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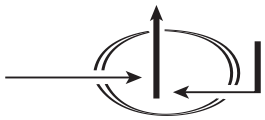

Financing Long-Term Care in New Jersey and Across the Nation

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INTRODUCTION

The diagnosis and treatment of disease and disability continues to change dramatically. These advances have not only resulted in increases in life expectancy but have also increased the likelihood that we will need long-term care at some point in our lives. Many more people are living longer with chronic health conditions as well as with physical and cognitive frailties resulting in more people who need help, over an extended period, with the tasks of daily life. It is the nature of this assistance that is commonly called "long-term care."

Anticipated demographic trends ensure that the number of people needing long-term assistance is likely to double between now and 2030.[1] Increasingly, after 2015, those needing care will be more likely to not have any children or certainly fewer children, on average, to depend on for assistance than in previous generations. Moreover, the decline in fertility rates which are the root cause for the relative decline in adult children will have also slowed the growth in the labor force, making it more difficult for long-term care providers.

Without changes in financing arrangements as well as changes in the organization of service delivery, access to needed care could be more difficult to obtain, even for the well to do, than it is today. State Medicaid programs, which pay for a substantial share of long-term care, will feel even greater pressure, finding it necessary to finance more care among a growing number of people desperate for assistance. Providers of long-term care will face the challenge of delivering quality care from within a tight labor market.

This issue brief examines long-term care from a national perspective. Although for the most part the national discussion is consistent with each state, there are important circumstances and institutional arrangements within each state (as well as across counties) that matter. Some of the key aspects that make New Jersey unique will be identified; however, it is beyond the scope of this paper to provide an in-depth analysis of New Jersey's approach, programs, and populations.

Defining Long-Term Care

Long-term care is the assistance that people need when they are no longer able to fully function on their own. People who need long-term care may need hands-on assistance or stand-by supervisory assistance to eat, use the toilet, get out of bed, get dressed, bathe, maintain their prescription drugs, go shopping, get to the doctor, obtain groceries, cook meals, manage their money, clean their laundry, or maintain their home. Some who need long-term care are physically unable to undertake these tasks while others are physically able to do it but need visual or verbal cueing and supervision.

Although some of the tasks can be scheduled, there are critical tasks that cannot. Shopping for groceries, paying bills, and doing the laundry for example are less time-sensitive and therefore referred to as Instrumental Activities of Daily Living (IADLs). Other limitations such as eating, toileting, bathing, getting out of bed, or moving about are more time-sensitive. These tasks are referred to as Activities of Daily Living (ADLs).

The Risk of Needing Long-Term Care

We are all at risk of needing long-term care. Genetic abnormalities at birth, cognitive imperfections, accidents, degenerative chronic conditions, as well as strokes and frailty have resulted in a diverse population

*The author would like to acknowledge the assistance provided by Katherine Mack also of the Center on an Aging Society in preparing this Issue Brief.

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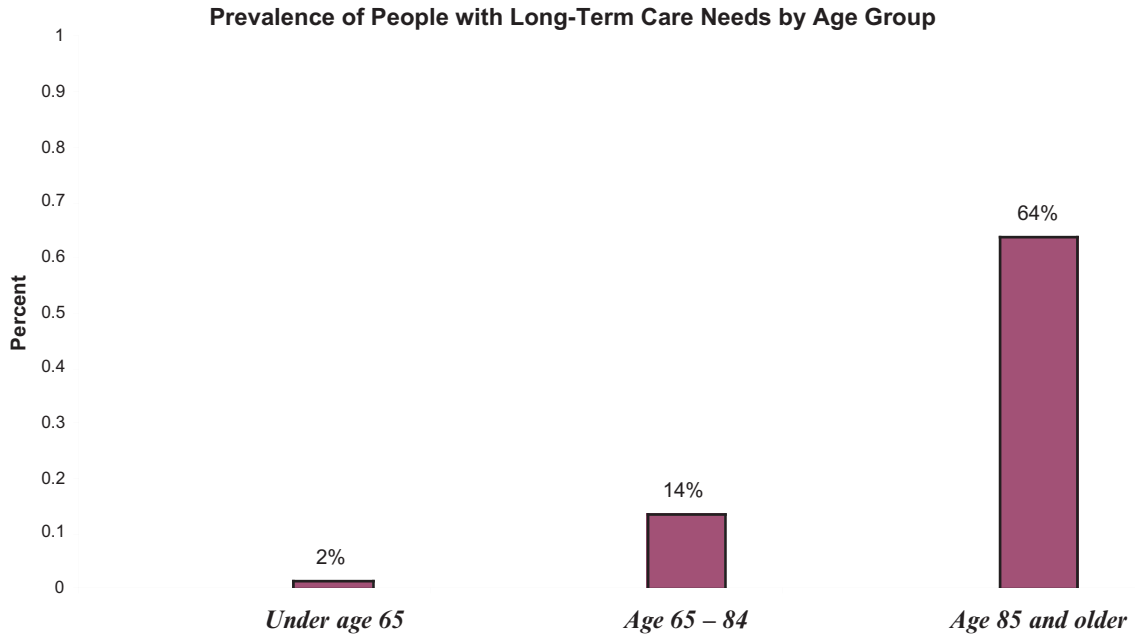
in need of assistance. In 2000, an estimated 9.5 million people nationwide needed long-term care.[2] Although the risk does increase with age, about 38 percent were under the age of 65. In 2000, about 2 percent of the population age 18 to 64 needed long-term care; whereas nearly two-thirds of people age 85 or older needed care.[3] (See Figure 1.) At least one simulation effort projects that after age 65, 30 percent are likely to die without ever needing long-term care, but 70 percent will at some point over the remainder of their lives need long-term care.[4] The variation in the scope and depth of care, however, is considerable. For example, in this particular simulation it was estimated that between age 65 and the end of their life, about 10 percent were likely to need less than one year of long-term care; 40 percent might need between one and four years, but that about 20 percent were likely to need care for five or more years.

