

The Council for Affordable Health Insurance



Testimony for the
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Committee on Ways and Means
Subcommittee on Health
Hearing on Long-Term Care

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On behalf of the Council for Affordable Health Insurance's (CAHI) board of directors and members, I applaud Chairman Johnson and members of the House Ways and Means Health Subcommittee for opening this dialogue on how to improve the long-term care delivery and financing mechanisms in the United States. We appreciate your consideration of our comments on this critical issue.

CAHI is a national non-profit research and advocacy association whose mission is to develop and promote free market solutions to America's health care challenges. Our membership includes health insurance companies (active in the individual, small group, HSA, long-term care and senior product markets), small businesses, physicians, actuaries and insurance brokers.

Our members represent a broad range of health care products, including long-term care and Medicare Supplement insurance, home health care services and prescription drug discount cards. They provide insurance policies that protect families from potential financial catastrophe, as well as critical services to people with disabling conditions and long-term health care needs.

Long-term care is the most significant health care funding expense Americans now face. Something must be done to stem the public's massive and growing dependence on government-funded long-term care – and it must be done now.

Our comments will focus on the following:

- Private long-term care financing options available today, including long-term care insurance;
- Obstacles facing the private long-term care market;
- Solutions to removing barriers to private market growth and reducing the burden on Medicaid.

Today's Private LTC Market

Beginning in 2011 the first baby boomers will turn 65. By 2031, all 76 million boomers will have reached retirement age, many of them woefully unprepared for the cost of long-term health care.

Americans are living much longer than in the past and the phenomenal advances in medicine will mean that many Americans will be living not only longer but also healthier and more fulfilling lives.

While these advances were unimaginable just decades ago, they come at a cost. The public policy question facing us is, “Who will pay?” Government cannot – and should not – pay for it all.

The private sector will have to provide workers with ways to protect their future health, independence and assets. The good news is that there are innovative and effective private long-term care financing options available to consumers today, such as long-term care insurance and home equity conversion.

Long-term care is usually provided in three venues – the home, an assisted living facility or a nursing home – and is financed primarily by three sources: private pay, Medicaid or Medicare. (The Congressional Budget Office estimates that if converted into dollars, donated care would represent 36% of all spending on long-term care for the elderly. Our focus here, however, is on paid care.)

Private long-term care (LTC) insurance protects assets and incomes from the devastating financial consequences of long-term health care costs. In existence since the early 1970s, LTC insurance policies initially piggybacked on Medicare’s skilled nursing benefit, providing short-term indemnity benefits for stays in a Medicare skilled nursing facility. Intermediate care and non-Medicare facility services were covered beginning in the late 1970s. Coverage for home care services emerged in the early 1980s. With the implementation of the National Association of Insurance Commissioners’ LTC insurance model regulations in the mid-1980s, coverage expanded to include care in assisted living facilities, and insurers began offering longer periods of covered care, including unlimited lifetime benefits and increased daily benefits.

Due to significant competition in the marketplace, LTC insurers are developing products with very flexible benefits to better meet consumers’ needs. Today’s comprehensive LTC insurance policies allow consumers to choose from a variety of benefits – including reimbursement for informal caregivers – and offer a wide range of coverage choices. They provide for care to be received in a variety of settings – nursing homes, homecare, assisted living facilities and adult day care – and some of the most recent policies are providing for a cash benefit that the consumer can spend anyway he/she feels is best. Additionally, insurers are coming out with hybrid products that are combined with life insurance and annuities.

Policy options offered by one CAHI member include:

- Short term facility care plan for stays of less than one year;
- A stand alone home health care plan;
- A benefit plan for substandard health risks; and,
- A comprehensive benefit package covering all care settings – facility, home and community.

Additionally, under a first-of-its-kind arrangement with a major university, their newest product incorporates an independent health promotion and disease prevention program, as well as caregiver support services.

LTC insurance allows individuals to take personal responsibility for their long-term health care needs and reduces the strain on state Medicaid budgets. By the year 2030, Medicaid’s nursing home expenditures are expected to reach more than \$130 billion a year. Private LTC insurance is the only real alternative to more state Medicaid spending on seniors.

