

Alternatives to Medicaid Financing for Long-Term Care

2005

Table of Contents

I.. Committee	3
II. Preface	4
III. Executive Summary	5-6
IV. Narrative	7
A. Redirecting Resources	
1. Long-Term Care Insurance	7
2. Partnerships	9
3. Annuities and Long-Term Care	10
4. Life Insurance with Long-Term Care Provision	12
5. Offerings through Employment and Unions	12
6. Reverse Mortgage or Home Equity Conversion	13
B. Enhancing Estate Recovery Program	15
V. Recommendation	18
VI. Bibliography	20
VII. Appendix	
A. Senate Memorial Bill 35 (2005)	21
B. Ronald Lucchino Biography	23

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PREFACE

Like most states, New Mexico faces a severe budget challenge driven in large part by Medicaid, especially long-term care costs for the older adult. New Mexico has a large population of needy citizens of all ages for whom Medicaid is a critical safety net. Although the state maintains a relatively tight Medicaid long-term care residential and community services eligibility, federal rules prevent targeting benefits only to the poor. This allows middle and upper-middle class people to qualify for Medicaid funds without spending down due to the use of Miller income trusts for higher income citizens and exemptions for homes and other assets. The state needs to preserve Medicaid for those whom it was intended by encouraging its citizens to utilize, where appropriate, their financial resources for their long-term care costs before relying on Medicaid.

In 2005 Senate Memorial Bill 35 (see appendix) was introduced into the 47th Legislative session to study the financial impact of long term care (community and residential care) on the Medicaid budget and identify alternative models of funding such care. Unfortunately, time ran out and the full Senate never considered the Bill on the last day of the session. Although the Memorial was not enacted, requesting individuals from the public and private sectors formed an ad hoc task force to comply with the spirit of Memorial Bill 35 with recognized expertise on alternative models for Medicaid funding to contribute to the contents of this document. Contribution to the content does not imply endorsement of the recommendations.

This intent of this report is to encourage the New Mexico legislature to: a) consider other options to Medicaid funding of long-term care and b) encourage New Mexico citizens with the financial resources to utilize these options prior to their relying on Medicaid. This is done by:

- **Providing information on the advantages and disadvantages of the various financial programs that may be used as alternatives to Medicaid support of long-term care cost, and**
- **Making recommendations for legislative action needed to encourage the utilization of these financial programs.**

Please note, this report does not endorse any particular financial program.

EXECUTIVE SUMMARY

Medicaid was established in 1965 with the aim of providing medical health care for the poor and to assist those with few resources and incomes too low to cover needed health services. Today, Medicaid expenditures exceed the cost of Medicare and will continue to explode. If Medicaid entitlement programs are under-funded today, in the future, the demand for long-term care, driven by longer life expectancy and the oncoming wave of Baby Boomers, will exhaust the program. Today 13% of the population is age 60 and over, by 2030 it will increase to 20%. By 2030, New Mexico will rank fourth in percentage over age 60 (Albuquerque Journal, April 22, 2005). Steps need to be taken to insure that Medicaid provides support to those the program was intended to serve. There are three approaches to insure adequate funding of Medicaid:

- Provide full funding of Medicaid (state and federal)
- Make Medicaid a pre-funded program such as Social Security and Medicare, and,
- Encourage the utilization of resources to fund long-term care before relying on Medicaid.

This report will focus on the utilization of resources to fund long-term care cost.

Presently approximately 75% of Medicaid recipients are poor adults (mostly women) and children. But this group accounts for only about one-third of Medicaid's costs. The remaining 25% of Medicaid recipients are aged, blind or disabled, and they account for two-thirds of the program's costs (Ellen O'Brien, 2005). The main cost driver for this latter group is long-term care for the elderly (age 65 and over). One reason contributing to this high cost is that Medicaid, in part, has become long-term care insurance for the middle social economic class (Stephen Moses, 2005).

Medicaid was never intended to be "long-term care insurance for the middle class" as it has become. As long as it remains "inheritance insurance" for the baby boom generation, Medicaid will continue to fail in its first responsibility—to provide a long-term care safety net for the disadvantaged (Stephen Moses, 2005). This will be exacerbated as the Baby Boomers begin to age beyond 65.

CMS (Center for Medicaid and Medicare Services) noted that the Medicaid program will only be sustainable if its resources are not drained to provide health care assistance to those with substantial ability to contribute to the costs of their own care (Stephen Moses, 2005).

A shift in the Medicaid funding paradigm is needed to encourage individuals who have the financial resources to take personal responsibility for their long-term care (National Governors Association (NGA, 2005). The NGA recommendations to promote such a shift are:

- Strengthen asset transfer rules;
- Use incentives and education to increase public awareness to use "alterative financing" to offset long-term Medicaid costs;
- Increase cost sharing for beneficiaries with annual incomes above the federal poverty level;
- Streamline the Medicaid waiver application process for states;
- Allow states to offer different benefit packages depending upon beneficiaries' health; and

- Pro-actively position states to immediately implement the federal Long-term Care Insurance Partnership programs once the federal government removes the restriction prohibiting the states from implementing the program.

