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Pay for the Doc Fix by Fixing Medicaid LTC

by

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The "Doc Fix" Problem

The sustainable growth rate (SGR) formula the government uses to pay physicians is set to slice nearly 30% off the doctors' Medicare reimbursement rates on January 1, 2012. Almost everyone agrees that can't be allowed to happen. But no one knows how to pay for avoiding it. The "Doc Fix" is estimated to cost \$30 billion per year, \$300 billion over ten years, and \$500 billion soon if nothing is done.

In the meantime, Medicaid long-term care is fraught with virtually boundless waste, fraud and abuse, as Cato's Michael Cannon has documented.¹ Recent exposés by video-muckraker James O'Keefe dramatize the problem.² All it would take to save most of the cost of the "Doc Fix" is to think clearly about Medicaid LTC and reform it. In other words, "Pay for the Doc Fix by Fixing Medicaid LTC." Here's how.

A Foundation in Facts

- Medicaid expenditures today are huge (\$366.5 billion for 2009)³ and growing rapidly (up 7.9% for 2010 and up 11.2% for 2011, estimated).⁴
- Medicaid is the biggest item in state budgets (22% on average), exceeding elementary and secondary education combined.⁵
- Long-term care (LTC) accounts for 22.0% to 63.7% of total Medicaid expenditures in the states, 33.3% on average.⁶
- Medicaid-financed nursing home care totaled \$45.0 billion and home care, \$24.3 billion in 2009.⁷
- Medicaid LTC recipients consume a disproportionate share of total program expenditures. For example, consider people eligible for Medicaid AND Medicare.
- Such "dual eligibles" account for 39% of Medicaid spending (\$142.9 billion for 2009), although they comprise only 15% of Medicaid recipients.⁸

- Dual eligibles are heavy users of long-term care (LTC is 70% of their Medicaid expenditures) and acute care services not covered by Medicare (5%). Medicaid pays for their Medicare premiums (9%) and cost-sharing (15%) too.⁹
- The aged, blind and disabled--also heavy users of LTC--are 1/4 of Medicaid recipients (25.3%) but account for 2/3 of program costs (67.1%), whereas poor women and children are 3/4 of the recipients (74.7%) but account for only 1/3 of the cost (32.4%).¹⁰

Key Points

- The heaviest users of Medicaid's most expensive benefit (LTC)--dual eligibles and the aged, blind and disabled (ABD)--consume a disproportionate share of Medicaid's total resources.¹¹
- Therefore, every actual or potential dual eligible, ABD or LTC recipient diverted from Medicaid dependency will result in a disproportionate savings to the Medicaid program.
- Conclusion: prevent Medicaid dependency for even a small number of these heavy LTC users, and the savings will be extraordinarily high.

Queries

- Aren't dual eligibles, the aged, blind and disabled, and heavy LTC users the poorest of the poor?
- Isn't Medicaid their safety net which protects them only after catastrophic spend down has devastated their life's savings and driven them into financial destitution?
- How can you possibly hope to divert such people from Medicaid dependency without destroying their lives and the lives of their spouses and dependants?

Examine Your Premises

- Are people on Medicaid necessarily poor? Only if they need acute or preventive medical care. Not if they're aged, blind or disabled and eligible because they need long-term care.
- Income is rarely an obstacle to Medicaid eligibility for people who require LTC. If they have too little income to pay all their medical expenses, including nursing home care, they're eligible.¹²
- In other words, you don't need to have low income to qualify for Medicaid long-term care benefits. All you need is a cash flow problem after you pay all your medical and LTC bills.
- Medicaid limits non-exempt assets for LTC recipients to \$2,000. But, exempt assets are practically unlimited.
- For example, a home and all contiguous property up to \$500,000 plus a business including the capital and cash flow, one automobile, prepaid burial plans, term life insurance, personal belongings and other resources are excluded without limit from eligibility asset caps.
- Married couples are assured of even higher income and asset protections, including up to \$2,739 of monthly income and up to \$109,560 of assets for the community spouse as of 2011.¹³

