POLICY REPORT

Long-Term Care Financing in North Carolina:

Good Intentions, Ambitious Efforts, Unintended Consequences

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Executive Summary

Long-term care in nursing homes, assisted living facilities, or an individual's own home, is the largest portion of North Carolina's Medicaid budget. It is also the fastest growing portion of that budget. As the state's population ages, it will drive even more demand for these services. Medicaid was not meant to be inheritance insurance for baby boomers, but current policy in North Carolina allows it to be exactly this. Encouraging more people to rely on private payment options, such as reverse mortgages or long-term care insurance, will mean lower state costs for care and better results for individuals. This paper examines the state of long-term care in North Carolina, current abuses of the system, and private payment options.

- Long-term care is labor-intensive, highly expensive, and bound to require ever greater public and private capital investment and spending for services.

- Tax-financed public spending funds the vast majority of formal, paid long-term care (LTC) services in North Carolina and throughout the United States.

- Exceptional efforts by North Carolina's Medicaid program to save money by funding and providing care in less expensive home- and community-based settings (instead of nursing homes) have not reduced total long-term care expenditures by the state and counties.

- By providing government-financed long-term care to growing numbers of North Carolinians in more desirable, less restrictive home- and community-based settings, the state may have increased the public's complacency about LTC risk and cost, lack of planning, and public dependency.

- Although North Carolina operates a Medicaid estate recovery program, the state could reasonably expect to recover an extra $60 million per year by implementing standards and methods used in more successful states.

- Home equity is by far the biggest repository of wealth that seniors could tap to fund high-quality long-term care in the private market. Yet North Carolina has done nothing to encourage the use of home equity conversion.

- Private long-term care insurance could be a viable funding source for many North Carolinians. Its market is impeded by generous public financing of long-term care, heavy marketing of Medicaid estate planning, the absence of a public education campaign to encourage its purchase and the lack of a strong sales force to market such a highly specialized product that is so difficult to sell.

- Because of long-term care's long tail – the need for insurers to set aside premiums and invest reserves for decades in order to be able to pay claims in the future – it may already be too late to save the Medicaid safety net by redirecting long-term care financing in North Carolina from taxpayer-generated current revenues toward consumer-generated private savings and insurance. But the state should begin that process immediately.

- North Carolina should maximize every means to target public financing of LTC to citizens most in need, use program savings thus generated to educate the public about the need for LTC planning and to incentivize LTC insurance and reverse mortgages for long-term care financing, dramatically increase Medicaid estate recoveries and educate the public that long-term care is a personal responsibility, not a government entitlement.

Introduction

Long-term care (LTC) is assistance provided for an extended period of time to people who are unable to care fully for themselves. Developmental disability, chronic illness, or frailty may create the need for such assistance. LTC can include skilled medical services, custodial care such as help with dressing and bathing, or a combination of the two. People of all ages may require long-term care, but the focus of this report is on the provision and financing of LTC services for older North Carolinians.

Demand for LTC in North Carolina is high already and is expected to increase rapidly. Of all people age 65 and older in the state, 43 percent have a sensory, physical, mobility, self-care, or cognitive disability. That is the 14th highest rate of elderly disability in the country. Older North Carolinians use nursing homes 10 percent less than the national average, but they have many more assisted living and residential care beds available than in most other states. Likewise, North Carolina ranks second in home health aides with 41 per 1,000 elderly, compared to 18 nationally.

Medicaid is one of the fastest-growing segments of the state budget, and long-term care is helping push that growth.

The over-85 population, those most likely to need long-term care, is expected to increase 52 percent between 2005 and 2020. This increase is more than twice as fast as the expected 23 percent growth in total population over the same period. By 2020, they will make up 1.8 percent of all people in the state, up from 1.5 percent in 2005.

Spending on LTC in North Carolina is also high and is expected to increase rapidly. "Most publicly funded long-term care services are financed through the state's Medicaid program, although some are financed through federal block grants and other federal and state appropriations," according to the state Division of Medical Assistance. Excluding services provided without compensation by families and friends, most LTC services are publicly funded. Federal Medicare funds short-term nursing home stays and skilled home care services. The State and County Special Assistance Program augments federal Supplemental Security Income (SSI), enabling low-income seniors to access adult care homes, assisted living facilities, and home care. This program cost state and county governments a combined $134 million in fiscal year (FY) 2005. Medicaid pays for nursing home care, personal care services, and home- and community-based services (HCBS) under a federal waiver. Total Medicaid LTC spending in FY 2005 was $2.7 billion, one-third of the program's $8.2 billion expenditures that year.

Change in Share of Medicad FY2001 - FY2006

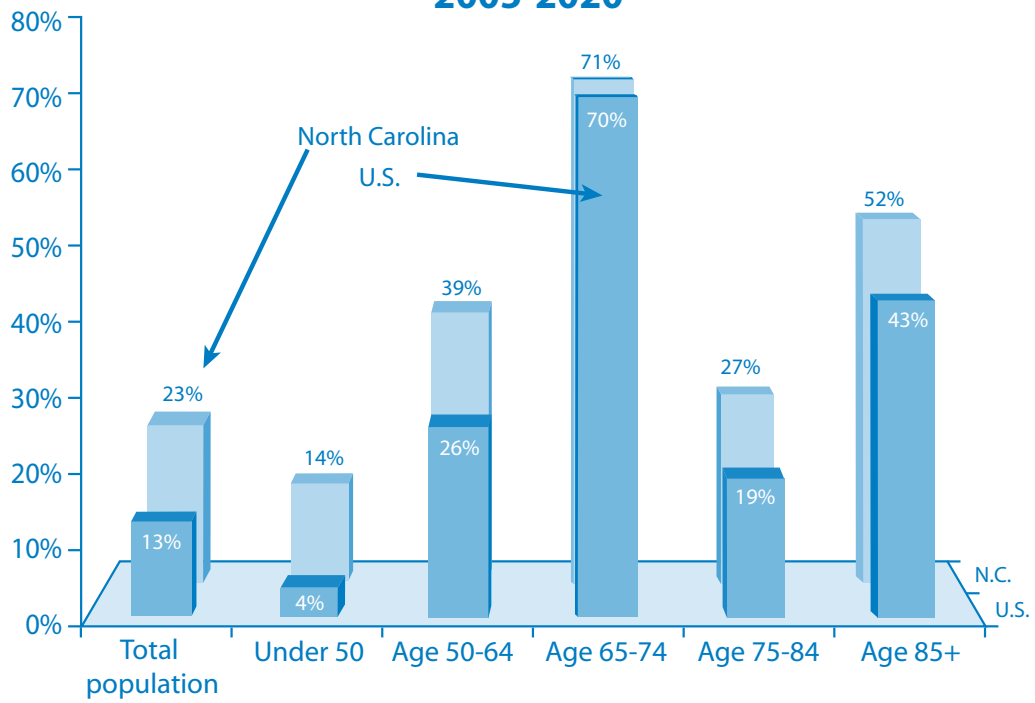
	Aged	All Recipients
Prescription Drugs	**-5.1%**	**-0.6%**
LTC Care	**5.8%**	**-2.8%**
Nursing Facility	27.1%	5.9%
ICF-MR	0.1%	-2.3%
Home Health	0.5%	0.4%
PCS	3.3%	1.5%
Adult Home Care	0.3%	-0.2%
Other Services	**-0.8%**	**3.4%**