This paradigm shift recommended for New Mexico is not directed at our current older adult population, but intended for those age 60 and younger. The well-publicized aging of the Baby Boomer generation threatens to place considerable stress on our state's long-term care system, specifically, the publicly financed Medicaid program. The state must fortify itself on impending need for long-term care services by ensuring that citizens who have the means to finance a portion or all of their long-term care services also possess the tools to do so. It will take time and education to bring about this change.

Nationally and locally, it has become recognized that changes must occur in the current Medicaid funding paradigm to: a) keep Medicaid solvent and reduce the cost burden to states; and, b) insure adequate funds are available to assist those with few resources and limited incomes by either pre-funding Medicaid, fully funding Medicaid, utilization of ones resources prior to accessing Medicaid, or posthumous financing through estate recovery. Pre-funding and fully funding Medicaid are the purview of the federal government and are not being considered. Therefore changes in the funding paradigm must focus on how to:

- A. Re-direct personal assets in estate planning to support long-term care, and
- B. Enhance estate asset recovery programs as a disincentive to asset transfer.

Our state should consider embarking on a new mission that is proactive by encouraging those who are soon-to-age or at risk for disability to focus on preparations for their needs. This preparation includes the state's critical involvement in identifying, characterizing, and educating the citizenry about the various private financing models available in the marketplace. Perhaps, most importantly, the individual autonomy promoted by private financing mechanisms is the ultimate expression of self-direction.

NARRATIVE

A. Re-directing personal assets with Estate Planning (Private Financing Options for Long-Term Care)

The transfer of assets varies with the level of assets held and demographic characteristics, such as the level of disability, marital status, and gender. Approximately 6 million, or about 22 percent, of all elderly households reported transferring cash during the last 2 years. Elderly (age 65 and over) households with higher asset levels were more likely to have transferred cash than households with lower asset levels.

Almost all of these cash transfers were made to children or stepchildren. Of the elderly households that transferred cash, the median income was \$37,000. The amount of cash transferred ranged from \$0 to \$725,600; median non-housing resources were \$128,000 and ranged from less than \$0 to \$12,535,000 (www.gao.gov/new.items/d05968.pdf).

This mind-set in asset transfer, as the main focus for estate planning must be re-directed to encourage individuals who have the financial ability to use these resources to pay for long-term care expenses.

Nationally, several options have gained prominence as viable methods for alternative financing for long-term care. They include:

1. Long-Term Care Insurance
2. State “Partnerships” for long-term care insurance
3. Annuities
4. Life Insurance with long-term care provisions
5. Long-Term Care Insurance offered through employment or unions
6. Reverse mortgages

Individually, none of these solutions represent a “cure-all” for the financing needs of New Mexicans; but taken collectively, these options can be matched to the needs and preferences of the growing Baby Boomer population, who are current residents of New Mexico or who will retire to our state.

The following sections provide a further description of these options including a short sketch of the intended audiences and the advantages and disadvantages of each.

1. Long-Term Care Insurance

Description: Similar to health insurance, long-term care insurance enables consumers to plan for costs in a manner that limits exposure to out-of-pocket expenses while meeting preferences for self-financing. The long-term care insurance policies can provide for a range of services, including nursing home benefits, assisted living, home and community-based care such as home health aides, personal assistance, and case management. The annual premium required by a policy will vary widely based on benefit selection(s) as well as age at the time of purchase.

Consumers who chose long-term insurance have two options: a non-forfeiture benefit policy (if default on premium, do not lose what was paid in) or a forfeiture policy (if default on premium all paid in lost), which is less expensive. In choosing the latter consumers should be sure the coverage does not lapse because the premium will be lost. The most important reason to purchase Long-term Care insurance is to maintain independence and control: i.e., to be able to purchase quality care in nursing home care. Asset protection is a secondary benefit of LTC insurance.

Since 1992, there has been a 300% increase in long-term care policies. Currently 9 million long-term care policies are in force. As result of the Health Insurance Portability and Accountability Act of 1996, (HIPAA), to reform healthcare those policies, that qualify, receive a federal tax exemption and several states have additional tax incentives. New Mexico does have tax credit for LTC insurance. National studies show market penetration in New Mexico is 1-5 percent over the age of 50, ranking New Mexico at the bottom quarter of states (www.ahip.org). Arizona and Colorado have market penetrations between 6-9 percent and Iowa and Nebraska more than 15 percent.

Target Groups: Consumers whose annual income is more than \$35,000 or if premiums account for less than seven percent of annual income. Traditionally, long-term care insurance was meant for those who possess the means to self-insure long-term care, but choose not to do so.