Home equity conversion (HEC) – which allows people to convert the illiquid equity in their homes into a liquid monthly income or a lump sum payment without having to repay the loan while they live in the home – is another private financing option for long-term care needs. Eighty-one percent of seniors own their homes. Seventy-three percent of elderly homeowners own their homes free and clear. Nearly \$2 trillion worth of home equity is held by seniors that could go to offset the cost of long-term care – enough money to solve the long-term care financing crisis now and in the future.¹

These reverse annuity mortgages are available to anyone 62 years of age or older and are strictly regulated by the government. Proceeds of a reverse mortgage can be used for any purpose. For example, when interest rates plummeted, many seniors turned to reverse annuity mortgages as a way to replace lost income.

Properly done, reverse mortgages are medically underwritten so that the mortgages are priced so that they do not come due while borrowers are still able to live at home. In other words, the lender is taking on risk that the borrower may live in the home longer than anticipated. Thus, the product is insurance, not just a loan. Borrowers can never lose their homes and do not pay back the reverse mortgage until they leave or sell the home, usually as a result of death or nursing home institutionalization. At that time and only then, the lender recoups principal and all accrued interest.

Recently, the Centers for Medicare and Medicaid Services and the National Council on the Aging (NCOA) have encouraged the use of home equity to pay for long-term care. In an estimate prepared for the NCOA by the Lewin Group, reverse mortgages could save Medicaid \$3 billion to \$5 billion annually by 2010 if sales reached certain levels.

Obstacles to Private Market Growth

Most seniors are financially ill-prepared to meet potential long-term care needs. According to the Congressional Budget Office, only 7% of American seniors have enough saved to cover one year of nursing home care.

Consumer education about the need for long-term care planning is critical. The largest disincentive to buying private LTC insurance, however, is Medicaid. As originally conceived, Medicaid was mainly intended to be an acute-care safety net for poor women and children. To this day, approximately 75% of Medicaid recipients are poor adults, mostly women and children, who account for only about one-third of Medicaid's costs.

The remaining 25% of Medicaid recipients are aged, blind or disabled, but they account for two-thirds of the program's costs. The main cost driver for this group is long-term care, principally nursing home care.

Medicaid spent \$50.9 billion on nursing home care in 2002 and paid for two-thirds of all nursing home residents.² Medicaid also spends a large and rapidly increasing amount for home and community-based

¹ Steve Moses, "The Long-Term Care Dilemma: What States are Doing Right and Wrong," 2004, http://www.cahi.org/cahi_contents/resources/pdf/LTCStudy2004.pdf.

² See: <http://www.cms.hhs.gov/statistics/nhe/historical/t7.asp>; "Table 7: Nursing Home Care Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1980-2002" and C. McKeen Cowles, *2002 Nursing Home Statistical Yearbook*, Cowles Research Group, Montgomery Village, MD, 2003, p. 64.

long-term care. Long-term care accounts for one-third to one-half of total Medicaid expenditures in most states.

The American public is in denial about the risk of long-term care because Medicaid and Medicare have paid for most expensive extended care services since 1965. When a care crisis occurs and large expenses begin to be incurred, families frequently turn to the public benefit programs and learn that qualifying for Medicaid is easier than they thought and that Medicare, although very limited in its benefits, has no means test to obstruct eligibility. Consequently, few people plan, save, invest or insure for long-term care and most people end up dependent on the public programs.

To qualify for Medicaid's long-term care benefits, someone must be aged, blind or disabled and medically in need of nursing-home level of care. Beyond that, there are two financial tests that must be passed: one is based on income and the other on assets.

Income eligibility is determined in two ways. Thirty-four states and the District of Columbia have "medically needy" income eligibility systems.³ In those states, medical expenses — including private nursing home costs, insurance premiums, medical expenses not covered by Medicare, etc. — are deducted from Medicaid applicants' income. If they have too little income to pay for their care, they are eligible for Medicaid — not just for long-term care but also for the full array of Medicaid services.

The remaining states have "income cap" Medicaid eligibility systems.⁴ In these states, anyone with income over \$1,692 per month (300% of the SSI monthly benefit of \$564) is ineligible for long-term care benefits. But \$1,692 is not enough to pay privately for nursing home care and one dollar more is too much to qualify for Medicaid, a Catch 22. So Congress approved "Miller Income Trusts" in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) that allow people to divert income into the trust and become eligible for Medicaid. The trust proceeds must then be used to offset their cost of care, and any balance in the trust at death reverts to Medicaid. Nevertheless, Miller Income Trusts allow people with incomes substantially over the limit to qualify for Medicaid, enjoy the program's low reimbursement rates and receive its extensive range of additional medical services.