- On top of these already generous income and asset limits, Medicaid planners use both simple and sophisticated techniques to protect additional hundreds of thousands of dollars for affluent clients and their heirs.
- Such techniques include gifting strategies, annuities, trusts, life care contracts and dozens of others delineated in hundreds of law journal and popular media articles and books.
- Google "Medicaid estate planning" to find thousands of methods and purveyors of self-impoverishment to qualify for Medicaid.
- Similar techniques allow people with substantial income and assets to avoid Medicaid's estate recovery requirements, which in any case, are rarely enforced effectively by the states.

Bottom Line

- Medicaid is not primarily a long-term care safety net for people who have spent down into impoverishment.
- Rather, Medicaid is the principal payor of long-term care for nearly everyone.
- Medicaid pays less than one-third of the dollars for nursing home care (32.8%),¹⁴ but covers nearly 2/3 of nursing home residents (64%)¹⁵ and touches over 80% of all nursing home patient days with its extremely low, quality-destroying reimbursement rates.¹⁶
- Out-of-pocket expenditures for nursing home care are down from 49.5% in 1970 to 29.1% in 2009.¹⁷
- Nearly half of these already low out-of-pocket costs actually come from the Social Security income of people already on Medicaid, not from asset spend down.¹⁸
- When you back out all nursing home costs paid by Medicaid, Medicare, private health insurance, Social Security and other personal income spend-through by Medicaid recipients, individuals' and families' assets are at risk for less than one dollar in six of nursing home costs.¹⁹
- Home care is even less a private burden. Only 8.8% of \$68.3 billion home health care costs in 2009 were paid out of pocket. Medicare (43.6%) and Medicaid (35.6%) paid 79.2% of the total and private insurance paid 7.3%.²⁰

Building on These Facts

- How can we take advantage of the fact that Medicaid LTC does not require impoverishment to improve the program, reduce its cost and generate substantial savings?
- First ask: what is the single biggest asset Medicaid protects from long-term care costs?
- Answer: the home. Medicaid exempts the home and all contiguous property up to an equity value of at least \$500,000 and up to \$750,000 in some states, *e.g.* NY, CA, ID.²¹
- What do we know about senior's home equity? Roughly 81% of seniors own their homes; 65% of these senior homeowners own their homes free and clear.²²
- Altogether, seniors own nearly two trillion dollars worth of home equity.²³
- This home equity wealth is currently illiquid, largely untapped for long-term care costs, mostly exempted from Medicaid eligibility limits, and usually avoids Medicaid estate recovery.

- There are ways to liquefy this wealth and put it to use financing quality long-term care for frail and chronically ill seniors. For example . . .
- Reverse mortgages are private financial products that allow people to convert illiquid home equity into usable income or assets which they can use in any way they see fit AND still remain in their homes as long as they are able.²⁴
- According to the National Council on the Aging (NCOA), 48% of America's 13.2 million households age 62 and older could get \$72,128 on average from reverse mortgages. "In total, an estimated \$953 billion could be available from reverse mortgages for immediate long-term care needs and to promote aging in place."²⁵
- Yet, reverse mortgages are rarely used to finance long-term care today. Why?
- Simple: Because Medicaid LTC financing co-opts the market for reverse mortgages by paying for most formal long-term care for most Americans, exempting most home equity, and thus obviating the need to tap home equity for long-term care.