Advantages: Long-term care insurance provides the purchaser with the ability to plan against catastrophic costs associated with extended aging-related illnesses. If not planned for, these costs may threaten assets, resulting in lost inheritances for family members or impoverishment. Long-term care insurance yields considerable choice in designing plan benefits as well as in accessing those services once the benefits are triggered.

Long-term care insurance is sold either as an individual policy or through an employer-sponsored model, similar to traditional health insurance.

Individual policies

The majority of policies are individual. The average age at time of purchase of an individual policy is 60, with an individual policies, the policyholder is protected by a contract with carrier, enforceable in court of law. The premium is 100% tax deductible to C-Corporation owners and scheduled according to the IRS medical expense deduction rules for S-Corporation owners, Partners, and Sole Proprietors.

Employer sponsored policies

Employer-sponsored policies are becoming increasingly popular. The average age at time of purchase for employer-sponsored policies is 45. Annual premiums are considerably cheaper at younger ages and with the additional funds over time from such a policy helps reduce premium costs for older applicants. Policies offered through the workplace are usually reviewed by the human resource department, provide objective policy recommendations and reduce the confusion from an array of different policies. Many times the policy is portable if the employee leaves their place of employment.

Disadvantages: The long-term care insurance market is very confusing due to an array of policy options. Picking the right one is fraught with many uncertainties. Policy standardization is occurring as more insurers offer policies that conform to standards regarded as “qualified”

according to HIPAA. Long-term care insurance is not a comprehensive solution for the entire population. The disabled cannot purchase long-term care insurance nor is long-term care insurance recommended for lower income households. Long-term care policies may experience significant increases in annual premiums making premiums unaffordable and cause significant policy lapses (currently less than 10%) for those with no non-forfeiture benefits.

2. State “Partnership” Policies for Long-Term Care Insurance

Description: The Partnership program is currently authorized in only four states (NY, CA, CT, IN). There is pending federal legislation to open this program to all states. The “Partnership” is the collaboration between long-term care insurance providers and state regulators to craft policy guidelines that provide increased consumer protection and standardization in long-term care insurance policies: inflation protection, non-forfeiture benefits, case management, home and community-based services and a standard “benefits trigger”.

The uniqueness of a Partnership policy combines traditional long-term care insurance with access to Medicaid benefits once these Partnership policy benefits expire, providing asset protection by waiving the traditional “spend-down” requirements. The amount of asset protection depends which of two public policies is available:

- 1) Dollar-for-dollar (currently in 3 of the 4 approved states). For each dollar of policy value, a dollar of assets was protected (and exempted from posthumous asset recovery efforts)
- 2) Total asset protection (New York State). The purchase of a Partnership policy enabled a purchaser to protect all assets, with no “spend-down” required prior to Medicaid eligibility. Total asset policies typically require 3 years of nursing home benefits or 6 years of home and community care benefits or some combination of the two.

The “Partnership” program began as a demonstration project sponsored by the Robert Wood Johnson Foundation. Four states: New York, Indiana, Connecticut and California implemented Partnership programs in the early 1990s.

- New York - 47,439 policies, Aug 2005 (www.nyspltc.org/sales.html)
- Indiana - 34,969 policies, March 2005 (www.in.gov/fssa/iltcp/quarter_404_report.html)
- Connecticut – 46,000, 2005(www.opm.state.ct.us/pd4/ltc/consume/consumer.htm#general)
- California – 96,774, June 2005 (www.dhl.ca.gov/cpltc)

Provisions in the Omnibus Budget Reconciliation Act (OBRA) of 1993 precluded additional states from offering partnership policy asset protection when accessing Medicaid services. Lobbying efforts, including support from the National Governors Association, National Association of Health Underwriters and the National Council of Insurance Legislators, are underway to jumpstart the partnership program. Recently, Senator Grassley (R-IA) introduced Senate Bill 1602 which would amend OBRA, 1993, to enable the Partnership model to expand. Currently, 8 states have passed partnership-enabling legislation in anticipation of the removal of Federal restrictions. New Mexico’s 2005 legislature introduced Senate Memorial 35 (see Appendix A), to study financing options. Unfortunately, the Senate memorial did not pass due to time constraints.

Target Audience: The “Partnership” program offers the opportunity of expanding the long-term care insurance market to include lower-wealth individuals by providing affordable and flexible policies to consumers who may not be able to afford traditional long-term care insurance. The Partnership program intent is to delay, and potentially eliminate, total reliance on Medicaid by enabling those who can afford to purchase long-term care insurance to initially pay for their long-term care needs.