Source: NC Division of Medical Assistance, Medicaid Tables

Medicaid is one of the fastest-growing segments of the state budget, and long-term care is helping push that growth. For example, Medicaid is by far the biggest payer for long-term care services in North Carolina. Between 1980 and 2004, Medicaid expenditures for nursing home care grew from $176 million to $1.5 billion, nearly a tenfold increase at a pace of 4.7 percent per year. In the same period, Medicaid home health care expenditures in the state grew from $1 million to $379 million, an annual growth rate of 17.1 percent. According to AARP, total Medicaid LTC spending in North Carolina increased to $2.7 billion in 2005, up 45 percent from the 2000 level. Approximately $1.8 billion of this total goes to LTC services for older adults and people with physical disabilities. The state spends 33 percent of its Medicaid service dollars on long-term care. Total Medicaid expenditures in 2006, including state, county, and federal contributions, were $8.6 billion, up 5.1 percent from $8.2 billion in 2005, a rate of increase two-thirds higher than the Consumer Price Index (CPI).

Continuation of these LTC cost increases at rates that have prevailed for the past 30 years would overwhelm North Carolina's budget sometime in the next three decades.

Projected Population Growth, NC vs US 2005-2020



Source: AARP

The Current State of Medicaid LTC

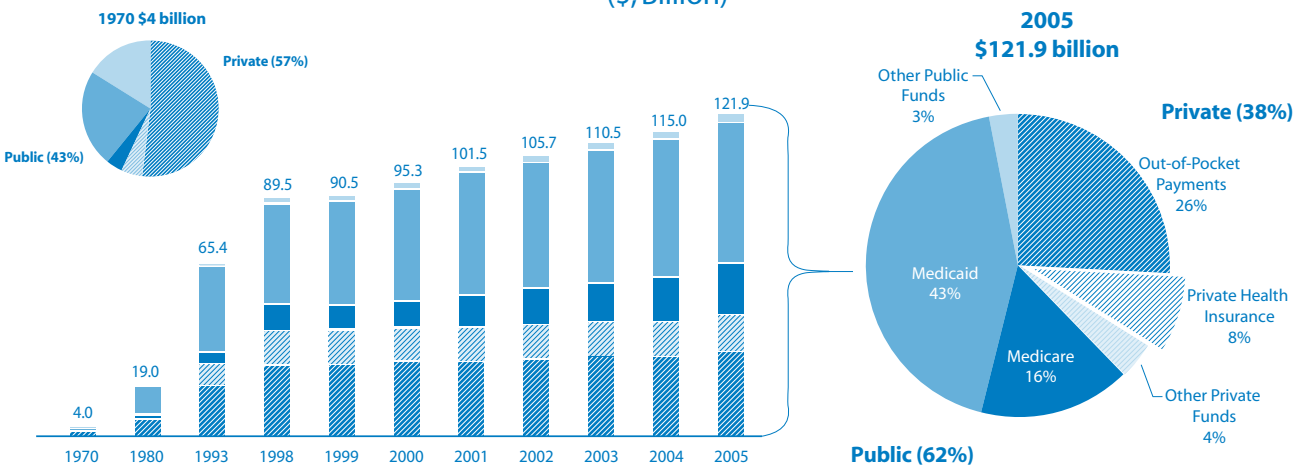
Public expenditures for long-term care in North Carolina are large, growing rapidly, and unlikely to subside. Clearly, ways must be found to finance long-term care in the future without bankrupting the state or crowding out other critical government services. The main private alternatives are using liquid assets such as cash and investments, tapping home equity, and private long-term care insurance. Unfortunately, easily obtained government financing of long-term care has limited demand for these alternatives.

Medicare and Medicaid paid 59.6 percent of the $121.9 billion spent nationally on nursing home care in 2005, up from 26.8 percent of total nursing home spending in 1970. Private out-of-pocket spending, which includes long-term care insurance (LTCi) benefits, over that 35-year period fell to 26.5 percent from 52 percent. The federal Center for Medicare and Medicaid Services (CMS) reported 7.5 percent of nursing home costs were paid by private health insurance (PHI) in 2005, but this percentage could be lower because CMS has no way to measure PHI nursing home payments. Other public and private funds accounted for the remaining 6.4 percent. Regardless, the consumer's liability for nursing home costs has declined almost by half in the past three and one-half decades, while the share paid by Medicaid and Medicare has more than doubled (see graph).

Consumers are even less at risk for nursing home costs than these data suggest. Over half of out-of-pocket expenses are contributions toward the cost of care by people already covered by Medicaid. If Medicaid pays even one dollar per month on top of what the resident pays, the nursing home must take Medicaid's relatively low reimbursement rate. Social Security benefits are the primary source of income for individuals on Medicaid. Whatever amount of his or her Social Security income the recipient spends on care counts as out-of-pocket spending, which means government spending (including Social Security) is even higher and private spending lower than statistics show. Thus, although Medicaid pays

National Nursing Home Care Expenditures, Selected Years1970-2005

($, Billion)



Source: Centers for Medicare & Medicaid Services

less than half the cost of nursing home care (43.9 percent in 2005), it covers two-thirds of all nursing home residents. Moreover, while Medicare pays for short stays, Medicaid pays for long-term residents, which means Medicaid pays in full or subsidizes up to four-fifths of all nursing home patient days.

Nursing homes are the most expensive setting for long-term care, but Medicaid rules make it the most financially attractive for consumers. This institutional bias becomes clear when you consider the alternatives. Consumers must use their income and assets to pay for care in their own homes or an assisted living facility, but can qualify for Medicaid in a nursing home based almost exclusively on income and avoid impoverishing their spouses.

Less than one out of every nine dollars spent on home health care comes out of the pockets of patients.