The Solution

- To save Medicaid billions of dollars every year and improve the program, replace the home equity exemption with a requirement that people consume their home equity with a reverse mortgage before they become eligible for Medicaid LTC benefits.
- How much could this save?
- Medicaid spent \$142.9 billion on 8.9 million dual eligibles in 2009 or \$16,056 per dually eligible recipient.²⁶
- To save \$30 billion per year, Medicaid would only need to reduce the number of dual eligibles by 1,868,460 or 21%.²⁷
- Is that feasible?
- Yes, because as NCOA reports, half of households headed by people over 62 could get over \$70,000 each from a reverse mortgage.
- That much money added to other income and assets and used for long-term care, especially private home and community-based services, could delay or prevent Medicaid eligibility for millions of Americans.
- The savings to Medicaid would easily exceed \$30,000,000,000 per year in combined state and federal expenditures, probably much more.
- Over time, Medicaid savings will increase rapidly beyond these initial estimates as more and more people plan ahead to pay their own LTC expenses by means of home equity conversion and private long-term care insurance, a product whose market will expand if and when it becomes needed to protect home equity from LTC expenses.

Poking Holes

- If this is such a great idea, **why don't people already use reverse mortgages for long-term care expenses?** Why would they when Medicaid exempts the home and all contiguous property regardless of value and estate recovery is easy to avoid? Put home equity at risk and consumers will take long-term care seriously, plan for it, and save, invest or insure against the risk. Consequently, many fewer will end up as dual eligibles.

- **How does requiring people to use their home equity improve Medicaid?** With fewer people to serve, Medicaid will have more resources to help those who are genuinely in need. Medicaid will require fewer eligibility workers and estate recovery staff, thus reducing administrative costs. Part of the Medicaid savings can be applied to increasing reimbursement rates and expanding the continuum of services provided, thus improving access to and quality of care. Finally, the jobs created in the financial services industry (reverse mortgage lenders) and the insurance industry (LTC insurance agents) will generate new tax revenues to help states and the federal government support Medicaid.
- **Wouldn't reverse mortgages impoverish spouses of Medicaid recipients and leave them dependent on public assistance?** No, just the opposite. Reverse mortgages provide extra income indefinitely. They are fully insured by the federal government so that families retain the income and the use of the home until they move, sell or die even if the home equity is entirely consumed.
- **Doesn't this take away a sacred right people have to pass their homes to heirs?** No, Congress made it clear over 20 years ago "that all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children will be used to defray the cost of supporting the individual in the institution."²⁸ That was the justification for estate recovery, which has not worked well because it is punitive, after the fact, and politically sensitive. Reverse mortgages as a pre-condition of eligibility would achieve the same objective far more efficiently.
- **Long-term care providers, including nursing homes, assisted living facilities, and home care agencies, would lose Medicaid patients, wouldn't they?** Yes, and they'll be thrilled to replace Medicaid recipients, whose reimbursement is often less than the cost of providing their care, with private patients who pay a sustainable market rate for access to the top quality care they demand and receive as paying customers. Furthermore, the influx of new revenue will improve access and quality for all long-term care patients, private pay and Medicaid.
- **Won't baby boomer heirs, who are counting on inheritances protected by Medicaid, scream bloody murder?** Probably, but why should Medicaid, which was intended as a safety net for the poor, be inheritance insurance for middle-class boomers anyway? Boomers are exactly the generation we need to awaken to long-term care risk and to their need to insure against it. For nearly 50 years, Medicaid has done exactly the opposite. It has anesthetized boomers to the risk by paying for their parents' long-term care. We worry about the unfunded liabilities of Social Security and Medicare, but at least those programs have putative "trust funds." Medicaid is a dead-weight drag on state and federal general funds. Medicaid has nowhere to turn as the demographic tsunami hits.
- **How would you prevent people from gaming this rule the same way they use Medicaid planning to circumvent the current system?** Most people who transfer assets to qualify for Medicaid do it after they have a long-term care crisis or when they (or usually their heirs) anticipate such a crisis coming soon. By that time, they don't qualify medically or cannot afford private LTC insurance, so they turn to Medicaid by hook or by crook. Confront them with a real Medicaid spend down liability while they are still young, healthy and affluent enough to insure privately and most people will do so. Unlike transfers of liquid assets or negotiable securities, real property transfers are publicly recorded and easily discovered. It would be simple to hold people accountable

who give away large amounts of home equity any time before applying for Medicaid, even a decade or more. The asset transfer look back period for real property should be at least ten years, instead of five as now.