Advantages: The Partnership program encourages individuals not to spend through their personal resources and become dependent on Medicaid but to finance their long-term care needs from a flexible menu of state-endorsed policies. This program should at least yield Medicaid cost neutrality but most likely produce costs-savings. Three of the four current Partnership states offer one-year policies, which are more affordable than the traditional three year long-term care insurance policies. An important incentive for the purchase of Partnership policies is the ability to protect assets while accessing the Medicaid program.

One major advantage of the Partnership program is improved collaboration and communication between the insurer community and state regulators.

Disadvantages: The Partnership programs in the original four demonstration states are not mature enough to conclusively document Medicaid cost-savings. The Partnership’s ability to reach farther down to lower-wealth individuals is not guaranteed and is predicated on program design and the program’s relation with the insurer community, specifically sales agents. A considerable gap in service type may exist as a purchaser transitions from long-term care benefits to Medicaid benefits. For example, a beneficiary may be using home care benefits via the Partnership policy, but similar services may not be available via Medicaid once Partnership benefits expire.

3. Annuities

Description: The basic annuity concept is simple. An individual, who has a large sum of money, but wants continuing income, transfers the funds to a commercial issuer (usually an insurance company) or a private person. The annuity issuer promises to provide a continuing stream of income payments. The payments can be promised for life, the joint lives of 2 people, a specific number of years, or a number of years with refund provisions if the annuitant dies before the term ends. The more payments made to an individual, the smaller each individual payment.

The basic concept supports many annuity variations:

- Is the first annuity payment immediately or deferred?
- What determines the span over which the issuer will make payments to the owner? (10 years certain? 20 years certain? or over a lifetime?)
- Although many annuities are purchased with a single lump-sum payment, multiple premium annuities are possible.
- Is the rate of return set in advance, responding to interest rates (fixed annuity) or subject to change based on market forces (variable annuity)?
- How much control does the purchaser have over the investment of the account?

- Is a charge imposed for surrender of the annuity? A frequent provision is a “back-end” charge that starts out fairly high, but is reduced each year, and phases out after seven years.
- Is there an insurance element and, if so, what is the effective cost? Most annuities include a death benefit provision of some type. **Some annuities are now offering Long-term Care benefit provisions.**
- Who regulates it? Variable annuity products are considered securities, so the person selling them must have a securities license. Fixed annuity products are considered to be insurance if sold through life insurance companies, so the person selling them must have a life insurance license.
- Will the annuity be tax qualified, (i.e., IRA)?

Target Audience: Annuities are useful in elder care financial planning. A person whose judgment is somewhat impaired might be capable of administering each month’s income and paying bills, but incapable of managing large principal sums. Annuities offer financial management to those individuals with large sums of money, but who are medically uninsurable for a traditional long-term care policy. Annuities also offer a financial tool for young investors who are looking to diversify portfolios and place funds in safer investments that offer an income stream for retirement or healthcare needs at a later date.

Advantages: Entry into the annuity marketplace requires no medical underwriting. The products are available to all ages. Some annuities offer early withdrawal provisions for the sole purpose of long-term care needs. The early withdrawal provisions allow the annuitant to draw monthly income payments for the long-term care without early withdrawal penalties. The annuitant must provide proof of long-term care needs by a doctor’s recommendation that he/she cannot perform 2 activities of daily living (bathing, toilet use, eating, grooming, walking). Annuities can be purchased with long-term care insurance policies to guarantee that the premium on the long-term care insurance policy gets paid. The coordinated purchase of the two policies allows the annuitant to stipulate that the annuity income be paid to the long-term care insurance company and, therefore, a premium is never missed because of a billing error, a payment error, a bank account closing, or a change in power of attorney. Annuities are not considered to be tax qualified under HIPAA and the proceeds for long-term care needs may be determined as taxable at some point in time. As of this date they are not being taxed.

Disadvantages: Annuities are not typically marketed to the young, underfinanced marketplace. Annuity fees may be a disincentive for investors. Although the company issuing the annuity has the opportunity to benefit from investment funds, it also has expenses related to marketing and administering the annuity. Thus, fees of various kinds are imposed, depending on the annuity contract. The various fees reduce the amount that will eventually be available to the owner of the annuity (or heirs). Because financial planners tend not to bring annuities into the plan because the commissions are not as great as other investment opportunities, the consumer is not well educated on annuities and their potential for long-term care financial planning. A minimum of \$50,000 is required to gain any significant LTC benefit which may not be possible for many New Mexico residents

4. Life Insurance with Long-Term Care Provisions

Description: Life insurance plays a significant role in financial planning. Life insurance can create an “instant estate” in particular for younger individuals. Life insurance traditionally has been used to help pay for things like estate taxes, burial costs, debts of the insured, ongoing living expenses of the beneficiaries, and education costs for children of the insured. In more recent times, life insurance is also being issued with a rider known as “Accelerated Death Benefits”.

