a state commonly perceived as having high prevalence of MEP due to sociodemographic characteristics, increased age of residents, access to elder law attorneys, the generosity of the State's Medicaid program, and the high quality of nursing

home care (Walker et al., 1998). Respondent groups of Medicaid eligibility workers, elder law attorneys and certified financial planners differed significantly in terms of their perceptions of trends in asset transfers, the nature and value of transfers, and the “typical” client who engages in MEP. Prevalence estimates must be examined in conjunction with the reported magnitude of transfers. For instance, while elder law attorneys may be involved in greater numbers of transfers, the amount of such transfers is significantly lower than those reported by certified financial planners (5.9% of attorneys report transfers in excess of \$200,000, as compared with 51.9% of certified financial planners). Forty-five percent of attorneys report clients transfer less than \$100,000. Medicaid workers report over half of applicants (52.1%) transfer less than \$50,000.

On the whole, empirical evidence regarding MEP prevalence is inconclusive, and varies in terms of approaches and findings. No study has actually quantified the magnitude of activity, or determined the cost-effectiveness of MEP enforcement programs. Although observers agree MEP is occurring at some level, there is no definitive empirical data about the scope of this activity. The disparate perceptions among elder law attorneys, Medicaid eligibility workers and certified financial planners (Walker et al., 1998) underscores the need for primary data from individual applicants and their families. There are no published studies regarding the role of individual motivations in MEP.

#### *D. Medicaid Spend-down*

Consumers of nursing home care experience one of three scenarios in paying for services. In the first, individuals enter the system as private pay residents and continue as private pay residents throughout the duration of their nursing home stay. In the second circumstance, individuals enter the nursing home on Medicaid and remain on Medicaid for the duration of their stay (this number is fewer than the private pay group). In the third situation, individuals enter the nursing home as private pay residents and become eligible for Medicaid during their stay. An individual who does not qualify for Medicaid benefits upon admission to a nursing home begins his or her stay as a private pay resident. Depending upon the length of stay and his or her available financial resources, the individual may exhaust both income and assets, eventually becoming eligible for Medicaid. This process is known as “spending-down” to Medicaid.

**Medicaid spend-down rates.** A number of studies directed at quantifying rates of spend-down have been published over the past 10 years (for an excellent synthesis of the empirical work to date, see Wiener et al., 1996). However, definitional inconsistencies, methodological variation and dissimilar data make comparisons across papers virtually impossible. Three types of spend-down have been defined, using distinct units of analysis. First, individual-level data assesses the probability of an individual entering a nursing home as private pay and depleting assets such that he or she would be eligible for Medicaid upon discharge. This is calculated with the numerator as all persons who are eligible for Medicaid at some point during their stay, and the denominator as all persons who begin their stay as private pay. Second, Medicaid program-level data determines the proportion of Medicaid eligible persons who were private pay at admission. This figure is computed with the numerator as all persons receiving Medicaid at discharge who began as private pay, and the denominator as all persons receiving Medicaid at discharge. The final measure of spend-down estimates the proportion of total nursing home users that spend-down to Medicaid, that is, those who were private pay at admission and Medicaid eligible at discharge. This is calculated with the

numerator as all persons receiving Medicaid at discharge who began as private pay, while the denominator is all persons who have nursing home stays.

Although estimates are highly variable, in general, the national data yield higher rates than state-specific data. National studies have produced estimates of individuals shifting from private pay to Medicaid ranging from 25.8 percent (Short et al., 1992) to 16.3 and 10.2 percent (Spence and Wiener, 1990 using the 1985 National Nursing Home Survey). Using state-specific data, Gruenberg and colleagues (1989) found that 16 percent of individuals spend-down, while over one-fourth entered the nursing home on Medicaid.

Studies estimate between 25% and 33% of discharged nursing home residents are eligible for Medicaid upon admission and roughly 25% to 40% are eligible at discharge (see summary by Wiener and colleagues, 1996). Most studies have been constrained by the fact that multiple stays were not tracked in the datasets. In an effort to address this methodological limitation, Wiener and colleagues (1996) reviewed the National Nursing Home Survey, extending the observation period beyond a single stay. As might be expected, the analysis found an increased proportion of the nursing home residents spent-down to Medicaid. Approximately 31% of discharged residents admitted as private pay spent-down to Medicaid. Nearly one-half (47%) of current residents admitted as private pay eventually spent-down. Lengthening the observation period beyond a single nursing home stay substantially increases the proportion of the nursing home population that spends down to Medicaid. Adams and colleagues (1993) offer the following observations upon a review of studies completed before 1993. First, approximately 1 in 4 individuals admitted as private pay stay long enough to deplete assets to Medicaid levels. Second, approximately 1 in 3 individuals eventually covered by Medicaid were not eligible for the program upon admission. Finally, 30% to 40% of Medicaid expenditures can be attributed to those spending-down to Medicaid during a nursing home stay.

