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# **Long-Term Care in New Jersey – Part II: From Medicaid Reform to Balancing Federal, State and Personal Responsibility**

Background information for . . .

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## INTRODUCTION

**In a comprehensive Issue Brief<sup>1</sup> entitled – “Financing Long-Term Care in New Jersey and Across the Nation” – Robert B. Friedland of Georgetown University’s Center on an Aging Society analyzed the current issues and challenges facing policymakers who are working on Long-Term Care (LTC) reform.**

**A short summary of Friedland’s brief follows<sup>2</sup>:**

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“Between 2005 and 2030, it is anticipated that the number of people needing long-term care is likely to double. Without changes in financing arrangements and in the organization of service delivery, access to needed care in the future could be more difficult to obtain, even for the well-to-do, than it is today. In large part this is because, after 2015, the number of people needing assistance is likely to be growing faster than the number of people available to provide long-term care . . .

State Medicaid programs, which currently pay for a substantial share of long-term care, will feel even greater pressure. As the number of people needing assistance increases faster than the number of people available to provide assistance, the costs of care will increase. Higher costs may result in larger proportions of persons who need long-term care at risk for more hospitalizations and impoverishment and therefore more applications for public assistance through Medicaid.

Currently there are relatively few options for persons to better plan for long-term care. Long-term care insurance is the most promising, but current products are not sufficiently comprehensive nor are they without their own risks. Nevertheless, virtually all public policy initiatives outside of Medicaid are directed at encouraging more people to purchase long-term care insurance. Medicaid has been focusing on improving the effectiveness and efficiency of targeting services and expanding home and community based care as a way of reducing nursing home expenditures.”

Friedland went on to outline a few of the policy options under consideration by individual states and federal policymakers:

### **State-Level Actions**

“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.

*Policy Implication:* 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.<sup>3</sup> 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.

*Policy Implication:* 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.

*Policy Implication:* The National Governors Association's Medicaid reform proposal reports that federal law prohibits the expansion of these partnerships beyond those four states, but 17 states have passed enabling legislation allowing them to begin such a program should the federal prohibition be repealed.

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.

### **Federal Directions**

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). (These kinds of tax preferences are currently available to the self-employed and to those with Health Savings Accounts.) 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 person's 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 at present 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.<sup>4</sup> 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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The following sections expand on the issues examined in the May 9, 2005 *Issue Brief*, with a specific focus on current state-level Medicaid LTC reform strategies.

## NATIONAL MEDICAID LONG-TERM CARE EXPENDITURES

The Medicaid program celebrated its 40th birthday this year and program costs and coverage have reached all-time highs. At present Medicaid provides health and long-term care services to 53 million low-income pregnant women, children, individuals with disabilities and seniors. Total Medicaid expenditures equaled \$282.2 billion in FY 2004; long-term care expenditures were \$89.3 billion (a 4.0 percent increase from FY 2003), or approximately 32 percent of total Medicaid expenditures. The Congressional Budget Office projects that 2005 Medicaid expenditures will increase to \$321 billion.

Nationally, reported Medicaid nursing home expenditures increased 0.6 percent in FY 2004, from \$45.6 billion to \$45.8 billion (Medstat “Long-Term Care Expenditures” *Memo*, May 11, 2005). Expenditures for community-based long-term care services continued to increase in FY 2004, as total home and community-based services increased by 10.2 percent to \$31.7 billion. Home and community-based (HCBS) waiver expenditures increased 12.7 percent to \$21.2 billion and account for two-thirds of community-based long-term care spending. Overall, spending for community-based long-term care services (HCBS waivers, personal care, and home health services) rose to 36 percent of all Medicaid long-term care costs, with 64 percent spent on institutional services. This distribution continues to change by one to three percentage points each year, as Medicaid programs continue to invest more resources in alternatives to institutional services.

According to the Centers for Medicare and Medicaid Services – the federal agency that administers both the Medicaid and Medicare programs – national spending on nursing home care from both public and private sectors in 2003 was \$111 billion. A general breakdown of payments indicates that Medicaid paid almost half of nursing home care costs, while out-of-pocket payments covered almost a third and private insurance paid less than 8 percent (Gross, 2005).