Accelerated Death Benefits, (ADB), may be made available on the basis of a diagnosis of terminal illness, or for either a terminal illness or chronic illness requiring long-term care. Nursing home, home health and adult day care are services that can be paid for with ADB life insurance. At the time of death, the life insurance proceeds that were not used for long-term care are paid to the designated beneficiary.

Target Audience: Anyone who buys life insurance should be educated about the use and add-on of the ADB rider.

Advantages: Life insurance is more universally known and purchased by all age groups. Life insurance has multiple purposes and one purchase could solve a myriad of financial planning situations. Life insurance underwriting concentrates on mortality not morbidity and is more easily issued on individuals who have minor illnesses and injuries. Life insurance with an ADB is also available to employer groups. Permanent life insurance policy premiums are guaranteed not to go up if the policy is set up correctly.

Disadvantages: Life insurance is more difficult to place on older ages because of the mortality tables and the health risks. Larger death benefits should be considered if the policy is to be used for long-term care and other personal life insurance needs. Older age prospects may not be able to afford the premium that it takes to purchase and keep the policy going.

5. Long-Term Care Insurance Through Employment or Unions

Description: Group Long-term Care Insurance (LTCi) is quickly becoming the “hottest” new benefit within the corporate scene. According to America’s Health Insurance Plans (AHIP), employer sponsored LTCi plans are growing at a rate of 32% per year. The National Council on Aging finds that seven out of ten employees want LTCi. And, by the year 2006, NCA estimates that 46% of all companies will be making this important benefit available to their employees.

The country’s 77 million Baby Boomers born between 1946 and 1964 now represent a quarter of the population. As they age, they’ll not only need LTCi for themselves and their spouses, but for their aging parents as well. When an employee takes time off to care for an elderly parent, this affects the workforce productivity.

As a benefit, LTCi is unique. It can be offered as a carve-out to a select group, such as the key executives. The flexibility of LTCi allows companies to pay premiums for some employees and offer the policy as a voluntary benefit for others. When it is offered as a voluntary group benefit,

the employees will be given the opportunity to take the policy with them if they leave the place of employment. Another unique feature is that LTCi benefits are tax-free benefits.

Employees can opt to take coverage on their spouses, parents, in-laws or other family members through the group LTCi benefits offered by the employer. Typically, the employee will be able to obtain the insurance without evidence of medical history (groups of 10+ employees); however, if the employee wishes to add a spouse, or parent or in-law to the plan, those individuals will need to qualify medically. The extended family members will have a much easier time getting group LTCi with their medical history than they would in the individual marketplace and the premiums are more reasonable.

Group Long-term Care Insurance is similar in design to the individual long-term care insurance and is tax qualified. NM has only one group long-term care insurance carrier in the marketplace and that is UNUM Insurance Company. UNUM has done a good job in designing the product to look like individual products with some limitations that make the policy affordable, but not uncompetitive with the individual market. Long-term care insurance can be a win-win benefit for both employers and employees that can provide for loved ones (including oneself) and help in employee retention and workplace production.

Target Audience: Employer groups with at least 15 eligible employees on the payroll. Minimum participation with UNUM is the greater of 15 employees or 10% of eligible employees.

Advantages:

- Reaching out to large population who needs the coverage rather than one at a time
- Reaching out to a younger age group
- Underwriting for the under age 65 employee is easier – no medical questions asked
- Pricing is very reasonable
- Policy is portable
- Policy can be extended to other immediate family members with medical underwriting
- Policy premiums can be run through a cafeteria plan option
- Benefits are not taxable
- Benefits are comprehensive and competitive with the individual products
- Rates can be guaranteed for up to 4 years for a specific policy type
- Premiums can be deducted off of payroll so that lapses are less likely

Disadvantages:

- Does not capture the very small employer groups (2-15 employees)
- Employer needs to be “sold” on the idea of offering another benefit for the employees
- Older employees will need to be medically underwritten and may be turned down
- To avoid cancellation, participation requirements must be maintained

6. Reverse Mortgages or Home Equity Conversion

Description: Reverse mortgages have emerged as a tool in making available the wealth of Americans’ most significant financial asset for financing long-term care, homes. Eighty-two percent of people over the age of 62 own homes and 74 percent of these own homes free and

clear. These older homeowners have nearly \$2 trillion in home equity, close to half of which could be unlocked to pay for long-term care by means of home equity conversion according to the National Council on Aging (Tatsha Robertson, Boston Globe, April 25, 2005).

Although the popular home equity loan can provide an up-front cash amount based on the home's equity, it does require the homeowner to repay this loan on a monthly basis. Seniors living on a fixed income are averse to taking a home equity loan for fear that they may default and lose the home.