Thus, whether you're in a "medically needy" or an "income cap" state, you don't have to be poor to qualify. You only need a *cash flow problem*. There is no set limit on how much income you can have and still qualify, as long as your private medical expenses are high enough and, if you are in an "income cap" state, you have a Miller Income Diversion Trust. Thus, income is rarely an obstacle to Medicaid long-term care benefits, as long as medical expenses are high enough. Only the top 10% or 15% of seniors would have too much income to qualify.

Most states allow individual Medicaid applicants to retain at least \$2,000 worth of otherwise nonexempt liquid assets. What you don't hear so often is that Medicaid also exempts the home and all contiguous property regardless of value. Simply express a subjective "intent to return" to the home and it remains exempt, whether or not there is any medical possibility the patient will ever be able to return. According to the Social Security Administration's Program Operations Manual System (POMS), Medicaid also exempts:

³ See "SI 011715.020 List of State Medicaid Programs for the Aged, Blind and Disabled" at <http://policy.ssa.gov/poms.nsf/1nx/0501715020>.

⁴ Ibid.

- One business, including the capital and cash flow, of unlimited value;
- A prepaid burial space for “the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value”;
- Unlimited term life insurance with no effect on eligibility;
- Home furnishings up to \$2,000, but they are rarely counted;
- One car of unlimited value, assuming it’s used for the benefit of the Medicaid recipient. (And because it is exempt, giving it away is not a transfer of assets to qualify for Medicaid.)

Many upper-middle-class people qualify for Medicaid by consulting legal specialists, known as elder law attorneys, who use an array of qualification techniques, including the purchase of annuities, irrevocable income-only trusts and life care contracts. Thus, even beyond Medicaid’s extremely generous basic eligibility rules as described above, savvy seniors with cunning legal advisors can stretch Medicaid long-term care eligibility much further still.

Medicaid planning has negative consequences beyond overloading the program with recipients who could have paid for their own care. Elder law attorneys routinely advise their Medicaid planning clients to retain enough “key money” to pay privately for at least a year of nursing home care. That’s because it’s common knowledge that patients cannot count on getting into a quality nursing home unless they can pay privately for an extended period of time. Once they’re in, however, state and federal laws prohibit nursing homes from removing them just because they convert from private-pay to Medicaid. So, the well-to-do divest or shelter most of their wealth, but save out enough to pay privately for a year, lock into a good nursing home, and later transfer the financial burden to Medicaid, tax payers and nursing homes. The tragedy is that poor people, whom Medicaid is supposed to help, do not have key money and consequently must occupy the less desirable beds in nursing homes more heavily dependent on Medicaid’s low reimbursement rates.

Although state Medicaid programs have been required since OBRA ‘93 to recover benefits paid from the estates of deceased recipients — and arguably from the estates of the spouses they predecease — few states do so efficiently and effectively.

Two states — Michigan and Texas — have not implemented estate recoveries to this day. Most states make only a half-hearted effort. CMS reports that state Medicaid programs recovered only \$350 million from estates in 2002 while spending \$46.5 billion on nursing home care — an almost negligible return of only 0.75%.

Even states like Oregon that pursue estate recoveries aggressively are hamstrung by restrictions in federal law that protect large amounts of money from recovery.⁵ Nevertheless, Oregon recovered \$13.7 million from estates in 2002, which is 6.9% of what the state spent on Medicaid nursing home benefits that year.⁶ If every state were as successful as Oregon, estate recoveries would total \$3.2 billion.⁷ With a growing industry devoted to helping individuals qualify for Medicaid, and with little or no effort on the part of the states in pursuing estate recovery or otherwise limiting Medicaid eligibility, it should

⁵ See SEC. 1917 [42 U.S.C. 1396p] of the Social Security Act, “Liens, Adjustments and Recoveries, and Transfers of Assets,” at http://www.ssa.gov/OP_Home/ssact/title19/1917.htm.

⁶ Moses.

⁷ Moses. This estimate is based on applying Oregon’s probate recovery rate of 6.9% to the national total Medicaid nursing home expenditures for FFY-02 of \$46.5 billion. Using the 8.1% estate recovery rate estimated by Oregon staff gives a total national estate recovery potential of \$3.8 billion.

come as no surprise that consumers view long-term care as an entitlement, and see no value in using their own money to purchase private LTC insurance or long-term care services directly.

Solutions

Encouraging individuals to plan for their own long-term care needs, and providing incentives to access the private market products to do so, are the two most important ways we can improve long-term care financing and delivery, and contain the growth of Medicaid.