Figure 1



Source: Georgetown University Health Policy Institute analysis of data from the 2000 National Health Interview Survey; and Centers for Disease Control and Prevention: The National Nursing Home Survey: 1999 Summary.

Nationwide about 83 percent of those who need long-term care live in the community, not in a nursing home.[5] Figure 2 provides a breakdown of where the long-term care population lived in 2000. Where people live, however, is not necessarily a fool-proof proxy for their level of needed assistance. There is no question that people in nursing homes need a tremendous amount of assistance; however, there are people living in the community who need just as much help. About 24 percent of assisted living residents, for example, were found to have cognitive impairments analogous to the level of impairment that is found in more than one-third – 38 percent – of nursing home residents.[6] Similarly, less than 12 percent of residents age 65 or older in community housing with services received assistance with 3 or more ADLs, while more than 65 percent of residents in a long-term care facility received that level of assistance.[7]

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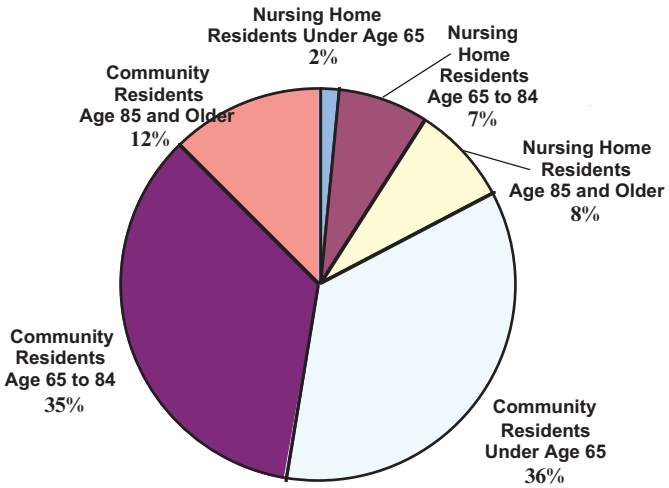
Figure 2

People Living in the Community or a Nursing Home with Long-Term Care Needs by Age, 2000



Total = 9.5 million

Note: Long-term care population among community residents is defined as someone three and older who responded that, due to a physical, mental, or emotional problem, they needed the help of another person with personal care needs, such as eating, bathing, dressing, or getting around inside the home; or someone 18 and older who needs the help of another person in handling routine needs. Anyone in a nursing home is considered part of the long-term care population.
Source: Rogers, S. & Komisar, H. (May 2003) *Who needs long-term care?* Fact Sheet (Washington, DC: Georgetown University Long Term Care Financing Project), http://ltc.georgetown.edu/pdfs/whois.pdf

Some Facts about New Jersey

The availability of long-term care services is dependent on the size, structure, age distribution, and income of a state's population as well as state policies regarding social services and Medicaid. Consequently each market area is unique. This section identifies some of the characteristics affecting long-term care in New Jersey.

The Risk of Needing Long-Term Care

- New Jersey has a population of 8.7 million, 2 percent of which are age 85 or older and 11 percent are age 65 to 84.
- In 2003, 16.5 percent of people age 18 or older living in New Jersey were disabled.[8]
- In 2000, 7.4 percent of people age 5 to 20, 17.4 percent of people age 21 to 64 and 38.6 percent of people age 65 or older were disabled.[9]
- About 19.7 percent of the population age 65 or older had "self-care" limitations, 14.7 percent had sensory limitations and 9.4 percent had cognitive or mental limitations.[10]
- As of 2002 the life expectancy at birth in New Jersey was 78.1 years and, as of 1999, life expectancy at age 65 was 17.8 – 16.2 for men age 65 and 19.1 for women age 65.[11]

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- Between 2010 and 2025, the population age 65 or older in New Jersey is expected to increase 44 percent, and the population age 85 or older is expected to increase 15 percent.

- Between 2010 and 2025, the number of people age 45 to 64 – the general pool of potential family caregivers – is expected to decrease from 2,348,046 to 2,264,439 – a decline of negative four percent.

Financing Long-Term Care

- Currently, Medicaid represents roughly 60 percent of nursing home revenues, Medicare represents 20 percent and private payers and long-term care insurance make up the remaining 20 percent.

Family Caregivers

- The majority of long-term care in New Jersey is provided by family members, friends or volunteers – current estimates suggest that there are roughly 831,953 caregivers in New Jersey each providing 891 hours per year.[12]

Medicare

- Long-term care providers do receive reimbursement from Medicare and health insurance for post-acute care. In 2001, of the 957,000 Medicare beneficiaries in New Jersey, 56,865 received care in a Medicare skilled nursing facility and 79,922 beneficiaries utilized care from a Medicare home health agency.[13]

Medicaid

- In 2003, New Jersey spent roughly $8 billion in Medicaid expenditures – 41.5 percent of which went towards long-term care while only 33 percent of went towards typical long-term care beneficiaries – the aged, blind or disabled.