**Length of time to spend-down.** The length of time to spend-down is a critical consideration in understanding both the impact of spend-down on Medicaid budgets and its relationship to Medicaid estate planning. Data suggest that individuals either spend-down very quickly after admission (over 40% exhaust assets within one year), or after a very long stay (estimates range from 9-16%) (see Bice and Pattee, 1990; Arling, 1991; Short et al., 1992; Temkin-Greener et al., 1993).

### III. Methodology

#### A. Data

The State of Connecticut Nursing Facility Registry, established in October of 1977, provides longitudinal data on all residents who entered a skilled or intermediate care facility<sup>1</sup> in the state of Connecticut through September 30, 1995. The Registry is updated annually, with additional information added for those residents who currently exist in the dataset as well as information provided on all new residents. One unique characteristic of the database is the ability to track residents who experienced multiple discharges and admissions from the same facility as well as transfers to other facilities over time. The longitudinal database contains three primary files:

1. Person File - The person file contains demographic information, including the town, county and state of residence of the resident at the time of admission. This file also contains a cumulative length of stay variable, excluding days spent outside the facility.
2. Stay File - The stay file is generated for each new admission to a facility. It also contains information on the place from which the resident was admitted and the resident's destination upon discharge where applicable. Primary diagnosis at the time of admission using ICD-8 and ICD-9 codes is included.
3. Annual File - An annual data record is generated for each admission, and for each person whose stay spanned a report year, i.e., from 10/1 of one year to 9/30 of the next year. Key variables in this file include functional status, payment source at the beginning of the record, and the payment source at the end of the annual record.

Matching two additional files to the longitudinal nursing home files further enhanced this data base. The first file contained Connecticut death certificates records.<sup>2</sup> Data include deaths that occurred in a nursing home or elsewhere. The second file was comprised of Medicaid "payment dates"<sup>3</sup> contained in Connecticut Department of Social Services (formerly Department of Income Maintenance) records for each resident who was on Medicaid at admission or became eligible for Medicaid any time during the nursing home stay.

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<sup>1</sup> "Nursing home" refers to facilities licensed by the Connecticut Department of Public Health (DPH) as either a Chronic and Convalescent Nursing Home (CCNH) or as a Rest Home with Nursing Supervision (RHNS). These licensure designations correspond to the former Federal Certification categories of Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF) respectively. Residential Care Homes (RCH) are not included, nor are they part of the longitudinal nursing home resident database.

<sup>2</sup> The Connecticut Department of Public Health (DPH) collects death certificate data. Staff at DPH completed the merge using Nursing Facility data through September 30, 1987 and death certificate data through October 31, 1988.

<sup>3</sup> Definition of "payment date" as provided by DSS includes the month/day/year Medicaid first paid the nursing facility bill for individual residents.

## B. *Limitations of the Database*

There are two notable limitations of this database. First, for residents on Medicaid, the date of Medicaid payment was determined from the Department of Social Services (DSS) file. In a few cases, residents in the nursing home lose their Medicaid eligibility status for a period of time. At a later date, sometimes within two or three days, the resident regains eligibility status. This eligibility status may fluctuate several times for one resident over the course of his or her nursing home stays, creating multiple dates of Medicaid eligibility. In order to be consistent with other studies produced using this data, the first date of Medicaid payment appearing in the DSS file was used. Spend-down was then computed in relationship to this date.

Second, the longitudinal nursing home data base was begun on October 1, 1977. As a result, the precise date of the first nursing home admission may not be accurate for all residents in the 1981-1982 cohort. It is possible, for example, that an individual had a brief nursing home stay in 1975 for a broken hip and was later readmitted in 1981 for an extended stay. While the 1975 admission would not be reflected in the nursing home registry, the 1981 admission would appear and be treated as a first admission. However, there is very little loss of data for the 1981-82 cohort due to this situation.

For the current study, a single cohort of nursing home residents was used. The group comprised individuals who experienced their first ever admission to a nursing home in Connecticut during the period October 1, 1981 through September 30, 1982. During this time period, 9,123 individuals experienced their first ever nursing home admission. In preparing the database, two sources of errors were found. In the first instance, though Medicaid paid for some portion of the stay, payment data was incomplete for 148 persons. These records were excluded from the analysis. In the second situation, 194 records were removed from the final analysis because of inaccurate or inconsistent discharge information. In total, less than 4% of all persons were deleted from the dataset for analysis. The findings from this study reflect the experience of 8,781 individuals. This study cohort was followed through September 30, 1995.