Tax Incentives: While pure demographics should spark some increased interest in LTC insurance, the onslaught of the baby boom generation is not enough in itself to encourage the purchase of the product. Today's private long-term care market continues to evolve with policy improvements, consumer protections and administrative efficiencies. It is competitive and innovative, changing to meet consumer demand. So why aren't consumers buying it?

Studies of "non-buyers" show that if LTC insurance could be purchased with tax incentives, they would seriously consider buying a policy. By giving Americans a tax break to purchase LTC insurance, Congress can help millions of families enjoy a financially secure retirement. While an income tax deduction is one way government has encouraged Americans to purchase LTC insurance, the deduction applies only to premium amounts that exceed 7.5% of adjusted gross income, thereby limiting it to very few taxpayers. Pending legislation would provide an above-the-line income tax deduction for LTC premiums.

One new LTC financing option is a Health Savings Account (HSA), which allows a worker to tax-shelter LTC insurance premiums. However, few people have an HSA, and some employers may never offer that option.

Congress can do much more. Many Americans are saving for their retirement years through IRAs, 401(k) and 403(b) plans, with personal contributions matched in whole or in part by employers. Allowing taxpayers age 50 or older to use funds from those plans, without withdrawal penalties, to buy LTC coverage can: (a) encourage the purchase of LTC insurance at younger ages when premiums are lower and people are healthier; (b) motivate consumers to take responsibility for their long term health care needs; and (c) if restricted to just IRAs, would be almost tax neutral.

However, when Congress or the state legislatures create new options, they sometimes feel compelled to impose new regulations on those options. It is important that Congress and the states not do to long-term care insurance what they – primarily the states – have done to health insurance: impose numerous mandates and restrictions that drive up premiums and reduce access to affordable coverage.

Long-Term Care Partnerships: The private long-term care insurance market is robust and competitive, with products that offer consumers comprehensive benefits and financial security. However, the ease with which people can shelter or transfer their assets reduces the incentive to purchase private LTC insurance and increases the number of people who rely on Medicaid for their long-term care.

Four states — Connecticut, California, Indiana and New York — have addressed the LTC problem by establishing public/private partnerships. These programs encourage people to purchase private LTC insurance by allowing insured persons to protect their assets in whole (New York) or in part if they exhaust their private LTC benefits. Thus, if partnership participants exhaust their LTC policies, they

will not forfeit their estate once they enroll in Medicaid. In other words, if people go to reasonable lengths to act responsibly and protect themselves by buying LTC coverage, their assets are not at risk if they must eventually turn to Medicaid.

While the current partnership programs are a step in the right direction, their mandated product design and administrative burdens encumber insurers. As a result, the products are expensive. Moreover, the Omnibus Budget Reconciliation Act of 1993 effectively precluded the establishment of partnership programs in new states by prohibiting the states from allowing participants who buy LTC coverage to be exempted from Medicaid's estate recovery provisions.

Yet the fundamental concept behind LTC insurance partnerships is sound and could attract consumers if the restrictions were removed.

A fresh, full examination of LTC partnerships is needed. An affordable partnership program would link the public and private sectors, allowing consumers to purchase private LTC insurance and making Medicaid the last option for long term care. What to do? First, Congress should allow states to establish an LTC partnership program by repealing the OBRA '93 ban on the forgiveness of estate recovery liability. Then, state legislators should advance public/private partnership programs that promote the development and availability of affordable, voluntary, private LTC insurance products.

Home Equity Conversion: Seniors' home equity is the biggest potential source of private long-term care financing that could relieve fiscal pressure on Medicaid. Home equity represents over half the wealth of the median elderly household. Yet home equity is not being widely used to finance long-term care. Why? Because Medicaid exempts the home and all contiguous property regardless of value for any recipient who expresses an "intent to return" to the home. Under federal law, the medical feasibility of returning to the home is immaterial (except in three or four 209b states⁸). Expressed intent is all that matters. Thus the Medicaid home exemption and the ease of transferring the home to avoid estate recovery liability chill the market for home equity conversion products.

The federal Medicaid program should require home equity conversion as a condition of qualifying for Medicaid-funded long-term care, and states should encourage the use of this program. This approach would prevent Medicaid from being "inheritance insurance" for baby boomer heirs as it is now, and it would wake up the boomers to the risk and cost of long-term care. With home equity genuinely at risk, most people would plan early to save, invest or insure for their long-term care needs. They would be less likely to ignore the problem until it's too late, as they do now, because if they did, they would have to consume their biggest asset before receiving public assistance. This approach would also unleash the long-term care insurance and home equity conversion markets, thus creating jobs and adding to state and federal tax revenues.