- Aged, blind or permanently disabled persons in New Jersey can qualify for Medicaid once countable assets reach $4,000 or less for nursing home care and $2,000 for home and community-based care.

- Income requirements are the same for both nursing homes and home and community based care, which are both set at 300 percent of the Supplemental Security Income (SSI).

- New Jersey applies medically needy spend down rules to nursing home participants, but not to waiver participants. New Jersey does treat spouses income and assets the same – as of 1998 $2,019 of the spouse's income and $80,760 of his or her other resources are not counted when determining Medicaid eligibility.

- All other income as well as the income of the nursing home resident – with the exception of a monthly personal needs allowance (PNA) of $35 – must be used towards the cost of nursing home care, with Medicaid covering the shortfall.

- Starting in 1996, New Jersey combined over 20 programs and 600 staff members under the "new" New Jersey Department of Health and Senior Services (NJDHSS) to reorganize the governance and administrative structure of the state government with the explicit intent of improving home and community based services and shifting care out of the nursing homes.

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- Between 1997 and 2002, home- and community-based expenditures as a percentage of total state long-term care expenditures increased from 7.3 to 15.3 percent.

- In 2002, the state spent roughly $24.4 million on Medicaid home- and community-based services.

- Since 1997, New Jersey has experienced a decline in the proportion of Medicaid expenditures for nursing home care – from 92.7 percent to 84.7 percent of total long-term care expenditures in 2002 – and the number of Medicaid nursing home residents decreased roughly 10 percent.

- Currently, however, nursing home care remains the primary – and most expensive – provider of long-term care. As of 2003, home health care represented 23.4 percent of the state's total Medicaid long-term care expenditures and institutional care represented 60 percent.[14]

- In 2003, Medicaid spent $3.5 million on long-term care expenses - $2,093 million and $817 million went to nursing facilities and home health and personal care, respectively.

Long-Term Care Insurance

- Relatively few people have long-term care insurance and most policyholders have not filed any claims and therefore long-term care insurance currently finances a minuscule portion of care purchased.

- As of 2002, between 6 and 9 percent of total long-term care insurance policies sold nationwide were sold in New Jersey.[15]

How Long-Term Care is Financed

Most long-term care is provided by family, friends and volunteers and therefore does not get tallied as an expenditure. Some call this care informal care; we prefer to call it family care. Over two-thirds of Medicare beneficiaries, age 65 or older with long-term care needs receive family care *only* and 26 percent receive *both* family care and some form of paid formal care.[16]

Most families have more than one caregiver, but the primary caregiver, which is typically the spouse or adult child, usually provides the most care and coordinates the other care provided. The typical primary caregiver is a 46-year-old woman who has at least some college experience and provides more than 20 hours of care each week to her mother.[17] About 41 percent of all primary caregivers to care recipients age 65 or older are spouses and 44 percent are adult children.[18] While for most circumstances paid care provided in the community is supplemental to family care, about 9 percent of persons age 65 and older living in the community do not have any family care and receive all of their care through paid providers.[19]

Although individuals purchase most of the long-term care services that are provided outside of a nursing home, long-term care expenditures are dominated by Medicaid and Medicare expenditures on nursing homes and home health agencies. This seeming anomaly occurs because care in a nursing home is substantially different than care purchased to supplement family care at home and care purchased by Medicaid, and virtually all of the care purchased by Medicare is for post-acute care and not long-term care. All health care payers, including private health care plans as well as Medicaid and Medicare, purchase post-acute care services provided by nursing homes and home health agencies as a way of minimizing inpatient hospital care expenditures.

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Medicare's Role in Financing Long-Term Care

Medicare covers up to 100 days in a skilled nursing facility for care following and related to a hospital stay of at least 3 days. The first 20 days of covered services are covered in full; but there is a daily co-payment of up to $114 for the next 80 days. Medicare also covers part-time, intermittent home health services if one is homebound and needs skilled nursing care, occupational, or physical therapy. Part-time, intermittent care has come to mean care needed on fewer than 7 days a week, or less than 8 hours a day for periods of 21 days or less. Any custodial unskilled care that might be a part of this care would also be intermittent and would only be covered if it were a necessary part of the skilled care prescribed by the physician. Someone who is homebound due to long-term care would need more than intermittent care.

Medicaid's Role in Financing Long-Term Care

Medicaid is the payer of last resort for health care, post-acute care and long-term care. Eligibility, however, depends on meeting categorical, functional and financial criteria. Categories include being age 65 or older or being disabled (meeting a medical, work-oriented definition of disabled). Functional need tends to mean being limited in 3 or more Activities of Daily Living. Assuming one meets the categorical and functional eligibility criterion, Medicaid coverage occurs once financial resources are nearly depleted and when health and long-term care expenses exceed a substantial portion of income.[20] In the case of nursing home care, Medicaid beneficiaries must pay all of their income, with the exception of a personal needs allowance towards the cost of care. Currently, the personal needs allowance is required to be at least $30 but could be as large as $90 a month.[21]

While there are ways in which people can accelerate their financial eligibility to Medicaid, states have been quite assertive in limiting the extent to which this can occur.[22] States are required to look back at all financial activities in the previous three years to determine a person's eligibility for Medicaid. Transferred assets within the past three years continue to count as the applicant's resources. Moreover, the state is obligated to make a claim against a nursing home resident's assets, such as their home, to help meet the costs of care provided by Medicaid after the beneficiary and their dependent has died.