## C. *Definitions of Key Variables*

There were three operational definitions developed in order to create the groups of individuals for this analysis:

- *Always private pay*: These individuals did not have any indicated date of Medicaid eligibility; they may have had other payment sources such as Medicare or private insurance for part or all of their stay, but they were never on Medicaid.
- *Always Medicaid*: These individuals had a Medicaid eligibility date that either preceded or precisely coincided with the date of their first admission to a nursing home.
- *Spend-down*: These individuals became eligible for Medicaid some time after their first entry into the nursing home.

*D. Research Questions*

A series of research questions were developed in collaboration with Office of Policy and Management (OPM) staff, and are defined in the contract with OPM as follows:

1. What is the average time for private payers to spend-down?
2. What percentage of people spend-down?
3. What percentage enter nursing homes as private payers?
4. What percentage enter nursing homes on Medicaid?
5. What percentage remain private payers?
6. What are the demographics of people who spend-down and how do they differ from those who remain private payers?
7. What is the average length of stay (LOS) for people who spend-down and how does it compare to the average LOS for those who remain private pay or enter a nursing home on Medicaid?
8. How much Medicaid funds are spent on those who spend-down? On those who enter the nursing home on Medicaid?
9. What is the risk of spending-down for those who enter as private payers?

The findings reported below directly address each of the questions of interest. However, the data are insufficient to answer question #8, the estimate of Medicaid expenditures for those who spend-down or who enter the nursing home on Medicaid. The database constructed for this analysis does not permit computation of aggregate Medicaid expenditures by each individual.

#### IV. Findings

##### A. *Payment Type of Persons Admitted to Connecticut Nursing Homes*

Table 1 reports the payment type of all individuals admitted to Connecticut nursing homes (note: for the purpose of this report, the term “resident” refers to an individual residing in a nursing home, as compared with “patient”). The majority (60.3%) of individuals continued to pay privately throughout their stay. The remaining 40% relied on Medicaid for some portion of their stay, one-quarter of whom spent-down to Medicaid.

The probability of spending-down for an individual who enters the nursing home as private pay is 30.9%. This probability is calculated as follows. The always Medicaid group is subtracted from the total sample, since they have no “risk” of spend-down, leaving 7,668 individuals who were admitted as private payers. This number is divided by the number of persons spending-down (2,369), resulting in a probability of 30.9%.

Although the probabilities for an individual are as reported above, it is also important to calculate the percentage of nursing home residents on any given day who are on Medicaid. Chart 1, provided by the Office of Policy and Management, indicates that, in 1996, 66% of all persons residing in a nursing home had Medicaid as a payment source. This is consistent with prior studies, that found that 61% of persons in nursing homes on a particular day (January 1, 1987) were enrolled in Medicaid (Short et al., 1992).

**Table 1**  
**Payment Type of Persons Admitted to**  
**Connecticut Nursing Homes (N=8,781)**

Payment Type	Number	Percent
Always Private	5,299	60.3%
Always Medicaid	1,113	12.7
Spend-down	<u>2,369</u>	<u>27.0</u>
	8,781	100.0

**Chart 1**  
**Age and Payment Source, by Gender, of Residents in**  
**Connecticut Nursing Facilities on September 30, 1996<sup>a</sup>**

Characteristic	Male		Female		Total	
	No.	%	No.	%	No.	%
<i>Age group (years)</i>						
<55	581	1.9	494	1.6	1,075	3.5
55-64	556	1.8	576	1.9	1,132	3.7
65-74	1,428	4.7	2,212	7.2	3,640	11.9
75-84	2,834	9.3	7,110	23.2	9,944	32.5
85+	2,580	8.4	12,220	39.9	14,800	48.3
Total <sup>b</sup>	7,979	26.1	22,617	73.9	30,596	100.0
<i>Payment source</i>						
Medicaid	4,999	16.4	15,077	49.3	20,076	65.7
Private	1,377	4.5	4,381	14.3	5,758	18.8
Medicare	1,223	4.0	2,649	8.7	3,872	12.7
Out-of-state Medicaid	160	0.5	279	0.9	439	1.4
Insurance	99	0.3	102	0.3	201	0.6
Other	110	0.4	104	0.3	214	0.7
Total <sup>c</sup>	7,968	26.0	22,592	73.9	30,560	100.0

<sup>a</sup> Totals may not add to 100% due to rounding

<sup>b</sup> Totals include five females for whom age was not reported

<sup>c</sup> Totals exclude 36 residents for whom payment source was not reported

**Source:** State of Connecticut Nursing Facility Registry, Office of Policy and Management, Policy Development and Planning Division

**B. Nursing Home Resident Demographics**

Nursing home resident demographic characteristics are reflected in Table 2. Data are reported for four groups: total sample, those who were always private pay, those who were always Medicaid, and those who spent-down. The mean age for all groups is about 79 (the always Medicaid group is somewhat younger, with a mean age of 75). As expected, the majority of individuals in all groups are in the older age ranges (80-84 and 85-89). It is interesting to note the proportions of persons age 90 or older in each group (11.4% to 13.3%). The always Medicaid group is younger than the others, with 20% younger than 65. The population is very homogeneous in terms of race, with the vast majority (88.6% to 98.1%) reported as white. The always Medicaid group had a higher proportion of non-whites (black or other), 11.4% as compared with less than 4% in the other groups. Consistent with national data on gender of nursing home residents, the majority of persons in all four groups were female, about two thirds (63% to 73.7%). The greatest proportion of females was in the spend-down group.

