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# Briefing Paper #6:
# Private Long-Term Care Financing Alternatives

There are only four sources of private financing that might offset Medicaid long-term care expenditures. These are (1) increased personal asset spend-down, (2) Medicaid estate recovery, (3) home equity conversion, and (4) private long-term care insurance. How well does the United States take advantage of these potential resources?

## Increased Personal Asset Spend-Down

As explained in Briefing Papers #2 on Medicaid Long-Term Care Eligibility and #3 on Medicaid Planning, asset spend-down for long-term care is very easy to avoid. Some people do pay privately for LTC for three common reasons. The poor, who are unaccustomed to consulting financial advisers, often lose everything to high-cost LTC before they find their way to Medicaid. The middle class and affluent may voluntarily pay out of pocket for highly desirable care venues, such as assisted living, which Medicaid does not usually fund. People with private long-term care insurance or who can otherwise afford the sentiment may pay privately because of a sense that turning to public welfare is unethical.

In the end, however, Medicaid is the dominant LTC payer and out-of-pocket expenditures are relatively small because of (1) easy access to Medicaid financing after care is needed, (2) the widely held belief that access to publicly financed long-term care is a "right," both legally and ethically appropriate for anyone who follows the lenient income and asset rules and (3) readily available legal advice on how to qualify for Medicaid without spending down assets. Medicaid will remain the dominant payer for expensive LTC unless and until measures are taken to (1) ensure that personal income is used first to purchase HCBS in the private market at market rates, (2) Medicaid's home equity exemption is reduced or eliminated so that real estate wealth is used to fund quality LTC, and (3) other wide-open, unlimited asset exemptions are limited to levels more commensurate with Medicaid's being a means-tested LTC safety net for the poor.

## Medicaid Estate Recovery

Medicaid estate recovery is another source of private financing for long-term care that is mandatory under federal law and expressly intended to relieve the financial burden on state and federal resources. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82) authorized state Medicaid programs to recover benefits correctly paid from the estates of deceased recipients or from the estates of the recipients' last surviving exempt relatives. The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) made estate recovery mandatory for every state Medicaid program as a condition of receiving federal matching funds. Nevertheless, few states enforce estate recoveries strongly; the federal government has not required states to recover at a reasonable minimum level; and some states, such as Georgia, Michigan, and Texas have only recently complied with the estate recovery mandate at all.

Oregon, the top-ranked state among comparable estate recovery programs, recovered $14 million or 5.8% of its Medicaid nursing home expenditures in 2004, the latest year for which we found national data.[1] The country as a whole recovered only .8% of Medicaid nursing home expenditures. If all states had recovered at the same rate as Oregon, total estate recoveries would have been $2.6 billion or $2.2 billion more than they actually were. Federal law includes many safeguards to protect Medicaid recipients and their families from excessive estate recoveries. For example, states may not recover from a recipient's estate if the recipient has a surviving dependent spouse or exempt child.

Medicaid planning advice on how to avoid estate recovery is readily available. For example, according to California Advocates for Nursing Home Reform:

> The best way to avoid an estate claim is to have nothing in the Medicaid beneficiary's estate at the time of death. The State can only claim for the amount of Medicaid benefits paid or the value of the estate, whichever is less. The "estate" is composed of what is in the beneficiary's name at the time of death. Minimizing the estate at the time of death will minimize the amount of the claim.

> The main asset in the estate is often the home. Protecting the home from recovery often entails transfer of title out of the beneficiary's name. However, there are a number of ways to transfer property and still retain some control over the property. Any such transfer should be discussed with a qualified estate planning attorney knowledgeable about Medicaid and the tax considerations related to real estate transfers.[2]

The gradual dwindling of assets, especially home equity, before and during Medicaid dependency, the ready availability of Medicaid planning advice on how to evade the estate recovery requirement, and the administrative difficulty of recovering from Medicaid recipients' estates severely limits the potential of Medicaid estate recoveries as a revenue source to offset public expenditures. Ensuring that assets are consumed for long-term care in the private marketplace before Medicaid begins to pay is a much more efficient way to reduce Medicaid's LTC expenditures.

**Home Equity Conversion**

Home equity conversion by means of reverse mortgages could generate a huge source of private long-term care financing to offset Medicaid LTC expenditures, especially to fund home- and community-based services. Four out of five elderly people own their homes and two-thirds of these own their homes free and clear of mortgage debt. People age 62 and older can access their home equity easily, and without incurring monthly payments, by means of "reverse mortgages." Reverse mortgages can be arranged formally through financial institutions or informally within families, whereby usually adult children engage to purchase the parents' home over time while the older generation remains in the home.

But very few people use reverse mortgages to fund home- and community-based services that would enable them to remain in their homes longer. Even fewer tap their home equity to supplement their income sufficiently to afford private LTC insurance premiums. Why is home equity so rarely used to fund long-term care? The median sale price of homes in the United States as of July 2011 was $244,000.[3] Medicaid's home equity exemption is at least $525,000, more than double the value of the median home. There is little wonder why few people tap the equity in their home to fund long-term care or to purchase LTC insurance when Medicaid financing is so easy to obtain and estate recovery is so simple to avoid.

On top of these reasons, reverse mortgage interviewees consulted during studies reported at www.centerltc.com stated that the product is heavily regulated in many regards, requires extensive outside counseling prior to closing, and receives a great deal of negative publicity, much of which is inaccurate and unfair. So, the interviewees explained, education of consumers, suitability of marketing, and fair evaluation of products are keys to the widest and most appropriate use of reverse mortgages for any purpose, including long-term care financing.