Over the past two decades, states have experimented with a wide variety of home and community-based long-term care efforts. This includes care provided in people's homes or care provided in facilities that people attend during the day, such as adult day care centers. Some Medicaid programs have even paid for some of the services provided in assisted living facilities.

Medicaid assistance, however, is much more likely in a nursing facility. All states must cover care in a nursing facility and therefore most states have many facilities. Home and community-based care is not a required Medicaid service and since it is not covered, for the purposes of providing long-term care the market is much less well developed then the nursing home market. Slightly more than half the states have varying degrees of personal care services delivered in the home while all states have a number of "waiver" programs that provide care in the community.

If a state decides to offer personal care services they must offer them state-wide to all Medicaid-eligible persons who meet the functional limitation levels. On the other hand, a state can apply for a waiver from the Medicaid rules to develop a program for a particular category of eligible persons in a particular location. Generally, "waiver" programs are designed so that they spend, on average, no more than what otherwise might be spent on institutional care, per person. And they must target people who, in the absence of such services, would require nursing home care. Consequently home and community programs are often quite limited and targeted. Figure 3 compares home and community-based spending with nursing home spending at two points in time. Clearly spending on home and community-based care has grown, but it is less than half the spending on nursing home care.

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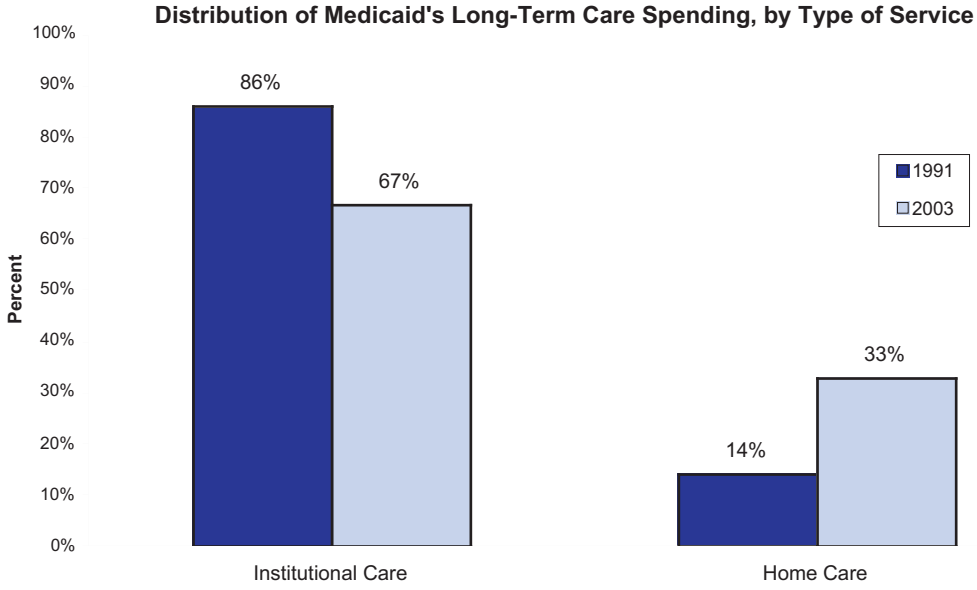
Figure 3



Source: Komisar, H. & Thompson, L. (July 2004) *Who pays for long-term care?* Fact Sheet (Washington, DC: Georgetown University Long-Term Care Financing Project), http://ltc.georgetown.edu/pdfs/whopays2004.pdf

It should be noted that state Medicaid programs vary considerably. States have some discretion in defining Medicaid eligibility, specific services and the scope of coverage. States have even more discretion in how the program is implemented and administered. As a consequence, two persons who are identical in age, health status, health needs, and financial circumstances, but living in two different states or even in two different counties in the same state can have very different experiences in terms of basic eligibility as well as access to assistance from Medicaid even if they are eligible.[23]

Long-Term Care Expenditures

Other public programs that finance long-term care include state programs that are not a part of Medicaid, and programs run by the Department of Veterans Affairs (VA). At last count, 34 states also had separate long-term care programs that were not a part of Medicaid.[24] The VA operates 114 nursing homes and 76 home-based primary care programs.[25] In 2003, VA nursing homes served, on average, 12,339 veterans a day while VA home-based care served 8,368.

Figure 4 shows the total spending on long-term care providers by payer. Nearly half of all the payments were from Medicaid. Over twenty percent of the payments were from persons using long-term care services.