**Table 2**  
**Characteristics of Residents Admitted to**  
**Connecticut Nursing Homes (N=8,781)<sup>a</sup>**

Age <sup>b</sup> Categories	N	Total Sample	Always Private	Always Medicaid	Spend-down
<65	742	8.5%	7.2%	20.0%	6.0%
65 – 69	525	6.0	5.7	9.1	5.2
70 – 74	941	10.8	10.5	12.3	10.6
75 – 79	1,489	17.0	17.6	14.4	17.0
80 – 84	1,997	22.9	23.6	16.2	24.3
85 – 89	1,901	21.8	22.0	16.5	23.6
90+	1,135	13.0	13.2	11.4	13.3
Mean		79.2	79.5	74.8	79.2
SD		11.3	11.0	14.5	11.3
Median		81.0	82.0	77.0	82.0
Race					
White	8,482	96.6%	98.1%	88.6%	97.0%
Black	254	2.9	1.6	9.4	2.7
Other	45	0.5	0.3	2.0	0.3
Gender					
Female	5,845	66.6%	63.0%	68.2%	73.7%
Male	2,936	33.4	37.0	31.8	26.3

<sup>a</sup> Totals may not add to 100% due to rounding

<sup>b</sup> Total excludes 51 residents for whom age was not reported

*C. Cumulative Length of Stay and Number of Admissions/Readmissions*

The cumulative length of all stays for the four groups is reported in Table 3. The proportions with lengths of stay less than 1 month differed across the groups, with 25.5% of the always private group having a stay of this duration, as compared with 9% of the always Medicaid. As might be expected, the greatest proportion of individuals in the spend-down group (22%) had a cumulative length of stay in excess of 7 years. As has been shown in prior studies (Weiner et al., 1996), there is a strong positive relationship between length of stay and spend-down. In this study, the mean length of stay for those spending down was four times greater than the always private pay group. It is also important to note the degree to which the length of stay differs when examining mean vs. median, which is a reflection of the distribution of long stayers.

**Table 3**  
**Cumulative Length of All Stays of Residents**  
**Admitted to Connecticut Nursing Homes (N=8,781)<sup>a</sup>**

Length of Stay Categories	N	Total Sample	Always Private	Always Medicaid	Spend-down
<1 month	1,464	16.8%	25.5%	9.0%	0.6%
1 month - <2 months	849	9.7	14.1	5.8	1.5
2 months - <3 months	535	6.1	8.7	4.2	1.1
3 months - <4 months	366	4.2	5.4	4.9	1.1
4 months - <5 months	247	2.8	3.4	3.5	1.1
5 months - <6 months	247	2.8	3.6	2.8	1.1
6 months - <1 year	841	9.6	10.5	10.6	7.0
<b>Subtotal for &lt;1 year</b>	<b>4,549</b>	<b>52.0</b>	<b>71.2</b>	<b>40.8</b>	<b>12.4</b>
1 year - <2 years	985	11.2	10.2	11.5	13.3
2 years - <3 years	741	8.4	6.0	9.5	13.5
3 years - <4 years	587	6.7	3.7	7.8	12.9
4 years - <5 years	438	5.0	2.6	5.6	10.1
5 years - <6 years	408	4.6	2.6	5.8	8.6
6 years - <7 years	240	2.7	1.0	4.0	6.0
7 years +	833	9.5	2.7	15.0	22.0
<b>Subtotal for 1+ years</b>	<b>4,232</b>	<b>48.1</b>	<b>28.8</b>	<b>59.2</b>	<b>86.4</b>
Mean length of stay (days)		856.6	431.8	1,167.2	1,666.4
SD (days)		1,141.0	758.8	1,333.3	1,265.9
Mean length of stay (years)		2.3	1.2	3.2	4.6
Median length of stay (days)		315.0	97.0	641.0	1,374.0
Median length of stay (years)		.86	.27	1.76	3.76

<sup>a</sup> Totals may not add up to 100% due to rounding

The number of readmissions is a critical variable that distinguishes this data set from others reported on previously. The number of admissions/readmissions for the four groups is reported in Table 4. Nearly half (47%) of the total sample had only a single admission. The proportion of always private individuals experiencing one admission was 59.5%, as compared with 40.2% for the always Medicaid group and 21.8% of the spend-down group. A notable segment (13.5%) of the spend-down group experienced six or more admissions. The mean number of stays was also greatest among this group (3.2).