Medicaid Long-Term Care Eligibility: Medicaid's income and asset limits are very severe for people who need acute care. The rules are much more generous for seniors who need long-term care. Income is rarely an obstacle to eligibility because applicants' medical expenses, including nursing home expenditures, are deducted from their income in 30 "medically needy" states. In the remaining "income

⁸ "209B states," refers to the states which retained the right, under Section 209(b) of the Supplemental Security Income (SSI) program, to continue to use their own eligibility criteria in determining Medicaid eligibility for the elderly and disabled rather than extend Medicaid coverage to all who qualify for SSI benefits. The Medicaid Resource Book, Kaiser Commission on Medicaid and the Uninsured.

cap” states, applicants can divert excess income into “Miller Income Trusts” in order to qualify for Medicaid coverage.

The key is to control eligibility. Many states have tried to reduce costs and improve service delivery by de-emphasizing nursing home care and encouraging home and community-based services. But in so doing, they’ve made their Medicaid programs more attractive and private financing less attractive. If they could control eligibility, however, so that people would access Medicaid only after consuming home equity, fewer people would become dependent on Medicaid, and the state could better afford to provide the most attractive home and community-based services (HCBS) and pay adequately for them.

Congress and CMS should encourage states to study their Medicaid eligibility systems to determine how much they lose as a result of generous Medicaid eligibility rules, early wealth transfers and Medicaid estate planning. Then they should consider:

- Tightening income and asset limits;
- Enforcing the rules more strongly;
- Joining Connecticut, Minnesota and Massachusetts in their 1115 waiver request to extend Medicaid’s “look-back” period for asset transfers; and, to eliminate the “half-a-loaf” loophole (giving away half your assets and spending down during the resulting shortened eligibility penalty) by starting eligibility penalties at the date of Medicaid qualification instead of the date of the transfer.

Medicaid Estate Recovery: Every state Medicaid program is required to recover the cost of care from the estates of deceased recipients (Omnibus Budget Reconciliation Act of 1993). Few states aggressively enforce the estate recovery requirements, however, and none effectively inform the public of this liability in advance. Oregon leads in estate recoveries, annually recouping 4.1% of its Medicaid nursing home expenditures from recipients’ estates. If every state recovered at the same rate, estate recoveries could generate nearly \$2 billion in nontax revenue to supplement Medicaid’s limited resources. If states warned citizens about the risk and cost of long-term care, the downside of enrolling in Medicaid — such as loss of independence and choice — and the use of estate recovery, many more people would plan earlier to save, invest or insure for long-term care costs, thus reducing the burden on taxpayers and the Medicaid program.

States should review their Medicaid estate recovery programs. If recoveries do not meet or exceed 5% of nursing home expenditures, states should consider: changing laws to encourage stronger recoveries; implementing “best practices” from other states; adding staff until recoveries are maximized; and publicizing the program to encourage responsible long-term care planning by consumers who are still young, healthy and affluent enough to purchase private insurance.

Conclusion

The United States is the richest country in the world. We have more than enough wealth to ensure access to long-term care for all American citizens. Yet our long-term care service delivery and financing system is seriously dysfunctional.

By making Medicaid nursing home benefits routinely available to virtually anyone since 1965, we created a nursing home-based, welfare-financed long-term care system that fails everyone, especially the poor.

While it is understandable that seniors want to protect their assets in order to pass something on to their families and friends, the best way to do that is to take financial responsibility and protect their assets by purchasing long-term care insurance, not becoming dependent on the Medicaid system.

The private LTC insurance industry continues to serve consumer expectations well in the design and offering of quality products. Disincentives to buy the products do not come from a lack of benefit plans – excellent, affordable coverage is available and new products continue to be developed. Concern for the stability of premium rates for these products has been addressed by the National Association of Insurance Commissioners, while meaningful consumer protections have been put in place in the states.

By providing individuals with the proper incentives to plan for their own long-term care financing, Congress can reduce the number of people dependent on Medicaid and allow the program to do a better job for its proper clientele: the poor. Medicaid could afford to offer home and community-based care, not just nursing home care, and perhaps it could pay long-term care providers something closer to market rates.

Thank you again for the opportunity to share our comments. Please feel free to contact me if I can provide any further information.