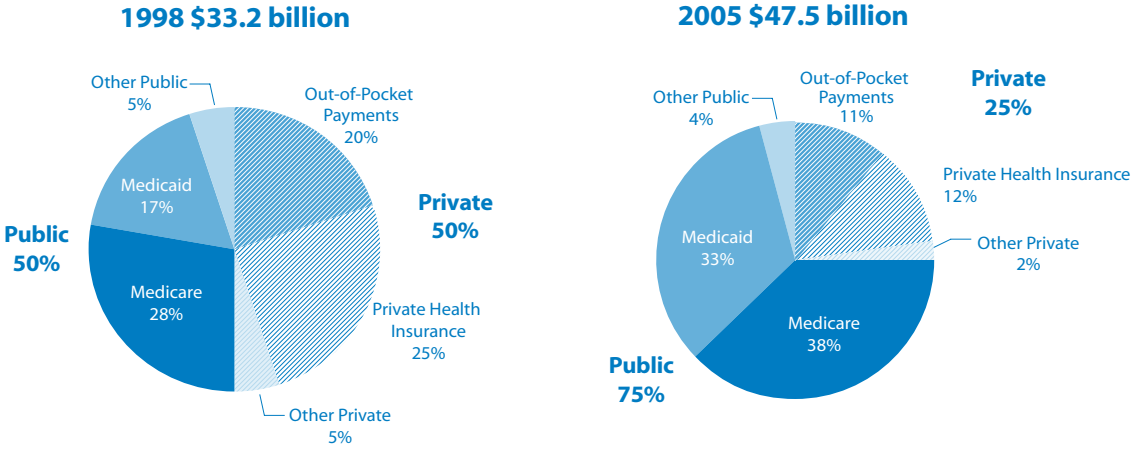
For most people, Medicaid nursing home benefits are easy to obtain without significantly spending down assets, and Medicaid's income contribution requirement is usually much less expensive than paying the full cost of assisted living. For example, Medicaid exempts one home and all contiguous property (up to $500,000 or $750,000, depending on the state), plus one business, and one automobile of unlimited value, plus many other non-countable assets. In addition, sophisticated asset sheltering and divestment techniques are marketed by Medicaid planning attorneys to help people with even greater wealth qualify for Medicaid without spending down their personal resources. As a result, many people who could afford assisted living by spending down their illiquid wealth, especially home equity, choose instead to take advantage of Medicaid nursing home benefits. In addition, the lower cost of assisted living facilities makes it harder for a person to receive assistance based on income: Those in nursing homes, however, rarely earn more monthly income than the cost of their care and so qualify easily for Medicaid.

Assisted living facilities (ALFs) must, therefore, attract enough private payers to be profitable. Government funding for ALFs, through Medicaid and the State and County Special Assistance program, is a much bigger factor in North Carolina than in other states. Public funding in North Carolina likely makes up a larger portion of assisted living facility income than the national average of 10 percent of the $35,616 cost per year. Genworth cites an average annual rate for a private ALF one-bedroom unit as $35,235 in Charlotte and $30,069 in the rest of the state. MetLife cites a "Base Rate Average" monthly charge of $3,252 for Raleigh/Durham ($39,024 annually) and $2,696 for Charlotte ($32,352 annually), but no statewide figure.

The situation with national home health care financing is very similar to nursing home financing. According to CMS, Americans spent $47.5 billion on home health care in 2005. Medicare (37.7 percent) and Medicaid (32.6 percent) paid 70.3 percent of this total, and private insurance paid 12.2 percent. Only 10.7 percent of home health care costs were paid out of pocket. The remainder came from several small public and private financing sources. So, less than one of every nine dollars spent on home health care comes out of the pockets of patients, and a large portion of that comes from the income (not assets) of people already on Medicaid. If the public were paying a bulk of the cost out of

Sources of National Home Health Care Expenditures in 1998 and 2005

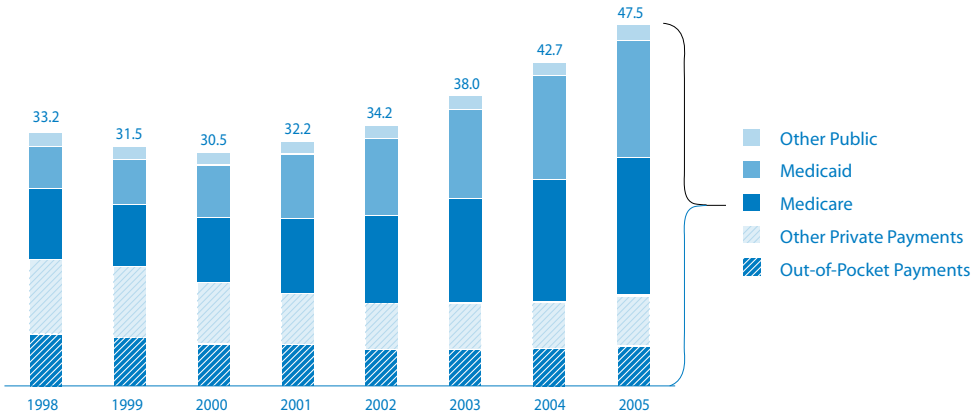
($, Billion)



Source: Centers for Medicare & Medicaid Services

National Home Health Spending, 1998-2005

($, Billion)



Source: Centers for Medicare & Medicaid Services

pocket, more people would feel the sense of urgency about this risk. But as long as people can ignore the financial risk of long-term care, avoid the premiums for private insurance, preserve their home equity, and get government to pay when and if such care is needed, they will remain in denial about the need for LTC planning.

In the Deficit Reduction Act of 2005 (DRA '05), Congress took some small steps toward addressing these problems. The DRA placed a cap on Medicaid's home equity exemption and ended several of the more egregious Medicaid planning abuses. But much more remains to be done.

A Brief History of Medicaid LTC Reforms

To understand why the system looks the way it does, we need to examine how it evolved. North Carolina has had a Medicaid program since 1970. Medicaid extended nursing home coverage to the medically needy in 1973. The medically needy are those who qualify for Medicaid because of their high medical expenses, such as nursing home care. Thus, for more than three decades, any elderly person in North Carolina with a nursing-home level of medical need and too little income to pay for care privately, and who also qualified based on asset limits (not a problem especially in the early years as explained soon), has been eligible for Medicaid-funded nursing home care and for the program's other covered services as well. Consequently, long-term care became equivalent to nursing home care, and it was free except for a "co-insurance" equal to most of a Medicaid recipient's income. Little wonder then that Medicaid nursing home expenditures increased rapidly after 1973; home- and community-based services, which were mostly private pay, languished for decades; and private long-term care insurance hardly existed.

Nor was asset eligibility for Medicaid LTC benefits a factor in North Carolina. It was not until 1981 that "a major eligibility loophole was closed by the General Assembly when it passed a law prohibiting people from giving away assets solely for the purpose of meeting Medicaid eligibility requirements." Since 1981, federal laws have encouraged all states, including North Carolina, to enforce rules intended to target Medicaid benefits to people most in need. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82) authorized liens and estate recoveries. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA '85) discouraged Medicaid qualifying trusts. The Medicare Catastrophic Coverage Act of 1988 (MCCA '88) made asset transfer penalties mandatory and required an examination of asset transfers in the 30 months before application (called a look back period). The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) made estate recoveries mandatory and further expanded the look back period to three full years and five years for trusts.