The reverse mortgage works in the opposite direction. A portion of the home's appraised value is provided to the homeowner either as lump sum, credit line or monthly payment, depending on the type of a reverse mortgage. The loan is based solely upon complete homeownership; therefore, the borrower's income, medical history or credit are not determinants of loan eligibility or amount. In addition, no payment is made to the lender as long as one of the homeowners still lives in the home. If a spouse should move to a nursing home while another remains in residence, the loan is still in deferment. When the home is no longer occupied by the owners, the home can be bought back by the family or the loan is paid via sale proceeds. Lastly, as long as the homeowner purchases mortgage insurance, the owed amount can never exceed the appraised value of the home.

Target Audience: Families who own homes without debt with adequate equity. Unlike long-term care insurance and partnership policies, this vehicle is not dependent on health status. There are no restrictions on policy denial to disabilities.

Reverse mortgages can be used by over 13 million Americans to remain independent and in their homes longer while at risk of quickly spending down assets and needing Medicaid. In addition, there are some 9.8 million elder households (aged 62 and older) that are dealing with impairments that can make it hard to live at home. In total, these households could access as much as \$695 billion through reverse mortgages.
(<http://www.ncoa.org/content.cfm?sectionID=105&detail=834>).

In 2004, NCOA (National Council on Aging) reported that 31.6% of those at high risk in receiving Medicaid could be eligible for reverse mortgages. In addition, 45.3% of these high-risk individuals could be described as potentially spending down their assets, making them eligible. Eligibility is much higher for reverse mortgage than it is for long-term care insurance within the sphere of the age 65+ marketplace. It is unknown how many of those residing in nursing homes own their homes <http://www.ncoa.org/content.cfm?sectionID=105&detail=576>). In 1989, the GAO found that 14% of the nursing home population receiving Medicaid owned homes in 8 states <http://archive.gao.gov/dl5t6/138099/pdf>.

The use of reverse mortgage to pay for long-term care can alleviate financial pressure for state Medicaid programs and the federal government. Increasing the market for reverse mortgages could save Medicaid \$3.3 billion (with a four percent take up rate) annually by 2010
(<http://www.ncoa.org/content.cfm?sectionID=105&detail=834>).

¹ Homeowners must continue to pay property taxes and keep the house in proper physical condition so that the unit does not devalue.

Advantages: Those who qualify for reverse mortgages through the Home Equity Conversion Mortgage (HECM) program can quickly access funds to pay for long-term care needs. Individuals do not need to coordinate benefits through a long-term care insurance policy; rather, they can direct funds according to their preferences. In addition, reverse mortgages offer a variety of ways for drawing funds. This tool eliminates the risk of defaulting on loans and subsequently jeopardizing home ownership. Furthermore, the concept of using home value to provide critical services is quite familiar to the Baby Boomers who have frequently used home equity to fund education and larger purchases.

Reverse mortgages are broadly available. Many older Americans own homes “free and clear.” However, Medicaid exempts homes and all contiguous property regardless of value. This decreases the chance of individuals using reverse mortgages. Congress is working on legislation to include homes as assets.

Disadvantages: The HECM product, as well as others, has several requirements that reduce the applicant pool for this tool. For example, any underlying liens on the home must be removed, the home must be in “acceptable” condition according to an independent appraisal, and the borrower must continue to pay property taxes. These fees and obligations can be paid from the loan amount, but in addition to closing fees and service charges, additional costs can reduce the loan value to a level where it loses its appropriateness. The homeowner must continue to pay property tax and keep the house in proper physical condition so that the home does not devalue.

Consumers are less aware of reverse mortgages than long-term care insurance. Outreach regarding reverse mortgages will be needed for this vehicle to take root. Adding additional complexity to acceptance of this model is the dream the home holds for Americans. Although, this program guarantees the home cannot be taken away while program requirements are met, many may continue to believe otherwise. Other potential program applicants may be concerned about reverse mortgages jeopardizing the home’s inclusion in inheritances.

B. Enhancing State Assets Recovery Programs

Background

Estate recovery has received increasing prominence among both national and state policy-makers as a method to recouping costs of Medicaid services funded by the state from the estates of deceased recipients.

Asset transfer to qualify for Medicaid is only a small part of the Medicaid eligibility issue. Most people qualify for Medicaid nursing home eligibility without hiding their income or assets or without spending down significantly. Medicaid has no guidelines on income (if medical expenses are high enough) and no hard limit on assets (if they are held in exempt form).

Only people with assets, especially real property assets, are likely to transfer significant assets to qualify for Medicaid. They are most likely to transfer real estate, and are highly likely to make such transfers at least three years in advance of applying for Medicaid to avoid the “look-back” window.

The Omnibus Budget Reconciliation Act (OBRA) of 1993 required that states establish estate recovery programs which, at a minimum; recoup the costs of individuals' Medicaid benefits from probate estates.