**Private Long-Term Care Insurance**

Private long-term care insurance is another potentially large funding source that could relieve Medicaid. Responsible people mitigate potentially catastrophic financial risks with private insurance. Most Americans have auto and health insurance; many own life insurance; but relatively few have long-term care insurance. Roughly 7.3 million LTC insurance policies were in force as of 2009, up 2.8% from 2008. Premiums earned by LTC insurance carriers were $137 billion in 2009, up 9.6% from 2008 and claims incurred were $55 billion in 2009, up 12% from 2008. That may sound impressive until you realize the USA already has nearly 100 million people age 50, the prime market for long-term care insurance.

Why isn't private long-term care insurance more commonly purchased? The usual reasons cited for the low rate of purchase are consumers' irrational denial of the risk and the product's unaffordability. But the risk and cost of long-term care are extremely high and well documented. The cost of LTC insurance is high but the cost of the risk being insured is much higher still. If every tenth house burned down, fire insurance would not be inexpensive either. So, the key question is: how can consumers remain in denial about such a huge risk and cost? What is the real reason most people do not purchase private long-term care insurance?

Published, peer-reviewed research confirms that between two-thirds and 90 percent of the private long-term care insurance market is crowded out by the availability of Medicaid-financed long-term care.[4] People don't fail to purchase private long-term care exclusively, or even mostly, because of denial or cost. Rather, they don't buy it because they don't think they need it and they don't think they need it because Medicaid has paid for most expensive long-term care since the program's inception in the 1960s. In fact,

the easy availability of Medicaid services after the insurable event occurs has enabled the public's denial of LTC risk and cost.

**LTC Partnerships, The CLASS Act and Tax Deductibility**

Over the years, policy makers have tried many ways to encourage more private LTC insurance. LTC Partnerships, created in the 1980s and reinvigorated by the Deficit Reduction Act of 2005, were designed to encourage the purchase of special LTC insurance policies by forgiving Medicaid spend-down requirements. Buy a certain amount of private coverage, say $100,000, and if you use it up, you can qualify for Medicaid while retaining $102,000 instead of the $2,000 limit otherwise. The Partnerships were less successful than hoped because, as Briefing Papers #2 and #3 in this series explained, Medicaid spend down requirements are lenient at best, easy to avoid, and would occur, if at all, many years after most people consider purchasing LTC insurance. The prospect of ending up in a Medicaid nursing home after consuming private insurance benefits in home care or assisted living also discouraged coordinating benefits between private insurance and public welfare.

The CLASS Act, passed in March 2010 as part of health reform, aspired to create a voluntary LTC funding system aimed primarily at the working disabled. Because of its lack of medical underwriting, unlimited lifetime benefits, expected adverse selection whereby good risks would avoid the program, and likely resultant rapid insolvency, the Obama Administration shelved the program in October 2011.

Roughly half the states have tried to encourage the purchase of private LTC insurance by means of tax incentives. Tax deductions or tax credits do increase the likelihood that people will purchase LTC insurance. Some analysts have argued, however, that people who purchase LTC insurance because of tax incentives are likely to be wealthy enough that they would not qualify for Medicaid anyway, so that tax incentives are unlikely to reduce Medicaid expenditures. The fallacy in such an analysis is that Medicaid LTC eligibility does not exclude higher income people with substantial wealth from the program because of the generous income and asset eligibility limits described in Briefing Paper #2 and because of Medicaid planning opportunities described in Briefing Paper #3.

## Conclusion

Easy access to Medicaid-financed long-term care after the insurable event has occurred results in Medicaid, an ostensibly means-tested public assistance program, paying for most expensive LTC in the United States. Consequently, most Americans do not worry about LTC until they need it because of a chronic long-term illness such as Alzheimers, Parkinson's or stroke. At that point, private insurance is unavailable; personal income and assets are at risk; but Medicaid protects most assets including seniors' biggest resource, home equity. In this way, perverse incentives in well-intentioned public policy discourage responsible LTC planning, overwhelm Medicaid's scarce resources, and severely limit care access and quality for the poor while subsidizing access and quality for the affluent who have "key money" to pay privately and gain access to the best LTC facilities. The whole system is now at risk of collapsing to the detriment of everyone.

## End Notes

[1] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, "Medicaid Estate Recovery Collections," Policy Brief No. 6, September 2005, http://aspe.hhs.gov/daltcp/Reports/estreccol.pdf.
[2] CANHR, "Your Home and Medi-Cal," last modified December 30, 2008, retrieved October 6, 2010; http://www.canhr.org/factsheets/medi-cal_fs/html/fs_medcal_your_home.htm.
[3] RealEstateABC.com, last updated October 2, 2011, information extracted October 25, 2011; http://www.realestateabc.com/outlook/overall.htm.
[4] For example: "We examine the interaction of the public Medicaid program with the private market for long-term care insurance and estimate that Medicaid can explain the lack of private insurance purchases for at least two-thirds and as much as 90 percent of the wealth distribution, even if comprehensive, actuarially fair private policies were available." (Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," National Bureau of Economic Research, December 2004, cited from the paper's abstract; http://www.nber.org/~afinkels/papers/Brown_Finkelstein_Medicaid_Dec_04.pdf.)