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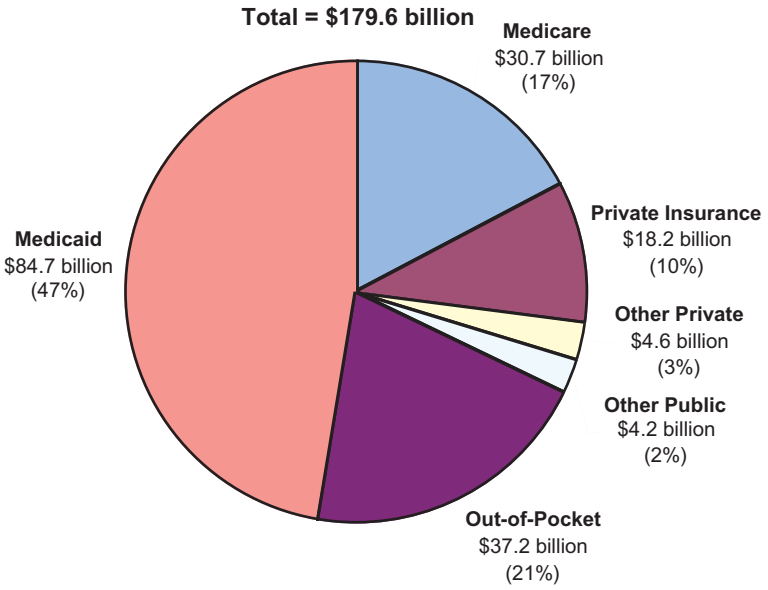
Figure 4

National Spending for Long-Term Care, by Payer (2002)



Source: Komisar, H. & Thompson, L. (July 2004) Who pays for long-term care? *Fact Sheet (Updated)* (Washington, DC: Georgetown University Long Term Care Financing Project), http://ltc.georgetown.edu/pdfs/whopays2004.pdf.

Confronting Long-Term Care

All of us are at risk of needing long-term care. Most of us will need some long-term care. About 40 percent of us will need less than 1 year of assistance, and about 20 percent of us will need assistance for 5 or more years. The relatively low annual risk but the incredible variation in needs among those who do need long-term care suggests that the most efficient way to pool the risks of long-term care is through some form of insurance. Nevertheless, long-term care remains one of life's largest contingencies for which there is an inadequate amount of risk pooling. As a consequence, access to needed services is uneven, not always efficient, and eventually beyond the means of most people.

Planning for Long-Term Care

Most people do not actively engage in long-range planning for long-term care. In fact, most formal retirement planning efforts only recently began to include long-term care in their curriculum. Given the relatively late planning for retirement that seems to occur, it is not surprising that long-term care planning would not be any more advanced. After all, retirement is considered a goal, while dependency is not. For most people the "default planning" for long-term care is learning the hard way what it means to apply for assistance from the state Medicaid program.

On the other hand there are really only a few options available to individuals. Clearly a step in the right direction would be to get people to recognize the need to plan for this contingency within their retirement planning. Saving more, generally, might be a good option. But saving for long-term care is not efficient and is likely to not be sufficient. While the annual risks for needing long-term care are relatively low, the potential costs are not only variable but also very expensive. Hence, even if one could save for long-term care, it would not be clear how much to save. Invariably savings are to either be too little or too much.[26]

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Beyond increasing savings one can buy into an insured "life-care community," or purchase a long-term care insurance policy. A life-care community or continuing care retirement community usually offers independent living in an apartment with assisted living services, medical services, skilled nursing services and long-term care, usually all in one location. Moving into a life-care community means moving from one's home and community and paying a substantial initial fee, with monthly fees thereafter.

Assuming the life care community is affordable; it does require moving into the community before one needs long-term care since the community pools the financial risks of community residents. As a result, like any insurance policy, the community must avoid admitting people who are most likely to need long-term care. Most people have not embraced this option, in part because they either prefer to remain in their current neighborhood or they cannot afford the move.[27]

Another alternative is to move into a comprehensive retirement community or an assisted living facility. The assisted living facility, in particular, provides congregate meals and some supportive services, but rarely provides the full range of services needed for long-term care. Most facilities let people hire additional help, but some facilities discourage people from remaining at the facility when the help that they need becomes too comprehensive.

Another option is to consider purchasing a long-term care insurance policy. Because consumers choose the scope and depth of coverage that they want or can afford, long-term care insurance policies do not necessarily cover the full financial risk of long-term care or all services needed. Nevertheless, long-term care insurance policies do offer the advantage of pre-funding a set amount of the financial risk associated with long-term care. The market for long-term care insurance, as measured by sales of policies, has been growing rapidly. However, this option is not available to children or people with medical conditions. Moreover, it is not affordable to the majority of older people. It is, however, affordable to nearly half of the population under age 50.[28]

In 2004 there were an estimated 4.2 million individual and 1.9 million employer-sponsored group long-term care insurance policies in force.[29] While more than 6 million people with a long-term care insurance policy is a substantial number of people, it is a small fraction of the population. A broker or agent sold the vast majority of long-term care insurance policies –76 percent – to individuals.[30] About 21 percent have been purchased through an employer sponsored long-term care insurance plan.

In 2002, the largest employer in the United States, the federal government, began offering its workers, annuitants, and family members of workers and annuitants access to a long-term care insurance policy marketed jointly by John Hancock Life Insurance Company and Metropolitan Life Insurance Company through Long Term Care Partners, LLC. As of March 2005, there were over 208,000 individuals enrolled in the federal long-term care insurance program. While this is a substantial number of policyholders, it is a relatively small percentage of the more than 20 million federal employees and annuitants and their dependents that are estimated to be eligible to purchase this insurance.[31]

Without an immediate and dramatic increase in the proportion of the population buying long-term care insurance, it will take another century before long-term care insurance is a meaningful source to finance long-term care. However, even if there were a dramatic increase in the number of sales, policyholders may still have exposure to the financial risks of long-term care, since the current long-term care insurance policies do not fully insure all the risks of long-term care.