When Medicaid LTC costs kept skyrocketing and none of these measures had much effect on the public's ability to qualify easily for Medicaid LTC benefits, then-president Bill Clinton and the Republican-led Congress took action in the Health Insurance Portability and Accountability Act of 1996 (HIPAA '96). They made it a crime to transfer assets to qualify for Medicaid LTC benefits. But that measure blew up in their faces when senior advocates called it the "throw granny in jail law." It was repealed by the Balanced Budget Act of 1997 (BBA '97) and replaced with the "throw granny's lawyer in jail law," which made it a crime for a financial adviser to recommend asset transfers as a means to qualify for Medicaid in exchange for a fee. This new measure was unenforceable because advisers could not be held legally culpable for recommending a practice – asset transfers to qualify for Medicaid – that was legal again after repeal of the "throw granny in jail law."

Long-term care became equivalent to nursing home care, and it was free except for a "co-insurance."

After BBA '97, legislators, policy makers, and public officials at the federal and state levels largely gave up on initiatives to preserve Medicaid as a

long-term care safety net for the poor by diverting middle-class and affluent people away from the program. The economy was good. Welfare rolls were down. Tax receipts were up. It was easier to spend the money on Medicaid than to confront the long-range, politically sensitive problems of LTC financing. Then came a recession early in the new millennium. Welfare rolls went up. Tax receipts went down. Budgets were pinched. Congress acted again with DRA '05.

The DRA sought to discourage the use of Medicaid LTC benefits by people with substantial wealth. It put a limit on Medicaid's home equity exemption of $500,000 or $750,000 (a state option). It lengthened the transfer of assets look back period for all transfers to five years. More importantly, it eliminated the commonplace Medicaid planning gimmick called "half-a-loaf," by starting the penalty at the date of Medicaid application instead of the date of the transfer. DRA '05 addressed many other eligibility "loopholes" and Medicaid planning techniques. It also encouraged (1) the use of LTC Partnerships to promote the purchase of private long-term care insurance and (2) the expansion of home and community-based services.

North Carolina, however, has not yet implemented the mandatory provisions of DRA '05. The law should have taken effect in North Carolina on October 1, 2006. Senior advocates and the elder law bar have managed to postpone implementation over "undue hardship" provisions proposed by the Division of Medical Assistance. State officials indicate that regulatory changes to implement the DRA are ready, including application of the home equity exemption limit at the $500,000 level, as soon as the hardship issue is resolved.

Median Household Income, Age 65+ as proportion of All Households

Sources: AARP, U.S. Census Bureau, Housing and Household Economic Statistics Division

But, in the meantime, North Carolina continues, in violation of the DRA, to (1) exempt unlimited home equity for anyone who expresses a subjective intent to return to the home, (2) disregard unlimited asset transfers that occur earlier than three years before Medicaid application, (3) permit the "half-a-loaf" strategy, (4) round down monthly asset transfers so that anyone can give away double the monthly cost of nursing home care less one dollar every month without being held ineligible for more than the month of the transfer, and (5) defer implementation of other new rules mandated by the DRA.

Even after North Carolina implements the DRA, however, nursing home benefits under its Medicaid program will be readily available to most residents of the state without significantly spending down their assets.

Income is rarely an obstacle to eligibility because the vast majority of frail or infirm elderly North Carolinians have incomes below the monthly cost of nursing home care. For example, the median income of people over age 75 in the state as of 2005 was $26,156 – $2,180 per month, or roughly half the $4,125 per month Medicaid nursing home reimbursement rate used as the state standard to determine Medicaid nursing home eligibility through June 30, 2007.

Nor is asset eligibility a problem for most people. According to the 2000 national census, the median net worth of people 75 years of age or older in the U.S. was $100,100 – of which all but $19,025 was home equity. If seniors in North Carolina also rely on their homes for roughly four-fifths of their net assets, most people would qualify for Medicaid nursing home benefits with very little spend down. Home equity at more than six times the median level will be exempt even after DRA implementation; other assets of at least $20,328 are protected for a community spouse if there is one; and if there is no spouse, such relatively small assets can be protected easily by purchasing exempt resources such as prepaid burials, an automobile, or personal belongings. Finally, the practice of Medicaid estate planning, i.e., attorney-assisted self-impoverishment to qualify for LTC benefits, allows North Carolinians with substantially more wealth than the median to qualify for benefits without spending all of their assets.

Medicaid Estate Planning: The Great Inhibitor of Responsible LTC Planning

Maybe people would wake up to the risk and cost of long-term care if it were not for the constant drumbeat of financial advice assuring them they have nothing to worry about. Rather than characterize what Medicaid planners are telling North Carolinians, here it is in their own words drawn from a brief Internet search and some follow-up inquiries:

From an article by an attorney representing Legal Services of Southern Piedmont:

> Recent changes in Medicaid rules significantly limit, but do not eliminate, the ability of individuals to divest themselves of countable income and assets to qualify for Medicaid eligibility. As of this writing, it is still permissible to transfer large amounts of assets, if the individual then waits 36 months to apply for Medicaid.
>
> Examples of still allowable strategies... include: (1) purchase burial plots and irrevocable pre-need burial contracts for applicant, spouse, other family members (plots only); (2) purchase items that will be excluded as household goods or personal effects (e.g. paintings, jewelry, furniture), which may be given away without penalty; (3) purchase a motor vehicle (or trade in for a more expensive vehicle), which may be given away without penalty, then purchase a second vehicle and give it away [known as the "two Mercedes rule"]; (4) purchasing services which have no continuing value as resources (e.g. home repairs); (5) pay off a mortgage on an exempt home and other debts; (6) purchase an annuity for the community spouse if there is no need to protect other income through the community spouse allowance; (7) establish a special needs trust for disabled individuals under age 65; (8) give away $4,799.
>
> Planning to reduce countable income is another important issue, since otherwise reducing countable assets may be of little or no benefit. Strategies include transferring title to income producing property to the community spouse, converting income producing assets to assets which don't produce income, changing the income beneficiary of an annuity to the community spouse or to a special needs trust, appealing the amount of income protected for the community spouse based on hardship, exploring pass-along eligibility, and converting countable cash contributions from relatives or a divorced spouse to excluded vendor payments.

How can Medicaid estate recovery recycle scarce welfare resources when everyone who owns any significant wealth can shield that wealth for their heirs?