- **This is a political non-starter because Medicaid is a "third rail" like Social Security and Medicare.** Nonsense. We are quickly approaching the time when failure to confront exploding Medicaid costs will exceed the political risk of confronting them honestly. How will politicians justify cutting dental benefits for poor children or slashing higher education or letting roads go unrepaired just so prosperous seniors can pass their wealth to affluent heirs at the expense of ever-skyrocketing Medicaid long-term care costs?
- **Do enough people currently receiving Medicaid LTC benefits own their homes to achieve such big savings immediately?** No, probably no more than 15% to 20% of people already receiving Medicaid still own their homes. Besides, policy makers would probably want to grandfather in current recipients under the status quo. The major savings will come over a period of three years as the Medicaid long-term care population turns over and fewer new recipients qualify until after they spend down their home equity with a reverse mortgage. The big question here is: what happens now to the homes owned by 81% of seniors by the time they qualify for Medicaid and most of them no longer own their homes? Are the homes being transferred to heirs? Are they being sold and the money used somehow? How? Evidently not for long-term care as the data explained above shows. Research is needed to answer these questions.

Summary

- Medicaid is supposed to be America's long-term care safety net for the poor. Instead, it is the principal LTC payor for nearly everyone.
- Medicaid's LTC benefit has become "inheritance insurance" for baby boomers, lulling them into a false sense of security regarding their own future long-term care needs.
- Medicaid's generous LTC eligibility and elastic income and asset limits create perverse incentives that invite abuse and discourage responsible long-term care planning.
- The conventional wisdom that most people must spend down their life savings before they qualify for Medicaid long-term care benefits is a myth, demonstrably false.
- If people's biggest asset, their home equity, were at risk to pay for long-term care, most people would plan early to save, invest and insure against that risk.
- Reverse mortgages permit people to withdraw supplemental income or assets from their otherwise illiquid home equity without giving up use of the home. This extra cash can purchase services to help them remain at home and delay or avoid Medicaid dependency altogether.
- The single most effective step Congress and the President can take to fix Medicaid, reduce its cost, and improve America's long-term care service delivery and financing system is to replace Medicaid's home equity exemption with a reverse mortgage as a pre-condition of eligibility.
- That simple measure will pump desperately needed financial oxygen into the LTC service delivery system, relieve the burden of Medicaid on taxpayers, enable Medicaid to provide better access to higher quality care for the genuinely needy, and expand the market for

LTC insurance and home equity conversion products, thus generating additional tax revenue for state and federal coffers.

- It can also pay for the "Doc Fix."

End Notes

¹ Michael Cannon, "Entitlement Bandits," *National Review Online*, July 5, 2011, <http://www.nationalreview.com/articles/271006/entitlement-bandits-michael-f-cannon?page=1#> and Michael Cannon, "Medicare/Medicaid Fraud: It's Everywhere; It's Brazen; It's Other People's Money," Cato Institute video, July 20, 2011, <http://us1.campaign-archive1.com/?u=98c97f42691d5de57bc944822&id=3db4e5afa2&e=1901039b9d>.

² Watch O'Keefe's explosive videos showing Medicaid eligibility workers suborning fraud here: <http://www.theprojectveritas.org/node/51>.

³ Kaiser Family Foundation, *StateHealthFacts.org*, extracted July 27, 2011; <http://www.statehealthfacts.org/comparecat.jsp?cat=4&rgn=6&rgn=1>.

⁴ National Governors Association and the National Association of State Budget Officers, *The Fiscal Survey of States*, Spring 2011, p. 51; <http://nasbo.org/LinkClick.aspx?fileticket=yNV8Jv3X7Is%3d&tabid=38>.