The Effect of Demographics

After 2020, the demographic shifts that are upon us may make the overall consequences of needing long-term care more difficult. Generally, after that point in time, the number of people needing assistance is likely to increase faster than the population available to provide assistance. Advances in technology may help, but most long-term care will require a person in the same room as the person who needs long-term care.

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Those at greatest risk of needing long-term care are people age 85 and older. Table 1 shows anticipated changes in the population while Table 2 shows the change in select age groups between the 2000 Census and various points through 2050. These projections suggest that between now and 2020, there will be plenty of adult children potentially available for many older parents. After all, by definition, the baby-boom reflects the fact that mothers of children born between 1946 and 1964 were more likely to have had 3 or more children while mothers prior to 1946 and subsequently since 1964 were more likely to have had 1 or 2 children.

In the twenty years between 2010 and 2030, the population age 85 and older is expected to increase 54 percent. Then in the subsequent ten years between 2030 and 2040, the population age 85 and older is projected to increase another 60 percent.[32] During this time, particularly after 2030, the pool of professional caregivers will shrink as will the pool of adult children of the population most likely to need long-term care.

To put this in perspective, there were nearly 10 people aged 50-64 years of age for every person age 85 or older in 2000. This crude ratio reflects the potential pool of adult children caregivers relative to their parents. By 2040 this ratio is likely to be less than half as large, at four-to-one, suggesting that those in need of long-term care may have smaller families from which to depend. Looking at younger age groups, it is clear that long-term care providers will be facing tighter labor markets than they have experienced lately.

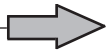
Table 1

TOTAL U.S.						
	2000	**2010**	**2025**	**2030**	**2040**	**2050**
Total Population	281,421,906	299,861,974	337,814,656	351,070,085	377,349,706	403,686,852
Population Age 25 to 44	85,040,251	78,293,415	86,105,456	87,973,004	92,433,270	100,045,883
% 25 to 44	30%	26%	25%	25%	24%	25%
Population Age 45 to 64	61,952,636	79,590,141	78,416,545	77,654,244	84,036,417	89,089,727
% 45 to 64	22%	27%	23%	22%	22%	22%
Population Age 65 or Older	35,081,145	39,715,126	62,641,170	70,319,071	77,177,066	81,998,974
% 65+	12%	13%	19%	20%	20%	20%
Population Age 85 or Older	4,294,969	5,785,840	7,440,797	8,930,816	14,283,787	19,352,063
% 85+	2%	2%	2%	3%	4%	5%
Ratio 45-64 to 65+	1.8	2.0	1.3	1.1	1.1	1.1
Ratio 45-64 to 85+	14.4	13.8	10.5	8.7	5.9	4.6

Table 2

Population Change

TOTAL U.S.					
	2000-2010	**2010-2025**	**2000-2025**	**2000-2030**	**2010-2030**
Total Population	6.6%	17.1%	20.0%	24.7%	17.1%
Population Age 25 to 44	-7.9%	10.0%	1.3%	3.4%	12.4%
Population Age 45 to 64	28.5%	-1.5%	26.6%	25.3%	-2.4%
Population Age 65 or Older	13.2%	57.7%	78.6%	100.4%	77.1%
Population Age 85 or Older	34.7%	28.6%	73.2%	107.9%	54.4%



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Policy Implications

Although long-term care is an insurable event, for most people, including some with long-term care insurance, most of the risk is not insured. Nevertheless, only rarely has this issue been a part of a national dialogue. In the rare moments when national attention has been focused on long-term care it was always a part of the national dialogue about health care reform and health care reform seemed to dominate most of the attention. Nevertheless, states along with families in their state, continue to be confronted with difficult decisions concerning the financing and delivery of long-term care.

State-Level Initiatives

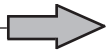
All states have been struggling with controlling their Medicaid expenditures. A central question for each state is how best to design home and community based programs that will shift the balance from nursing home care to care at home to reduce overall long-term care expenses.

In addition, at least 26 states (but not New Jersey) have amended their tax code to provide explicit incentives, such as a tax credit or deduction for the premiums paid for long-term care insurance. It is hoped that by providing tax incentives, more people will purchase long-term care insurance. Furthermore it is either assumed or hoped that insurance will delay or avoid the need for assistance from Medicaid. Obviously the tax incentive means a loss of state revenues. This suggests that some anticipate that long-term care insurance will eventually result in lower Medicaid expenditures and that these savings will exceed the foregone revenue from the tax incentives.

Four states (California, Connecticut, Indiana and New York) have established explicit partnerships with insurance companies to sell a policy that if purchased changes the resource test for Medicaid eligibility. The approach varies slightly in each state, but the basic idea is that those who purchase a state approved long-term care insurance policy would be able to apply for Medicaid assistance without counting some of their financial assets. For example, in Connecticut, if a partnership long-term care policy is purchased that will cover 3 years of long-term care at $200/day then when this policy is exhausted (and $219,000 has been expended) then that policyholder will be able to exclude $219,000 from countable assets when they apply for assistance from Medicaid. Note that the categorical, functional, and income tests remain the same, however.