**Table 4**  
**Number of Admissions/Readmissions of Residents**  
**Admitted to Connecticut Nursing Homes (N=8,781)<sup>a</sup>**

Number of Admissions Categories	N	Total Sample	Always Private	Always Medicaid	Spend-down
One	4,117	47.0%	59.5%	40.2%	21.8%
Two	1,971	22.4	20.8	24.1	25.4
Three	1,166	13.3	10.3	14.7	19.2
Four	636	7.2	4.5	8.2	13.0
Five	335	3.8	2.4	3.8	7.1
Six or more	556	6.3	2.6	9.1	13.5
Mean number of stays		2.3	1.8	2.6	3.2

<sup>a</sup> Totals may not add up to 100% due to rounding

*D. Admission Source of Residents Admitted to Connecticut Nursing Homes*

The source of admissions (for the first admission only) is reflected in Table 5. About two-thirds of each group was admitted from a general hospital. The next most common setting from which people were admitted was their home, with approximately one quarter (20.7% to 29.9%) transitioning from their home into the nursing home.

**Table 5**  
**Admission Source of Residents**  
**Admitted to Connecticut Nursing Homes**  
**(Data Reported for First Admission Only) (N=8,781)<sup>a</sup>**

Admitted From	N	Total Sample	Always Private	Always Medicaid	Spend-down
General hospital	5,840	66.5%	68.6%	64.4%	62.8%
Home	2,061	23.5	20.7	22.9	29.9
Other	274	3.1	3.5	3.2	2.3
Mental hospital	241	2.7	3.2	4.1	1.1
Skilled nursing facility	190	2.2	2.3	1.9	1.9
Intermediate care facility	175	2.0	1.7	3.4	2.0

<sup>a</sup> Totals may not add up to 100% due to rounding

E. *Final Discharge Destination of Individuals Admitted to Connecticut Nursing Homes*

The discharge destination for all individuals admitted to Connecticut nursing homes for each of the four groups is reported in Table 6. Over half (59.0%) of the total sample died. While this was true for the always private and always Medicaid groups as well, the proportion of the spend-down group having died was notably higher (71.3%). About 1 in 5 of the private pay individuals was transferred to their home (21%), as compared with 10.2% of the always Medicaid and 1.8% of the spend-down group.

**Table 6**  
**Final Discharge Destination of Residents**  
**Admitted to Connecticut Nursing Homes (N=8,781)<sup>a</sup>**

Discharge Destination	N <sup>b</sup>	Total Sample	Always Private	Always Medicaid	Spend-down
Died	5,175	59.0%	54.2%	55.2%	71.3%
General hospital	1,644	18.7	17.2	23.8	19.8
Home	1,272	14.5	21.0	10.2	1.8
“Still alive” <sup>c</sup>	202	2.3	0.6	5.6	4.6
Skilled nursing facility	162	1.8	2.7	0.7	0.5
Other	111	1.3	1.5	1.4	0.8
Intermediate care facility	74	0.8	1.0	0.9	0.4
Mental hospital	71	0.8	0.9	1.3	0.4
VA hospital	41	0.5	0.7	0.2	0.0
Chronic disease hospital	26	0.3	0.2	0.6	0.3

<sup>a</sup> Totals may not add to 100% due to rounding

<sup>b</sup> Total excludes 3 residents for whom discharge destination was not reported

<sup>c</sup> Residents that are still active (residing a CT nursing home) in the database

F. *Mean Length of Stay by Admission Source and Age*

Tables 7 and 8 report analyses of length of stay data by admission source and age. The shortest lengths of stay occurred for those admitted from their home in each of the four groups. However, there was substantial variation across the groups, with the always private having a mean length of stay of seven months and the spend-down group having a mean length of stay greater than three and one-half years. These findings were similar across all admission sources, though the length of stay differences were not as dramatic.

**Table 7**  
**Mean Length of Stay (Days) by Admission Source**  
**for Residents Admitted to Connecticut Nursing Homes (N=8,781)**

Admitted From	N	Total Sample	Always Private	Always Medicaid	Spend-down
General hospital	5,840	868.0	500.9	1,128.1	1,425.3
Home	2,061	395.1	222.5	599.8	1,284.4
Other	274	2,123.1	1,443.5	2,436.3	2,313.7
Mental hospital	241	1,210.4	795.5	1,341.2	1,660.1
Skilled nursing facility	190	1,604.1	1,023.1	2,011.4	1,927.9
Intermediate care facility	175	1,728.8	1,297.3	1,895.3	2,008.2

Mean length of stay was also examined with respect to age; findings are reported in Table 8. The always Medicaid and spend-down groups had the highest mean lengths of stay, particularly among those under the age of 65 (2,238 days for the spend-down group under 65). The trend was true for the overall sample, in which the mean length of stay was greatest for those under 65 (1,089 days) and slowly decreased as age increased (mean length of stay was 661 days for those age 90 or older).