Estate Recovery in New Mexico

New Mexico's program is based on OBRA 1993, and contains many features and definitions common to other states' recovery plans:

- Definition of estates subject to recovery is limited to assets that pass through probate and to Medicaid beneficiaries who were over the age of 55 at the time of receiving Medicaid services defined as nursing home care, home and community-based services, or prescription drugs;
- Basic administrative processes, including notification of new Medicaid beneficiaries of the potential for estate recovery as well as the posthumous notification to heirs of repayment obligations;
- Specifications for waiver of estate recovery efforts, including conditions for surviving spouses or dependent children, and if recovery efforts will cause surviving heirs to qualify for assistance programs (TANF or Medicaid) or conversely, if estate proceeds will enable an heir to leave assistance programs.

New Mexico reported zero probate recoveries to the federal government in 2002 and in 2004 reported \$28,200 probate recovery. Although New Mexico has not fully implemented the expanded definition of "estate" authorized by OBRA, '93, it is in the process of a policy change to be more aggressive. A perception that the state's estate recovery efforts are not widely enforced discourages the use of partnership's asset protection program. The problem is that the state of New Mexico is the last in line to receive any award from the estate.

National Trends

The recent emphasis on estate recovery efforts has spurred additional research on programs' design, implementation and outcomes. Programs have changed and expanded in response to heightened scrutiny by the federal government. The most comprehensive and comparative study on estate recovery programs was produced in June 2005 through a joint effort by the American Bar Association's Commission on Law and Aging and the American Association of Retired Persons'. There is some concern that the report grossly understates estate recoveries and underestimates potential recovery. Salient findings from this report are relevant to New Mexico's of its estate recovery regulations include:

- **Modest dollar amount of recovery:** For fiscal year 2003, 46 states with active programs collected a total of \$347.4 million, with a median amount of \$3,562,363. As a proportion of states' total long-term care Medicaid expenditures, recovery efforts ranged from 0.01% in Louisiana to 2.2% in Oregon with the mean of 0.57% for Medicaid expenditures collected. If every state recovery were 2.2% the national recoveries would be \$1.8 billion.
- Under current federal law it is easy to **transfer assets** before becoming eligible for Medicaid. Making it difficult for states to recover from estates. NM could

implement a high quality MER (Medicaid Expenditures Recovery) program like Oregon's and lobby for changes in federal law to unleash its potential for estate recovery. The data is based on an older population of 12%, but in 20 years the aging population will be close to 20%. The percentage of asset recovery will increase accordingly

- **Cost effectiveness:** Nine states recover over \$14 for every administrated dollar invested in the estate recovery program.
- **Operations:** A few states employ outside contractors to conduct estate recoveries and compensate these firms through a percentage of the dollar amount collected.
- **Program expansion:** States are expanding definitions of estate beyond probate to include annuities, trusts and life estates.

Additional Benefit: Changing Incentives?

Proponents feel that the stringent posthumous estate recovery of assets will offset Medicaid costs. and the aggressive expansion of an estate recovery program may be the incentive that individuals need to plan for long term care needs through home ownership, long term care insurance, annuities, and/or life insurance.

REQUEST FOR THE NM HEALTH POLICY COMMISSION TO LEAD A STUDY OF ALTERNATIVE MODELS TO MEDICAID IN FINANCING LONG-TERM CARE OF

It is the recommendation of the ad hoc task force to the Legislative Interim Health and Human Service Committee to submit a joint memorial to the 2006 NM Legislative session addressing alternative funding long-term care needs of the state's population.

We recommend that the following language be included in the joint memorial:

WHEREAS, the population of New Mexicans over the age of sixty-five is growing and will almost double by the year 2020; and

WHEREAS, due to medical advances, people are living longer, but not necessarily healthier, lives; and

WHEREAS, the population over the age of eighty-five is growing twice the rate of people over sixty-five, and these are the most frail of the elderly; and

WHEREAS, a large and growing number of aging people are suffering from the ravages of Alzheimer's disease and are unable to care for themselves; and

WHEREAS, the Medicaid program in New Mexico covers the cost of nursing home care and home- and community-based services for the elderly and disabled and provides in excess of two hundred twenty-one million dollars (\$221,000,000) in combined state and federal funding for these services; and

WHEREAS, the private cost of nursing home care is unaffordable for most people in need of nursing home care and therefore most families have come to rely on Medicaid to fund this level of care for their elderly relatives; and

WHEREAS, people are finding it relatively easy to qualify for Medicaid long-term care services, despite seemingly restrictive eligibility rules, and this relaxed access has resulted in an entitlement mentality regarding the financing of these services; and

WHEREAS, use of private, out-of-pocket and insurance financing of these long-term care services has languished while Medicaid costs have skyrocketed; and

WHEREAS, long-term care insurance, home equity conversion and other alternative mechanisms for private financing of long-term care services have been underutilized;