From the website of another elder law firm with offices in Winston-Salem and Kernersville, N.C.:

> When planning for long-term care, the goal should be qualifying for Medicaid without becoming impoverished and allowing your estate to pass onto your heirs free from liens. With the right plan in place, you will be able to do this [and] potentially save hundreds of thousands of dollars…

Finally, this is from a national Medicaid planning firm that promises to help people in North Carolina prevent "thousands of dollars" from "going down the nursing home drain":

We show you how to transfer assets and qualify for North Carolina Medicaid sooner. Medicaid eligibility is no secret...you just need to know how it works. This easy-to-understand Medicaid information is what you've been looking for. How do we know? Because we've helped thousands of families qualify for Medicaid while saving millions of dollars - people just like you…

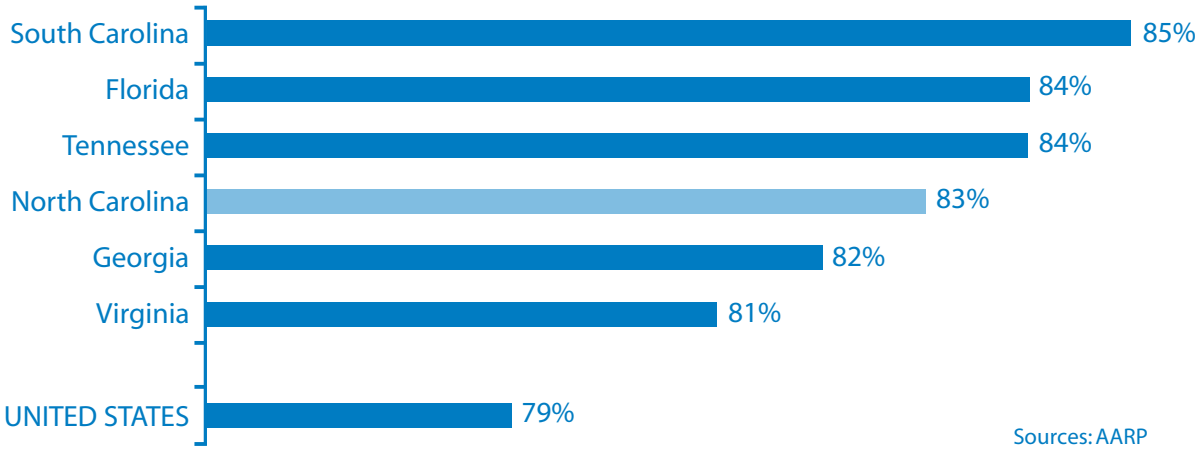
Thousands of dollars are going down the nursing home drain, assets that rightfully should go to the patient's family, not the nursing home. And when it's gone it's gone forever...and you can never get it back.

But it doesn't have to be that way. You can still protect much of the remaining assets, but with each passing day the nursing home takes another hefty bite, leaving less to protect.

With this kind of information omnipresent on the Internet, in magazine ads, and in both the popular and academic/legal media, what chance do responsible financial advisers have to compete? How can insurance agents persuade people to plan decades in advance for long-term care and pay thousands of dollars for insurance premiums when today's elderly are being channeled into free or subsidized publicly financed care? Is there any reason to wonder why no one takes out a reverse mortgage to use their home equity to fund long-term care when methods to protect the home's value and evade estate recovery are commonplace? What chance do Medicaid eligibility workers in the counties have to ensure that long-term care benefits go to people truly in need? The poor do not understand the system and lose everything while the affluent have their letter-perfect, mail-in applications filled out by lawyers and paralegals. How can Medicaid estate recovery recycle scarce welfare resources when everyone who owns any significant wealth can shield that wealth for their heirs with the help of Medicaid planners?

Responsible public officials have a moral and fiduciary responsibility to state and federal taxpayers to eliminate these practices.

More than Four-Fifths of Seniors Own a Home



Sources: AARP

Deinstitutionalization as a Long-Term Care Financing Strategy

While working to limit seniors' ability to hide assets and ensure only those most in need, Medicaid officials in North Carolina and throughout the country have also pursued another policy to restrain Medicaid LTC costs and to provide the kinds of services people prefer. "Medicaid focused on the development of home and community based long term care," as early as 1980, according to an online "History of North Carolina Medicaid Program" from the NC Department of Health and Human Services. The dominant principle guiding long-term care financing policy in North Carolina has become to move people on Medicaid to levels of care that are less expensive, but more appealing, than nursing homes. A blue-ribbon task force directed by the North Carolina Institute of Medicine (NCIOM) recommended as much in its 2001 report, which has been updated as recently as 2007 to make a priority: "North Carolina's policy for long-term care is to support older adults and persons with disabilities needing long-term care, and their families, in making their own choices with regard to living arrangements and long-term care services that will result in appropriate, high-quality, cost-effective care provided in the least restrictive setting."

Medicaid's early and long-standing focus on funding nursing home care prevented the development of a private long-term care insurance market.

Interestingly, the original 2001 NCIOM report gave the lack of sufficient private insurance or public funding as a reason for pursuing the stronger focus on home- and community-based services (HCBS):

> Without adequate private long-term care insurance or public funding, some individuals in need of long-term care services are faced with three options: (1) find a family member to provide unpaid care; (2) pay a caregiver out-of pocket; or (3) enter a long-term care facility where, as they more quickly use up their resources to pay for institutional care, they are more likely to qualify for public subsidies.

This puts the causal cart before the horse. The lack of adequate private or public funding of long-term care did not cause the need for better marshaling of public funds. Rather, more logically, Medicaid's early and long-standing focus on funding nursing home care for almost everyone prevented the development of a cost-effective private HCBS marketplace and the growth of a private long-term care insurance market to help pay for it.

Be that as it may, North Carolina Medicaid has wholeheartedly adopted a strategy to divert as many people as possible away from the nursing home level of care. A new admission screening system is being developed to facilitate appropriate placement. Numerous programs and initiatives aim to provide services in the most desirable and least expensive settings, including in the recipient's home, in adult care homes, and in assisted living facilities. The focus is on providing care and assistance that enable people to manage for themselves or with family help in the least restrictive settings. Home health care and personal care services are funded by a tangled skein of public revenue streams through a maze of different programs, each with its own complicated rules. These sources include Federal Supplemental Security Income, State and County Special Assistance, and Medicaid payments for

home health care and personal care services. Most recently North Carolina received a five-year, $17 million "money follows the person" grant to provide more home- and community-based services to more people.

Many people can become certified for nursing home level of care even if their actual need is something less.

One problem with this HCBS, or deinstitutionalization, approach is that arcane and anachronistic federal Medicaid rules inhibit the state's ability to utilize available funds in the most rational and cost-effective ways. Over and over again LTC providers at every care level told us in interviews that the system is structured to push all Medicaid recipients toward a higher level of care than they actually need. In-home care providers complained the system is biased in favor of adult care homes because people with incomes above $851 per month have to spend down to $242 to qualify, but can qualify for Medicaid in an adult care home with monthly income of $1,148 plus a $66 personal needs allowance. Adult care homes and assisted living providers complained that the system is biased in favor of nursing home institutionalization, because anyone with monthly income higher than $1,204 is excluded from getting help in the adult care home but qualifies easily for nursing home care.

Ironically, nursing home providers complained that people bumped into their level of care who do not really need it reduce the nursing facilities' level of reimbursement, which is based on the case mix of residents. The perception is that many people, especially those with savvy or influential families, can become certified for nursing home level of care even if their actual need is something less. The incentive is to get Medicaid to pay. In 2006, the Lewin Group concluded institutional bias is strong in North Carolina Medicaid. It seems that no matter how hard everyone tries, the system is structured to prevent the most reasonable and cost-effective use of perpetually scarce public LTC resources.