It is hoped, by some, that by providing Medicaid on the back-end of the *long-term* long-term care risk, people will be encouraged to purchase a policy. In essence for most people the purchase of a 2- to 4-year long-term care insurance policy tied to Medicaid would effectively provide them with lifetime coverage, particularly for nursing home care. Moreover, there are virtually no up-front revenue losses to the state (as there is with tax incentives to purchase long-term care insurance). States, however, are gambling that the long-term care insurance coverage will delay or even avoid many more middle-income persons from becoming eligible for Medicaid. This will occur, if people insure for more than they have in financial assets or if a disproportionate number of people receiving long-term care die prior to becoming eligible for Medicaid; otherwise, it is likely that persons who might never have become eligible for Medicaid become eligible due to the partnership policy.

It is still too soon to know how successful these four explicit Medicaid partnerships have been, particularly for the state. It is clear that the state's attention to qualifying long-term care insurance policies for the partnership did have an impact on the state's views and regulations of all other long-term care insurance.[33] However, within each of those states, most policies sold are not Medicaid partnership policies. Overall, since 1994, about 181,600 partnership policies have been sold in the four states, and as of June 2004, about 149,300 policies were still in-force.[34] At this point, partnership policies represent less than 11 percent of all long-term care insurance policies sold in the four states.[35]



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Federal Discussions about Financing Long-Term Care

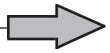
Currently, federal policy discussions about financing long-term care are focused on expanding private long-term care insurance. The insurance industry would like all taxpayers to be able to deduct long-term care insurance premiums from their taxable income. Moreover, they would like all employees to be able to purchase long-term care insurance on a pre-tax basis through their employers' health reimbursement or flexible savings account (or employee benefits cafeteria plan).[36]

Proponents of this approach argue that the tax incentives would help to encourage sales by signaling the importance of long-term care insurance. Opponents suggest that most of the forgone revenue would be on behalf of persons who would have bought the policy anyway.

The President has advocated enabling legislation that would allow states to establish Medicaid-private insurance partnerships similar to the partnerships that exist in California and Connecticut. The key provision that needs to be changed is the ability of states to *not* recover the estates of some deceased Medicaid beneficiaries. Under current law the state must seek reimbursement of Medicaid expenses by making claims against those assets that have not been included in the asset test (like the persons' home). Under a partnership policy, states would need the ability to seek only those assets that exceed the assets that were protected by virtue of the coverage from the state approved long-term care insurance policy.

Although there does not seem to be any strong interest in expanding public programs or establishing a national public-private partnership, such proposals have been made at other times. For example, in 1990, the U.S. Bipartisan Commission on Comprehensive Health Care, a bipartisan Congressional Commission, proposed 3 months of up-front public coverage and then back-end coverage after 2 years.[37] This would have likely encouraged the sale of a two-year long-term care insurance policy with a 90-day deductible. Others have proposed variations of this approach, with most public programs stepping in after 2 or 3 years and leaving the private market to sell coverage for the first 2 or 3 years.

Such front-end or back-end public approaches represent the array of possibilities for a two or three-legged stool for pooling the risk of long-term care. Such an arrangement would be analogous to retirement income which depends on individual savings, pension plan participation, and Social Security to pool the risks of living a long time in retirement.



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[20] There are important variations, but generally countable financial assets must be $2,000 or less for individuals and $3,000 for couples (after excluding between $1,492 and $2,265 per month of the spouse's assets for the spouse not asking for assistance, when seeking support in a nursing home). O'Brien, E. & Elias, R. (May 2004) *Medicaid and Long-Term Care* (Washington, DC: Kaiser Commission for Medicaid and the Uninsured p. 7), http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=36296. The home, which for many is the most significant asset, is not included in countable assets. For more information on Medicaid eligibility requirements, see http://www.allhealth.org.

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[21] The spouse remaining in the community is able to keep substantially more of the couple's income (at least $8,132 and no more than $90,660, in most states), but all the rest of the income must be applied towards the cost of the nursing home. O'Brien, E. & Elias, R. (May 2004) *Medicaid and Long-Term Care* (Washington, DC: Kaiser Commission on the Uninsured, Kaiser Family Foundation), http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=36296.

[22] It should be noted that most older people are not rich. In 2002, 70 percent of people age 65 and older had family incomes less than $40,000. Median financial wealth was $35,278 for married couples and $17,932 for individuals, suggesting that a relatively small proportion of people have substantial wealth. Social Security Administration (SSA) (2005) *Income of the Population 55 or Older, 2002* (Washington, DC: SSA).

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[26] It should be noted that "reverse mortgages" provide a way of spending the equity in one's home without having to move out of the home.

[27] Center on an Aging Society tabulations of income and assets data suggest that only 8 percent of the population age 65 or older had home equity sufficiently large to finance this move. If people were willing to sell their home and liquidate financial assets then about 35 percent of the population age 65 and older would have total net wealth sufficiently large to afford moving to a life-care community.

[28] For example, a $200/day 5-year comprehensive policy with inflation protection and a 30-day waiting period would cost about 6 percent of gross income for 50 percent of the population age 40 to 50; but would cost 24 percent of gross income or more for 50 percent of the population age 65 and 85 percent of gross income for 50 percent of the population age 75. Center on an Aging Society tabulations based on the premiums for the long-term care insurance policy available to federal employees and Census Bureau estimates of household income.