⁵ *Ibid.*

⁶ Kaiser Family Foundation, *StateHealthFacts.org*, extracted July 27, 2011; <http://www.statehealthfacts.org/comparecat.jsp?cat=4&rgn=6&rgn=1>.

⁷ Centers for Medicare and Medicaid Services, National Health Expenditure Data, Table 9: Nursing Care Facilities and Continuing Care Retirement Communities Aggregate, Per Capita Amounts, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970-2009 and Table 4: National Health Expenditures, by Source of Funds and Type of Expenditure: Calendar Years 2003-2009, extracted July 27, 2011; <http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>.

⁸ Kaiser Family Foundation, "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries," May 2011, p. 2; <http://www.kff.org/medicaid/upload/4091-08.pdf>.

⁹ *Ibid.*

¹⁰ Kaiser Family Foundation, *StateHealthFacts.org*, extracted July 27, 2011; <http://www.statehealthfacts.org/comparemactable.jsp?ind=858&cat=4>.

¹¹ "Per capita spending for dual eligibles in nursing facilities averages \$44,600, or about four times greater than spending for dual eligibles in the community (\$10,900) or for other Medicare beneficiaries (\$8,400). Because Medicare does not cover long-term care, the higher costs for the institutionalized fall heavily on the Medicaid program and account for nearly 4 out of 5 dollars that Medicaid spends on dual eligibles." Judy Kasper, Risa Elias and Barbara Lyons, "Dual Eligibles: Medicaid's Role in Filling Medicare's Gaps," Kaiser Commission on Medicaid and the Uninsured, March 2004, p. 10,

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=33892>.

¹² This is true in "medically needy" states. In "income cap" states, a Miller income diversion trust achieves the same purpose.

¹³ These "spousal impoverishment" protections began at \$1,500 per month of income and \$60,000 in assets with passage of the Medicare Catastrophic Coverage Act in 1988. They increase with inflation annually.

¹⁴ Centers for Medicare and Medicaid Services, National Health Expenditure Data, Table 9: Nursing Care Facilities and Continuing Care Retirement Communities Aggregate, Per Capita Amounts, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970-2009, extracted July 29, 2011; <http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>.

¹⁵ Ari Houser, Wendy Fox-Grage, Mary Jo Gibson, "Across the States: Profiles of Long-Term Care and Independent Living," eighth edition, 2009, AARP, Washington, DC, http://assets.aarp.org/rgcenter/il/d19105_2008_ats.pdf.

¹⁶ S. Feinleib, P. Cunningham, and P. Short, *Use of Nursing and Personal Care Homes by the Civilian Population, 1987* (AHCPH Pub. No. 94-0096), National Medical Expenditure Survey Research Findings 23, Agency for Health Care Policy and Research, Rockville, MD: Public Health Service, August 1994, p. 4.

¹⁷ Centers for Medicare and Medicaid Services, National Health Expenditure Data, Table 9: Nursing Care Facilities and Continuing Care Retirement Communities Aggregate, Per Capita Amounts, and Percent Distribution, by Source

of Funds: Selected Calendar Years 1970-2009, extracted July 29, 2011;
<http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>.

¹⁸ Although Social Security is not usually considered to be a financing source for nursing home care, the fact is that it contributes very significantly albeit indirectly as “spend-through.” Social security spend-through refers to income most seniors collect in the form of Social Security benefits which must be contributed toward their cost of care when they receive nursing-home services paid for by Medicaid. According to HCFA: “An estimated 41 percent...of out-of-pocket spending for nursing home care was received as income by patients or their representatives from monthly social security benefits.” (Helen C. Lazenby and Suzanne W. Letsch, “National Health Expenditures, 1989,” *Health Care Financing Review*, Vol. 12, No. 2, Winter 1990, p. 8.) Later research confirmed that Social Security spend-through is almost half of nursing home out-of-pocket costs. (Nelda McCall, “Long Term Care: Definition, Demand, Cost, and Financing,” in Nelda McCall, editor, *Who Will Pay for Long-Term Care*, Health Administration Press, Chicago, Illinois, 2001, p. 19.)