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE and HOUSE OF REPRESENTATIVES OF THE STATE OF NEW MEXICO that the NM Health Policy Commission lead a study based on the information in 2005 ad hoc committee report "Alternatives to Medicaid Financing for Long-Term Care" with the cooperation of the Human Services Department and the Aging and Long-term Services Department and any other appropriate statewide public or private organizations representing aging, long-term care services

and financing to study the financial impact of facility-based and home- and community-based care on the Medicaid budget and identify alternative models of financing such care; and

BE IT FURTHER RESOLVED that the study identify appropriate incentives to encourage self-care and the use of insurance, explore potential ways to limit asset identification and asset transfers and promote a study to maximum Medicaid estate recovery; explore the mechanisms to adopt the Federal Long-Term Care Partnership legislation when passed and identify any loopholes in that federal legislation that would have an adverse consequence to the state including but not limited to gaps in coverage when transitioning from private insurance to public financial aid, and explore tax incentives for businesses and individuals to purchase long-term care insurance, and

BE IT FURTHER RESOLVED that the NM Health Policy Commission support the efforts of a statewide organization representing the needs of people with Alzheimer's disease, and others as appropriate, to hold a conference exploring alternative models of financing long-term care services; and

BE IT FURTHER RESOLVED that the NM Department of Insurance support the development of funding alternatives for long-term care by maintaining a list of long-term care insurance policies that are federally qualified according to HIPAA which can be accessed by the NM public and by supporting broker education on long-term care insurance, and aiding in the development of a statewide database of employers who offer group long-term care insurance, and

BE IT FURTHER RESOLVED that the NM Health Policy Commission develop recommendations for education, incentives and implementation of alternative mechanisms for financing long-term care services and report its findings and recommendations to the interim legislative health and human services committee at the October, 2006, meeting; and

BE IT FURTHER RESOLVED that the NM Health Policy Commission provide copies of the report to appropriate public and private statewide organizations representing aging and long-term care; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the NM Health Policy Commission, the Aging and Long-term Services Department and the Human Services Department.

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APPENDIX A

47TH LEGISLATURE - STATE OF NEW MEXICO

INTRODUCED BY Dede Feldman

MEMORIAL Bill 35

REQUESTING THE AGING AND LONG-TERM SERVICES DEPARTMENT TO LEAD A STUDY ON THE FINANCIAL IMPACT OF FACILITY-BASED CARE ON THE MEDICAID BUDGET AND IDENTIFY ALTERNATIVE MODELS OF FINANCING SUCH CARE.

WHEREAS, the population of New Mexicans over the age of sixty-five is growing and will almost double by the year 2020; and

WHEREAS, due to medical advances, people are living longer, but not necessarily healthier, lives; and

WHEREAS, the population of people over the age of eighty five is growing twice as fast as that of people over sixty five, and these are the most frail of the elderly; and

WHEREAS, a large and growing number of aging people are suffering from the ravages of Alzheimer's disease and are unable to care for themselves; and

WHEREAS, the Medicaid program in New Mexico covers the cost of nursing home care and home- and community-based services for the elderly and disabled and provides in excess of two hundred twenty-one million dollars (\$221,000,000) in combined state and federal funding for these services; and

WHEREAS, the private cost of nursing home care is unaffordable for most people in need of nursing home care and therefore most families have come to rely on Medicaid to fund this level of care for their elderly relatives; and

WHEREAS, people are finding it relatively easy to qualify for Medicaid long-term care services, despite seemingly restrictive eligibility rules, and this relaxed access has resulted in an entitlement mentality regarding the financing of these services; and WHEREAS, use of private, out-of-pocket and insurance financing of these long-term care services has languished while Medicaid costs have skyrocketed; and

WHEREAS, long-term care insurance, home equity conversion and other alternative mechanisms for private financing of long-term care services have been little utilized;

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF THE STATE OF NEW MEXICO that the aging and long-term services department be requested to lead a study with the cooperation of the human services department and appropriate statewide organizations representing aging and long-term care services to study the financial impact of facility-based and home- and community based care on the Medicaid budget and identify alternative models of financing such care; and

BE IT FURTHER RESOLVED that this study identify appropriate incentives to encourage self-care and the use of insurance, explore potential ways to limit asset identification and asset transfers and promote maximum Medicaid estate recovery; and BE IT FURTHER RESOLVED that the aging and long-term services department support the efforts of a statewide organization

representing the needs of people with Alzheimer's disease, and others as appropriate, to hold a conference exploring alternative models of financing long-term care services; and

BE IT FURTHER RESOLVED that the aging and long-term services department develop recommendations on implementation of alternative mechanisms for financing long-term care services and report its findings and recommendations to the interim legislative health and human services committee at its October 2005 meeting; and

BE IT FURTHER RESOLVED that the aging and long-term services department and the human services department provide copies of the report to appropriate statewide organizations representing aging and long-term care; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the aging and long-term services department and the human services department