[29] Douglas, J. (2004) *Long-Term Care and Medicare Supplement* (Windsor, CT: LIMRA International, Inc.). And, Douglas, J. (2004) *U.S. Group Long-Term Care Insurance* (Windsor, CT: LIMRA International, Inc.).

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[31] At the end of 2004 206,200 policies had been sold. See Long-Term Care Partners, January 11, 2005 "OPM Announces Addition of 5,500 Enrollees in Federal Long-Term Care Insurance Program in 2004" Press Release (Washington, DC: U.S. Office of Personnel Management (OPM)),http://www.ltcfeds.com/about/resource_library/press_release/opmannounces2004enrollees.html. Paul Forte, an executive with the combined company selling the policy, announced in an April 2005 public meeting that over 208,000 had been sold.

[32] Annual rates of increase are more telling. From 2000 to 2010, the average annual rate of increase among the population age 85 and older is projected to be 3.0 percent. From 2010 to 2030 the annual rate of increase is 2.2 percent, but from 2030 to 2040 it is 4.7 percent.

[33] Alexis Ahlstrom, Emily Clements, Anne Tumlinson, and Jeanne Lambrew, *The Long-Term Care Partnership Program: Issues and Options*, accessed at www.retirementsecurityproject.org on April 26, 2005.

[34] That is, people were still paying premiums for the policies. Data is from Julie Stone-Axelrad, Medicaid's Long-Term Care Insurance Partnership Program, January 21, 2005, CRS Report for Congress.

[35] Based on data provided by America's Health Insurance Plans, 14 percent of all policies ever sold were sold in these four states.

[36] These kinds of tax preferences are currently available to the self-employed and to those with Health Savings Accounts.

[37] The Pepper Commission, U.S. Bipartisan Commission on Comprehensive Health Care, *A Call For Action: Final Report*, (Washington DC: United States Government Printing Office, September 1990).

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APPENDIX I

STATE OF NEW JERSEY INSTITUTIONAL AND HOME- AND COMMUNITY-BASED SERVICES STATE FISCAL YEAR 2004

PROGRAM	STATE APPROPRIATIONS	FUNDING SOURCES	AVERAGE CLIENTS SERVED PER MONTH
Nursing Home	$228,306,000	State, Federal	28,340
Alternate Family Care			48
Assisted Living Residence			1,352
Assisted Living Program	$18, 540,000	State, Federal	97
Comprehensive Personal Care Home			614
Eldercare includes:	$15,000,000		
• Jersey Assistance for Community Caregivers		State	1,703
• Caregiver Assistance Program		State, Federal	1,160
Community Care Program for the Elderly and Disabled	$28,026,000	CRF, Federal	3,512

Sources: Budget Book 04-05, Unisys Medicaid Reports, SIBA

The Division of Aging and Community Services is one of three senior services divisions in the Department of Health and Senior Services (DHSS) and is designated as the State Unit on Aging for the receipt of federal funds under the Older Americans Act as well as the State Administering Agency for two Medicaid 1915(c) waivers. The Division of Aging and Community Services (DACS) is comprised of seven offices: the Office of Administration and Finance; Office of Area Agency on Aging (AAA) Administration; Office of Community Education and Wellness; Office of Community Programs; Office of Community Choice Options; Office of the Public Guardian and Elder Rights; Office of the Ombudsman for the Institutionalized Elderly.

➢ Total budget is $379 million, including $121.3 million in state funding, $214.2 million in federal funding, and $43.5 million in casino revenue dollars.

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APPENDIX II

STATE OF NEW JERSEY SUMMARY OF INSTITUTIONAL LONG-TERM CARE (LTC) MARCH 2005

- The total New Jersey State FY '05 budget = $26 billion
- The total New Jersey Medicaid FY '05 budget (State and federal) = $8.0 billion
- The total New Jersey Medicaid FY '05 budget for LTC (State and federal) =$1.2 billion

In New Jersey, total LTC institutional costs (excludes drugs, hospitalization, physicians– if included, costs would be doubled):

$1.2 billion	Medicaid (state and federal)
.5 billion	Medicare
1.3 billion	private pay and LTC insurance
$3.0 billion	TOTAL LTC costs in New Jersey

National BDO Seidman Study for the American Health Care Association (of all states) indicates that New Jersey nursing homes which provide Medicaid services are underfunded by approximately $280 million annually (almost $28 per day).

NURSING FACILITIES IN NEW JERSEY

- 2.6 percent of New Jersey's seniors live in a Medicaid nursing facility
- 354 licensed New Jersey nursing facilities
- 325 Medicaid-certified New Jersey nursing facilities
- 50,000 New Jersey nursing facility beds
- 29,000 New Jersey nursing home beds occupied by Medicaid residents
  - -- Medicaid residents in New Jersey Medicaid certified nursing facilities average 65 percent of the resident population
- 85 percent of New Jersey nursing facility Medicaid population is older than 75 years
- 50 percent of New Jersey nursing facility Medicaid population is older than 85 years
- 14 New Jersey nursing facilities have closed since 2000
- 1,817 New Jersey nursing facility beds were eliminated by closing
- No new nursing facility has been approved in New Jersey since 1993

Sources: Health Care Association of New Jersey; American Health Care Association; BDO Seidman Study for the American Health Care Association.