**Table 8**  
**Mean Length of Stay (Days) by Age of Residents**  
**Admitted to Connecticut Nursing Homes (N=8,781)<sup>a</sup>**

Age Categories	N	Total Sample	Always Private	Always Medicaid	Spend-down
<65	742	1,089.3	489.0	1,397.5	2,238.1
65 – 69	525	917.3	355.3	1,414.2	1,905.8
70 – 74	941	902.9	416.0	1,265.7	1,793.4
75 – 79	1,489	893.6	463.7	1,240.1	1,754.3
80 – 84	1,997	846.9	461.7	982.0	1,643.8
85 – 89	1,901	828.2	431.8	1,074.0	1,582.4
90+	1,135	661.3	355.2	787.5	1,297.6

<sup>a</sup> Total excludes 51 residents for whom age was not reported

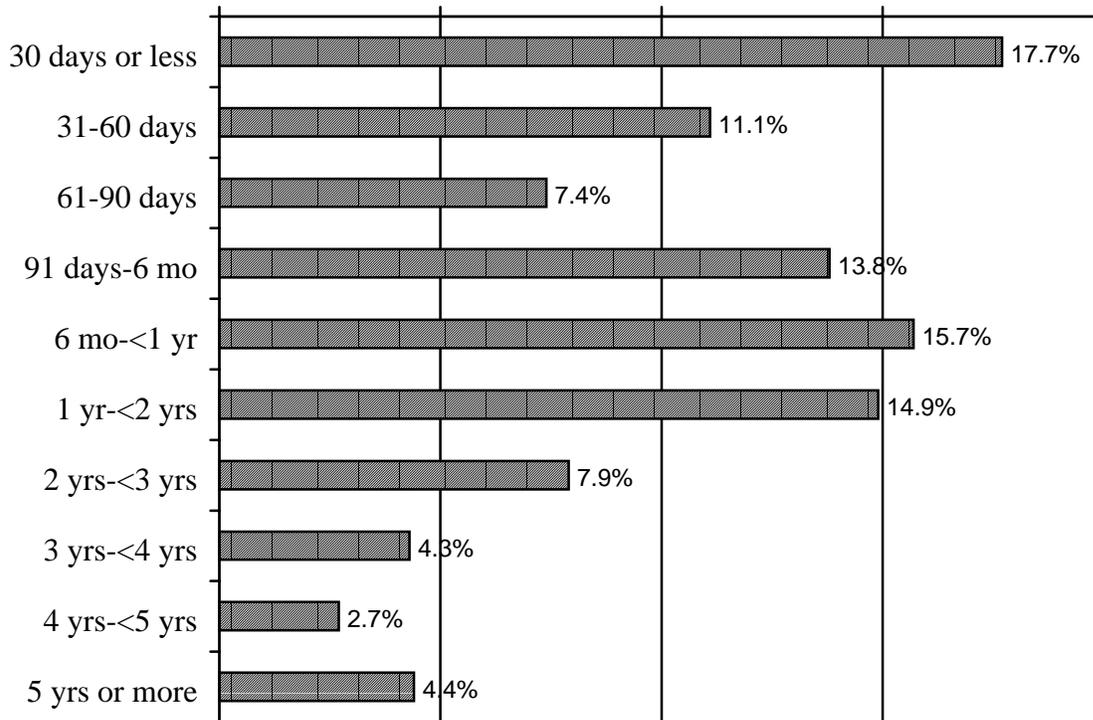
G. *Length of Stay (Days) and Proportion of Total Resident Days by Payment Type*

Length of stay was very different among the three groups (Table 9). The average length of stay for the private pay group was half as long as for the other two groups (432 days compared with 1,167 for always Medicaid and 1,666 for spend-down). The percentage of total resident days was distributed as follows: 30.4% for the always private group, 17.2% for always Medicaid and 52.4% for the spend-down group. It is important to note that not only is there great disparity between average length of stay by payment type, but also the numbers of persons in each category. Though the spend-down population comprises only one-fourth of the entire population, they account for the majority of total resident days (52.4%). This may be in part a consequence of the structure of the variable, in that many individuals resided in a nursing home as private pay patients for less than 30 days before becoming eligible for Medicaid (17.7%). Almost one-third (28%) spent down after 60 days (see Chart 2). Rather than being considered an always Medicaid individual, those with the very short stay were counted in the spend-down group.