A bigger problem with the deinstitutionalization strategy for financing Medicaid long-term care is the countervailing effect it has on the public's sense of urgency about the risk, cost, and need to plan for LTC. A good analogy is what happened to the private long-term care insurance industry when it responded to consumer demand for broader coverage. When LTC insurance was limited to nursing home coverage, people were reluctant to claim on their policies: families struggled to help loved ones remain at home even though their policies would cover the cost of nursing home care. As private LTC insurance evolved to cover home care, adult day care, respite care, case management, and assisted living as well as nursing home care, policy holders became much more likely to file claims (induced demand) and to allege eligibility for services whether they qualified or not (moral hazard). Increased utilization of covered services by LTC insurance contributed to the product's recent need for premium increases.

Public programs are likely to experience similar effects. The more they fund levels of long-term care that people prefer over nursing home care, the more people will seek to obtain those subsidized benefits, the more they will seek the help of Medicaid planners to qualify for such assistance, and the less likely they will be to insure privately against the long-term care risk. Ironically, state and federal initiatives to save money and provide more desirable services

may have an opposite and inimical effect. They may reduce the potential for private financing alternatives to (1) relieve the LTC funding pressures on public programs and (2) provide full private-pay funding for the LTC services people prefer. Thus, Medicaid could be left carrying more of the burden of LTC financing than it should or can for very long.

Depending more and more on Medicaid financing of long-term care is more than a budgetary problem. Representatives of every level of care provider we interviewed in North Carolina complained that Medicaid reimbursement for their services was inadequate. Rates are set by government fiat, not by the interaction of consumers' demand and providers' supply in competitive markets. Nursing homes are reimbursed $150 million less each year than Medicaid would allow. Their trade association claims that a state Division of Medical Assistance audit and an independent national study both confirmed this. According to assisted living representatives: "We are on a $70 per month deficit [per case]; we're lucky to get a $0.40 per day increase." Medicaid reimbursement for in-home care similarly undercuts private pay rates. Low, politically determined reimbursement rates for LTC contribute to Medicaid's nationwide reputation for impeded access and questionable quality. Getting more private money to fund LTC for North Carolinians is a humanitarian, not just a budgetary, imperative.

Private LTC Financing Alternatives to Relieve the Fiscal Pressure on Government

There are only three potential private sources for long-term care funding: greater asset spend down, home equity conversion, or private long-term care insurance. We will address each of those options in the context of current LTC public policy in North Carolina.

Forcing people to spend down into total impoverishment before they qualify for public assistance is neither socially desirable nor politically feasible. Recovering benefits paid by Medicaid from the estates of deceased recipients is more acceptable and, since OBRA '93, mandatory under federal law. Without estate recoveries, Medicaid becomes free inheritance insurance for heirs, especially adult children who transfer the responsibility and expense of caring for their elderly parents to the public welfare program.

Medicaid estate recoveries

In compliance with federal law, North Carolina operates a Medicaid estate recovery (MER) program. The MER program is part of a larger Third Party Liability (TPL) unit, which seeks recovery of Medicaid expenditures from other responsible parties such as health insurance carriers or personal injury settlements. In the past year, North Carolina recovered approximately $10 million from the estates of deceased Medicaid recipients, up from $4.1 million in 2003 and $7.4 million in 2005. This is well over $1 million for each of the seven full-time-equivalent (FTE) positions dedicated to estate recovery, including support from the state Attorney General's office. The process of estate recovery in North Carolina is almost fully automated from notification of death to generation of an invoice for

Medicaid benefits paid to filing and tracking claims on probated estates. When asked what the upside potential for estate recoveries would be if North Carolina pursued this non-tax revenue source more assertively, the MER supervisor responded: "Don't know."

Based on further research, we conclude that the potential for Medicaid estate recoveries to offset program costs in North Carolina is much higher than is currently being realized. According to a recent report on national estate recoveries by AARP, North Carolina's rate of recovery (MER as a percentage of total Medicaid LTC expenditures) is only 0.27 percent compared to a national average of 0.61 percent and a national median of 0.50 percent. By raising its estate recovery rate to the national average, the state could more than double its recoveries to over $20 million per year. If North Carolina could match Idaho's MER rate, one of the highest in the country at 2.09 percent, estate recoveries would jump more than seven-fold to $77.4 million per year. Even more important is the potential that the more estate recoveries reimburse Medicaid before the wealth passes to heirs, the more likely the next generation is to take the risk and cost of long-term care financing seriously and plan to pay for it.

North Carolina is leaving a lot of money on the table that could be used to help fund the state's Medicaid long-term care services.

The state's MER unit, however, is not permitted to pursue recovery unless Medicaid paid at least $3,000 in claims for the deceased recipient and the recipient's estate exceeds $5,000 in value. In Oregon, historically one of the most successful MER programs in the country, the average recovery per estate is only $2,500. Thus, North Carolina does not attempt to pursue estates at the dollar levels that generate most of the revenue for a more successful state.

Unlike Oregon, North Carolina does not pursue "spousal recoveries," i.e., recovery of benefits paid to a pre-deceased Medicaid spouse from the estate of a surviving non-Medicaid spouse. Nor does North Carolina recover from the estates of people who received legally recoverable Medicaid LTC benefits but left the program before dying. Nor has North Carolina adopted the broader definition of "estate" authorized by OBRA '93, which allows states to recover assets such as jointly owned assets that pass directly to the surviving owner without going through a "probate estate."

Medicaid recipients are allowed to keep $2,000 in liquid assets, which are sometimes kept in accounts managed by the nursing home. North Carolina lacks a system like the one required by state law in Oregon to ensure that nursing homes managing such accounts return the money directly to the MER unit instead of to the recipients' families. Families do receive the money as soon as the MER unit in Oregon determines the state has no claim on it.

North Carolina also has state legislative authority to place liens on real property when Medicaid LTC recipients have been medically determined to be unable to return to the home, but the state does not exercise this authority (which was originally granted by TEFRA '82). Without liens to secure real estate

wealth (Medicaid recipients' biggest exempt asset) for later recovery, homes have a way of disappearing from the recipients' possession before estate recovery can be achieved.

The state has no formal outreach program to notify the public about the legal responsibility to reimburse Medicaid from recipients' estates, although MER staff accept invitations to speak to community groups. Finally, the large and well-advertised Medicaid estate-planning bar in North Carolina aggressively promotes methods to avoid estate recovery.

For all these reasons, and probably more, North Carolina is leaving a lot of money on the table that could be used to help fund the state's Medicaid long-term care services. North Carolina is also losing potential savings from future cost avoidance that could occur as families, to avoid the liability for estate recovery, mobilized to provide and finance long-term care in ways other than depending on public welfare benefits.

Unfortunately, the NCIOM Long-Term Care Task Force report made the following recommendation: "The Task Force does not support further restrictions in Medicaid through tightening transfer of assets provisions or estate recovery." Unless and until policy makers in North Carolina accept the moral high ground of Medicaid estate recoveries, the state will continue to use scarce Medicaid resources to subsidize heirs of well-off program recipients for their failure to fund their benefactors' long-term care and for transferring that cost to public assistance.