¹⁹ Centers for Medicare and Medicaid Services, National Health Expenditure Data, Table 9: Nursing Care Facilities and Continuing Care Retirement Communities Aggregate, Per Capita Amounts, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970-2009, extracted July 29, 2011;
<http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>.

²⁰ Centers for Medicare and Medicaid Services, National Health Expenditure Data, Table 4: National Health Expenditures, by Source of Funds and Type of Expenditure: Calendar Years 2003-2009, extracted July 29, 2011;
<http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>.

²¹ Medicaid exempted one home without regardless of value until the Deficit Reduction Act of 2005 set the home equity limit at \$500,000 or, at each state legislature's option, at \$750,000.

²² As of 2010, 81.6% of people 65-69 years of age; 82.4% of those 70-74 and 78.9% of those 75 and older own their homes. (U.S. Census Bureau, Housing Vacancies and Home Ownership: Annual Statistics: 2010 (Including Historical Data by State and MSA), Table 17, “Homeownership Rates by Age of Householder and Family Status for the United States;” <http://www.census.gov/hhes/www/housing/hvs/annual10/ann10ind.html>.)

As of 2009, 65.3% of elderly households are owned free and clear of mortgage debt. (U.S. Census Bureau, American Housing Survey National Tables: 2009, Table 3-15 Mortgage Characteristics--Owner-Occupied Units, <http://www.census.gov/hhes/www/housing/ahs/ahs09/3-15.xls>.)

For comparison: “Recent studies show that older Americans, including those who have serious health problems and need long-term care, want to live at home rather than in an institution. Most elders (81% of those age 62 and older) own their homes and 74% of those own them free and clear. With \$1.9 trillion tied up in home equity, this financial resource has the potential to dramatically increase the ability of seniors to pay for long-term care at home. Reverse mortgages can free up needed cash while enabling seniors to continue to own their home.” (Press Release of the National Council on the Aging, “Use Your Home to Stay at Home(tm) Program Study Shows That Reverse Mortgages Can Help Many with Long-Term Care Expenses,” April 15, 2004.)

²³ Press Release of the National Council on the Aging, “Use Your Home to Stay at Home(tm) Program Study Shows That Reverse Mortgages Can Help Many with Long-Term Care Expenses,” April 15, 2004.

²⁴ A good source of information on home equity conversion is the National Reverse Mortgage Lenders Association at <http://www.reversemortgage.org/default.aspx>. Also see AARP's website at <http://www.aarp.org/revmort/> and the National Center for Home Equity Conversion at <http://www.reverse.org/>.

²⁵ National Council on the Aging Press Release and Fact Sheet, “Use Your Home to Stay at Home(tm): Program Study Shows That Reverse Mortgages Can Help Many with Long-Term Care Expenses,” April 15, 2004.

²⁶ Kaiser Family Foundation, “Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries,” May 2011, p. 1; <http://www.kff.org/medicaid/upload/4091-08.pdf>.

²⁷ More than a third of dual eligibles, 3.4 million, are younger persons with disabilities, including the MRDD population, Mentally Retarded and Developmentally Disabled. Very few of these recipients can be diverted from Medicaid dependency. If we consider only the 5.5 million dual eligibles over age 65, saving \$30 billion per year would require diverting 34% of them from dependency on Medicaid, arguably doable though difficult. (Dual eligible numbers come from Kaiser Family Foundation, “Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries,” May 2011, p. 1; <http://www.kff.org/medicaid/upload/4091-08.pdf>.)

²⁸ United States Code, Congressional and Administrative News, 97th Congress—Second Session—1982, Legislative History (Public Laws 97-146 to 97-248) Volume 2, St. Paul, Minnesota, West Publishing Company, p. 814.