**Table 9**  
**Length of Stay (Days) and Proportion of Total Resident Days by Payment Type**

Payment Type	Average Length of Stay	Percentage of Total Resident Days	Number of Persons
Always private	431.7	30.4%	5,299
Always Medicaid	1,167.2	17.2	1,113
Spend-down	<u>1,666.4</u>	<u>52.4</u>	<u>2,369</u>
	858.1	100.0	8,781

**Chart 2**  
**Length of Time as Private Pay Until Spend-down**



*H. Breakdown of Number of Days Paid Privately and by Medicaid for the Spend-down Population*

Table 10 provides greater detail of the substantial impact of spend-down on payment patterns. This table reports how many days of a nursing home stay for those who spend-down are covered by private and Medicaid funds. A total of 2,369 persons spend-down while in the nursing home to become eligible for Medicaid. The average number of days in the nursing home for this group was 1,666.4. Residents paid privately for an average of 433.6 days, or 26% of their entire stay. The remaining days (1,232.8) were paid for by Medicaid, or 74% of all nursing home days. Individuals who spend-down pay privately for an average of 14.3 months, while Medicaid pays for the remaining three and one third years of their stay.

**Table 10**  
**Average Number of Days Paid by Payment**  
**Source for the Spend-down Population**

Payer Group	Mean Number of Days	Percentage of Total Resident Days
Private	433.6	26.0%
Medicaid	1,232.8	74.0

*I. Average Number and Percent of Nursing Home Resident Days by Source of Payment by Payment Group*

Table 11 presents data related to the payor, number of residents and number of days financed by payor type. This table displays the proportion of total days that was paid for by Medicaid out of the entire group. Medicaid days include both those who were admitted as Medicaid residents and those who spent down. In total, Medicaid paid for 56% of all nursing home days, or slightly over 3 years for each Medicaid-financed resident. For those in the spend-down group, the number of Medicaid days accounted for 38.8% of total days. Those who are always Medicaid constitute 17.2% of total Medicaid days. For the privately financed days, about one third (30.4%) of total days are always private, or approximately 14 months. For those who spend-down, about one fourth of all days are privately financed before spending down. The total days paid by Medicaid were 4,219,541. The total days paid privately were 3,315,074.

**Table 11**  
**Average Number and Percent of Nursing Home Resident Days**  
**by Source of Payment by Payment Group**

Payer	Payer Group	Number of Residents	Number of Days	% of Total Days
Medicaid days	Always Medicaid	1,113	1,167.2 (3.2 yr.)	17.2%
	Spend-down*	<u>2,369</u>	<u>1,232.8</u> (3.4 yr.)	<u>38.8</u>
	<b>Total</b>	<b>3,482</b>	<b>1,211.8</b> (3.3 yr.)	<b>56.0</b>
Private Financed Days	Always private	5,299	431.7 (1.2 yr.)	30.4
	Spend-down*	<u>2,369</u>	<u>433.6</u> (1.2 yr.)	<u>13.6</u>
	<b>Total</b>	<b>7,668</b>	<b>432.3</b> (1.2 yr.)	<b>44.0</b>

\* Note that the total of those spending-down is the combination of both Medicaid and private days (52.4%).

Other studies have reported the length of time to spend-down as approximately 40% spend-down within one year, while 9-16% spend-down after a very long stay. The rates are somewhat different in this study. A sizable proportion (17.7%) spend-down within 30 days or less; this may be an artifact of the structure of the “spend-down” variable, in that many of the individuals in that group had a length of stay of 1 day before transitioning onto Medicaid. Approximately two-thirds (65.7%) spend-down within one year.

## V. Discussion

The policy interest in Medicaid spend-down reflects both individual and governmental concerns. Individuals fear exhausting all of their assets in paying for care, resulting in loss of financial independence and the stigma of welfare, as well as concerns about the quality of care provided for Medicaid residents. Policymakers on federal and state levels have considerable interest in estimating rates of spend-down as Medicaid financing for long term care continues to increase exponentially. The prevalence of spend-down directly affects the number of people eligible for Medicaid benefits for nursing home care. Spend-down estimates also offer some insight regarding affordability of nursing home care to the older population; high rates of spend-down are reflective of less affordable care (Wiener et al., 1996). The extent to which Medicaid provides a safety net for middle class individuals can be approximated by calculating rates for those who enter as private pay and become eligible for benefits during their stay (Wiener et al., 1996).

Data regarding Medicaid spend-down may be viewed from at least two distinct but related vantage points. From a Medicaid program budgetary perspective, the critical data is the percentage of individuals in nursing homes on any given day who are on Medicaid. A one-day snapshot of payment sources provides insights into the distribution of patient-days by payment source over a longer period, such as a year (Short et al., 1992). However, this approach does not characterize the impact of various policy approaches on *individuals*, since the large proportion of people with very short stays is underrepresented in such data. Those interested in the individual experience (what is the risk that I will become impoverished if I require a nursing home stay, or become a permanent resident?) will examine the individual risk of spending down to Medicaid. Many studies have quantified the risks that concern individuals by using admission or discharge cohorts. This type of information can be very useful in strategies to encourage individuals to consider alternative means of financing their care, such as long term care insurance.