Home equity conversion and reverse mortgages

The second potential private funding source for long-term care is home equity. Nationwide, more than 80 percent of seniors own their homes, and more than 70 percent of older homeowners own their homes free and clear. The National Reverse Mortgage Lenders Association estimates that Americans aged 62 and older hold $4.3 trillion of home equity. According to the National Council on the Aging, older American households could tap on average $72,000 each from their home equities by means of reverse mortgages to help finance their long-term care. The average value of homes in North Carolina is somewhat less than the national average – $108,300 compared to $119,600 – according to 2000 Census data, but still substantial. On the other hand, home ownership by elderly North Carolinians is greater than the national average: 83 percent compared to 78.6 percent for the country as a whole, ranking North Carolina 12th in that category.

What are reverse mortgages, and what role do they play in funding long-term care for North Carolinians? Reverse mortgages are federally insured and regulated loans that permit people 62 years of age or older to withdraw otherwise illiquid equity from their homes in lump sums, monthly payments, or through open-ended lines of credit without having to make monthly payments. The loans only come due after the borrowers die, move out, or sell their homes. It is beyond the scope of this report to describe reverse mortgages in more detail or to discuss their pros and cons. We did, however, interview several reverse mortgage (RM) lenders for

North Carolina is losing potential savings from future cost avoidance that could occur as families mobilize to provide and finance long-term care in ways other than public welfare benefits.

this study and learned that, although the market for RMs is growing very rapidly in North Carolina, it is extremely rare for seniors to use these loans for the purpose of financing their long-term care.

Formal reverse mortgages arranged through financial institutions are not the only means of home equity conversion. Seniors can set up informal arrangements with adult children or other heirs whereby they gradually trade equity in the home for cash assistance. They can use conventional forward loans to liquefy home equity, although such loans have the disadvantage of requiring monthly payments. They can sell their homes and use the proceeds to fund long-term care, but many seniors are reluctant to give up their homes even after they're unable personally to occupy them because of infirmity or frailty.

If home equity of the elderly is so great and long-term care so expensive, why is home equity conversion of one kind or another so rarely used to fund LTC? There are many reasons. First and foremost, Medicaid exempts home equity for purposes of eligibility, and estate recovery often misses home equity for one reason or another, including active attorney-assisted, pre-planned avoidance. Another reason is that home property often has personal value to seniors far beyond its cash equity. Reverse mortgage lenders in North Carolina reported that misconceptions about the product interfere. People think "they'll take your home," which is not true; borrowers or their heirs are liable only for the value extracted plus interest; the remaining equity stays with the homeowner or passes to heirs. Furthermore, reverse mortgages are "non-recourse." Borrowers can never owe more than the market value of the home. A common complaint is that RMs are too expensive. But objective observers should ask, compared to what? Less costly forward mortgages require people to have solid monthly incomes, to make regular monthly payments, and to pay off their loans during a set period of time. Reverse mortgages carry none of these requirements.

Bottom line, whatever the reasons, home equity of seniors is an enormous, virtually untapped resource that could help frail and infirm elderly obtain high quality LTC at the most appropriate level in the private market. If home equity were so used, it would significantly relieve the burden on Medicaid to finance long-term care for people most in need. Nevertheless, the 2001 NCIOM report on long-term care states, "The Task Force does not recommend that the NC General Assembly rely on reverse mortgages as a means of financing long-term care services." Its 2007 update explains: "No action taken by NC General Assembly to encourage people to use reverse mortgages to finance long-term care." Public policy makers and their advisers may need to reassess such positions as the gap between the cost of long-term care and government's ability to pay for it grows in the future.

Home ownership by elderly North Carolinians is greater than the national average: 83 percent compared to 78.6 percent for the country as a whole.

Long-term care insurance

The third potential private financing source for long-term care is private insurance. Long-term care insurance (LTCi) comes in many forms, and information about it is readily available from numerous books and reports. Suffice it to say that agents marketing the product in North Carolina told us that high-quality private insurance is readily available for long-term care in North Carolina but very difficult to sell. They estimated that only 20 companies sell the product in the state and that perhaps 50 to

100 agents specialize in long-term care insurance statewide. They complained that most LTCi is sold by numerous "dabblers," advisers who specialize in other financial products and know very little about LTC insurance, but who sell one or two policies a year. LTCi specialists do not believe outright abuse or misrepresentation by sales agents is a problem, but they believe the dabblers' lack of expertise can be a serious problem despite their good intentions.

North Carolina does little to incentivize the purchase of long-term care insurance, even though the NCGA restored the state income tax credit for the purchase of LTCi in 2007.

Regulation of LTCi in North Carolina is good and strong, according to the LTCi producers we interviewed, but getting marketing materials approved can be very difficult and does impede product sales. AHIP, the national insurance trade association, estimates that only 6 percent to 9 percent of North Carolinians age 50 or older have purchased LTCi. Our interviewees said that North Carolina does little to incentivize the purchase of long-term care insurance, even though the NCGA restored the state income tax credit for the purchase of LTCi in 2007.

Representatives of the North Carolina Department of Insurance were not available for interview, but did respond to written queries. According to the Department, 121,512 North Carolinians were covered by LTC insurance as of June 28, 2006. That equates to 1.3 percent of the general population or 11.6 percent of the elderly population. It's up from 91,379 covered lives in 2004, an increase of 33 percent in two years. Nationally, the LTCi market has been flat or down recently. North Carolina has adopted the National Association of Insurance Commissioners model LTC insurance statutes including provisions governing the mandatory offer of non-forfeiture benefits, i.e. some reduced benefit if a policy is lapsed; inflation protection; and premium rate stability. The Department of Insurance also reports that state Medicaid officials are currently developing the standards for a North Carolina Long-Term Care Partnership plan, which would allow Medicaid recipients to keep their assets up to the amount of LTCi benefits purchased and actually used. Long-Term Care Partnership programs were reauthorized by the Deficit Reduction Act of 2005.

"Medicaid can explain the lack of private insurance purchases for at least two-thirds and as much as 90 percent of the wealth distribution, even if comprehensive, actuarially fair private policies were available," according to estimates by Jeff Brown and Amy Finkelstein, two scholars at the National Bureau of Economic Research.

In another study, they concluded:

> [I]f every state in the country moved from their current Medicaid asset eligibility requirements to the most stringent Medicaid eligibility requirements allowed by federal law – a change that would decrease average household assets protected by Medicaid by about $25,000 – demand for private long-term care insurance would rise by 2.7 percentage points.

Even the "most stringent Medicaid eligibility requirements allowed by federal law," however, are extremely lenient, allowing Medicaid LTC recipients to qualify, at least for nursing home care, despite possessing very substantial incomes and while retaining virtually unlimited assets. If a slight

reduction of Medicaid's asset protections of $25,000 would increase LTCi market penetration to 11.8 percent nationally from the current 9.1 percent, imagine the effect of a more substantial change, such as reducing the home equity exemption to $50,000 from $500,000.