It is important to note that definitional and methodological inconsistencies make comparisons across published studies very difficult. There are several unique features of the State of Connecticut Nursing Facility Registry (CNFR) that distinguish it from other state and national databases (Bice and Pattee, 1990). First, the CNFR allows for approximation of an individual's lifetime experience of nursing home use, as compared with most other studies that have relied on discharge or survey data reflecting individuals' most recent episode of care. Consequently, the CNFR studies have produced higher estimates of spend-down than previously reported studies using other databases. When the spend-down rate is conceived from beginning with the first admission, as opposed to the most recent admission, the estimate of individuals spending-down to Medicaid eligibility nearly doubles (Wiener et al., 1996; Farbstein et al., 1990). Second, the longitudinal nature of the CNFR permits examination in trends in lengths of stay and spend-down that cannot be measured with cross-sectional discharge data. The fact that the average individual discharged from a nursing home in Connecticut had more than two admissions highlights the importance of using longitudinal data linking multiple records. Finally, the inclusion of all nursing home entrants (private pay and Medicaid) facilitates two types of calculations of spend-down: the proportion of private payors who convert to Medicaid and the proportion of all Medicaid recipients who became eligible by virtue of spending-down. Studies utilizing Medicaid data alone can only generate estimates of the latter group.

This study is similar to the one reported by Leonard Gruenberg in 1989, with three notable exceptions. First, the cohort selected for analysis was from the 1981-82 time period, as opposed to 1978-79. Second, the Gruenberg study followed persons for 8 years, while the current study followed individuals for 14 years. Third, in 1981, the State Medicaid data collection and processing systems were refined and improved, making the data more accurate and easier to extract from the system. Despite the differences in the data bases, the results of the two studies are similar in certain respects. The demographic characteristics of nursing home residents are very similar, as are the data regarding length of stay and number of admissions/readmissions. Most individuals in both studies entered the nursing home as private pay. As observed previously, those on Medicaid experienced much longer lengths of stay than those who remained private pay (a mean of 3.2 years as compared with 1.2 years in the current study, and a mean of 2.7 years compared with 1.1 years in the Gruenberg study). The spend-down group in both studies experienced substantially longer stays (4.6 years in the current study and 4.3 years in the Gruenberg study). The data indicate that the private payments for nursing home care are significant. Nearly two thirds of all individuals enter paying privately and continue paying privately throughout their stay (it should be noted that private pay includes Medicare, suggesting the subacute/rehabilitation benefit may play a significant role).

As has been found previously, there were comparatively few individuals who spent-down in this study. Possible explanations include methodological issues, lack of consideration of spend-down associated with community-based care prior to admission, the role of welfare stigma, and the potential that nursing home populations may be drawn disproportionately from a lower-income population (Wiener et al., 1996). Despite the relatively low numbers of spend-downers, however, it is important to note those who spend-down account for more than 50% of total resident days (some hypothesize they account for an even higher percent of the total dollar expenditure, although the data are not available).

It has been observed that reliance on public insurance in the form of Medicaid requires individuals to pay a deductible equal to their entire life savings before benefiting from such insurance (Temkin-Greener et al., 1993). Policy approaches that integrate the public and private sectors (such as the Connecticut Partnership for Long-Term Care) have been introduced in recent years. One goal of the Partnership is to encourage and support the purchase of high quality long term care insurance products by individuals who might otherwise be at risk for spending down to Medicaid. It is likely that the group of individuals known as “always Medicaid” in this study included at least some persons who engaged in Medicaid estate planning in order to access Medicaid benefits. Alternatives such as the Partnership are intended to reduce this activity by providing such individuals reasonable mechanisms to protect assets while also accepting a level of personal responsibility in paying insurance premiums. The merits of integrating public and private responsibilities in the financing of long term care have been discussed from a number of perspectives. Successful long term care policy will encourage private responsibility while reflecting social norms about the role of government in paying for care (Walker et al., 1998). In the case of Medicaid spend-down, options such as long term care insurance provide individuals with the opportunity to plan ahead for their potential long term care needs. However, models such as the Partnership also demonstrate a recognition of the government’s role in paying for care by allowing access to Medicaid funds after a reasonable contribution on the part of the individual.

Policymakers are faced with continuing challenges in the development of equitable and feasible approaches to financing nursing home care in the years ahead. Pressing questions include: how many middle class, private pay individuals are becoming impoverished by a nursing home stay? Do we have a social responsibility to protect individuals and families from impoverishment as a result of a nursing home stay? How many Medicaid-covered nursing home residents held sufficient assets on admission and might have been prevented from accessing Medicaid support if other payment mechanisms were in place? What is the role of asset divestiture in Medicaid financing of long term care?

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