Unlike its opposition to Medicaid estate recoveries and reverse mortgages, the NCIOM Long-Term Care Task Force encouraged the spread of private long-term care insurance, saying:

> The purchase of private long-term care insurance offers two benefits: (1) it helps pay for needed services, thereby allowing the individual to preserve his or her assets; and (2) it provides people with a greater choice of providers than people who rely on Medicaid or other public sources to pay for services.

Unfortunately, other than reinstating the tax credit for LTCi purchases and studying the creation of a Long Term Care Partnership, North Carolina's state government has done little to expand the market for this product.

As long as people can ignore the risk of long-term care, avoid the premiums for private insurance, wait to see if they ever need long-term care, and if they do, shift the cost to Medicaid, the public is unlikely to embrace the idea of taking early personal responsibility for this risk. Therefore, it remains doubtful whether any amount of education or positive financial incentives would persuade people to plan for long-term care and save, invest, or insure for the risk.

Conclusions and Recommendations

Well-intentioned public financing of long-term care services, in North Carolina as elsewhere in the U.S., has had unintended effects. It has created institutional bias in the LTC service delivery system and crowded out sources of private LTC financing which would be far more likely, based on consumer preferences, to be spent on and to encourage the development of lower-cost home- and community-based care. Ironically, the more government money North Carolina invests in improving publicly financed long-term care, the more attractive it becomes – despite its problems of access, quality and care-level bias – and the less likely consumers are to plan early to pay privately for long-term care. As the Age Wave begins to crest, the fiscal end game nears. At some point, probably not far in the future, costs will trump revenue and this complicated, convoluted system will fail.

So what keeps such a dysfunctional system going in spite of all the logic and evidence that cries out for reform? Arguably, Americans in general and North Carolinians in particular have developed an "entitlement mentality," an expectation that government will provide so personal responsibility is unnecessary. People expect Social Security to supplement retirement income and Medicare to pay for old-age health care. Most do not give long-term care a second thought until they are in a crisis. They do not plan consciously to rely on Medicaid, but because Medicaid has been the primary payer for long-term care for the past 40 years, the public's denial of long-term care risk has been thus enabled. People ignore the problem of long-term care until it's too late to save, invest, or insure. At that point, Medicaid is the easiest and financially most attractive alternative.

But not for much longer. Medicaid LTC depends heavily on Medicare's generous nursing home reimbursements to make up for the welfare program's underfunding of institutional care. But Medicare's $75 trillion unfunded liability guarantees it will not be able to prop up Medicaid indefinitely. Likewise, Social Security income of people already receiving Medicaid LTC benefits helps close the gap between what Medicaid pays for long-term care and what LTC providers need to provide decent care. But Social Security's $15 trillion unfunded liability threatens to reduce that support to 75 cents on the dollar. The Social Security Administration warns everyone covered by the program annually that their benefits will go down by 25 percent unless the program's financial shortfall is somehow filled. A third problem facing continuance of Medicaid LTC levels in the future at levels approaching those of the past is that the federal government is moving more and more aggressively to discourage initiatives, commonplace for decades in North Carolina, to shift costs from state to federal responsibility. Thus mainstays like provider taxes, used now to maximize federal matching funds without increasing state costs, are under scrutiny and likely to be curtailed.

Americans in general and North Carolinians in particular have developed an "entitlement mentality," an expectation that government will provide so personal responsibility is unnecessary.

Consequently, the problem of financing long-term care is approaching critical mass. LTC policy makers in North Carolina should follow the fundamental principle of responsible medicine: "First do no harm." Stop making the problem worse by funding too much LTC through public programs, permitting easy access to government-financed care, and thus preventing the growth of private financing alternatives. Unfortunately, the state's hands are tied by federal rules that prevent full application of this advice. So, North Carolina should do what it can do as follows:

- Reconsider the public policy recommendations of the NCIOM LTC Task Force that encourage spending more and more on public benefits without a comparable emphasis on encouraging personal responsibility, early planning, and private LTC financing alternatives.

- Immediately implement all of the provisions of the Deficit Reduction Act of 2005, including the $500,000 cap on Medicaid's home equity exemption, the five-year look back for assets transferred to qualify for Medicaid, and the change in the date of the asset transfer penalty.

- If North Carolina's Medicaid planning bar continues to obstruct DRA implementation, the Atlanta Regional Office of the Centers for Medicare and Medicaid Services should require compliance with the law as a condition of continued federal financial participation in North Carolina's Medicaid program.

- The state should conduct a study of Medicaid estate planning in North Carolina, including a valid random sample of nursing home cases to determine how widespread the practice is, how much it costs the state and counties in service payments, how much is lost to estate recovery, and to what extent program resources are being diverted away from North Carolinians most in need.

- North Carolina should carefully review the Medicaid estate recovery program to find out why its collections are so much lower than those of many other states. Study the laws, practices, and techniques used in the more successful states and determine if they would be applicable to North Carolina. Educate the public about estate recoveries and the importance of planning early to avoid Medicaid dependency. Educate state legislators and policy makers about the importance of preventing Medicaid from becoming free inheritance insurance for baby boomer heirs.

- Implement a Long-Term Care Partnership program to incentivize the purchase of private coverage. Examine Department of Insurance policies to be sure well-intentioned regulation is not preventing viable marketing of affordable LTC insurance products in the state. Educate the public about the importance of planning for long-term care through savings, investments, and insurance.

- Encourage the use of home equity conversion through reverse mortgages and other means to fund long-term care in lieu of Medicaid dependency. Consider removing regulations that interfere with the marketability of RMs, such as the requirement that every borrower receive a face-to-face briefing on the product. (Sometimes issues of cost or mobility make a telephone counseling session more effective.)

- Recognize that federal funding of LTC (through direct Medicaid funding; provider taxes and other Medicaid-maximizing methods; Social Security spend-through supplementing recipients' cost of care; and Medicare) is likely to decrease rather than increase in the future. Integrate that hard financial reality into long-range state budgetary planning.

- Resist the temptation to "spend and tax," i.e., expand LTC financing in good times and raise taxes to cover the inevitable shortfalls when bad economic times arrive. As the boomer generation retires and starts taking benefits out of Social Security and Medicare instead of putting payroll taxes in, future recessions may be deeper and recoveries less robust. When welfare rolls are up, tax receipts down, and budgets tight, take the opportunity to tackle public policy initiatives like the ones recommended here that may be too politically sensitive to implement when budgets are in surplus.

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The John Locke Foundation is a nonprofit, nonpartisan policy institute based in Raleigh. Its mission is to develop and promote solutions to the state's most critical challenges. The Locke Foundation seeks to transform state and local government through the principles of competition, innovation, personal freedom, and personal responsibility in order to strike a better balance between the public sector and private institutions of family, faith, community, and enterprise.

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"To prejudge other men's notions before we have looked into them is not to show their darkness but to put out our own eyes."

JOHN LOCKE (1632–1704)

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