## EMERGING FEDERAL CONCERNS: LONG-TERM CARE FINANCING – GROWING DEMAND AND COST OF SERVICES ARE STRAINING FEDERAL AND STATE BUDGETS (GAO REPORT)<sup>5</sup>

The U.S. Government Accountability Office (GAO) recently reported on issues related to LTC financing. As part of its rationale for the report, the office pointed out that long-term care relies heavily on financing by public payers, especially Medicaid, and has significant implications for state budgets as well as the federal budget. In testimony before the Subcommittee on Health, Committee on Energy and Commerce, in the House of Representatives, the GAO outlined the anticipated pressures on the budget and on the society as a whole from the anticipated increase in demand for long-term care services. Kathryn Allen, GAO's Director of Health Care-Medicaid and Private Health Insurance Issues presented the future expectations of the growth of the entitlement programs – Medicare, Medicaid and Social Security – as the baby boom population ages over the next 40 years. (Full testimony is available at <http://www.gao.gov/new.items/d05564t.pdf>)

Allen suggested that policymakers will need to consider “what options exist for rethinking the federal, state, and private roles in financing long-term care.” In considering options for reforming long-term care financing, GAO notes that long-term care is not just about health care. It also comprises a variety of health and social services which an aged or disabled person requires to maintain quality of life. Given the challenges in providing and paying for the growing needs of the aging population, GAO has identified several considerations for shaping federal reform proposals that include:

- **Determining societal responsibilities.** The fundamental question is how much the choices of how long-term care needs are met should depend upon an individual's own resources or whether society should supplement those resources to broaden the range of choices.
- **Considering the potential role of social insurance in financing.** Government's role in many instances has extended beyond providing a safety net, and in consideration of future proposals, careful attention needs to be paid to the limitation and conditions under which services will be provided and expanded.
- **Encouraging personal preparedness.** The public sector has at least two important potential roles in encouraging personal preparedness: to adequately educate people about the current limits of public support; and to assure the availability of sound private long-term insurance policies and possibly to create incentives for their purchase.
- **Recognizing the benefits, burdens, and costs of informal caregiving.** Effective policy must create incentives and supports for enabling informal caregivers to continue to provide assistance, while not resulting in informal care being inappropriately supplanted by formal paid services.
- **Assessing the balance of federal and state responsibilities to ensure adequate and equitable satisfaction of needs.** The differences between states in Medicaid spending on long-term care are reflective of the difference in generosity of services as well as the fiscal capacity of the state. The reevaluation of traditional federal and state financing roles would better ensure an equitable distribution of public support for individuals with disabilities.
- **Adopting effective and efficient implementation and administration of reforms.** Proposed reforms should complement already existing services and financing sources





while being administratively feasible, effective in reaching the target population and unmet needs, and efficiently provide needed services.

- **Developing financially sustainable public commitments.** Before committing to any additional public role in financing long-term care, it is imperative to provide reasonable assurance that revenues will be available to fund its future costs.

## MEDICAID AND LONG-TERM CARE REFORM PROPOSALS – THE STATES RESPOND

As part of the fiscal year 2006 budget resolution approved by Congress in April, federal lawmakers established a federal commission to recommend proposals to eliminate \$10 billion from Medicaid over the next five years and to develop long-term proposals to reduce Medicaid costs. States continue to grapple with efforts to reduce Medicaid spending as this past year state Medicaid spending – at 22 percent of the state budget spending on average – outpaced K-12 education spending to become the largest and fastest growing component of state budgets. Medicaid reform currently dominates the policy concerns of governors across the country.<sup>6</sup> In its report on Medicaid reform, the Changes in Health Care Financing Organization points out that: “because the majority of rising costs are not caused by inefficiency of the Medicaid program itself, but rather by more systemic problems – such as the increasing number of people without insurance, the aging of the U.S. population, and the rising costs of health care in general – reining in the costs of the program will require comprehensive solutions that consider these long-term trends and their effects.”<sup>7</sup>

### National Governors Association – Medicaid Reform Recommendations

A National Governors Association (NGA) bipartisan group of 11 governors issued a paper in June 2005 – *Medicaid Reform: A Preliminary Report* – which outlines a series of Medicaid reform recommendations (NGA *NewsRoom*, June 16, 2005, [www.nga.org](http://www.nga.org)). The recommendations were billed as “short-term reforms” to “help modernize, streamline and strengthen this critical state program,” and included: prescription drug improvements, asset policy reforms, cost sharing provisions, benefit package flexibility, comprehensive waiver reforms, judicial reforms, and Medicaid partnership payment review by territory and jurisdiction. At present four states – Missouri, Florida, Georgia and South Carolina – are among states seeking significant structural changes to their Medicaid programs. South Carolina’s Republican Governor Mark Sanford, for example, wants to dramatically transform Medicaid by offering beneficiaries a fixed amount of money to purchase coverage and pay out-of-pocket costs each year. If beneficiaries do not spend their allotment, they can save the remaining dollars for future medical expenses (Gleckman, 2005).<sup>8</sup> State reform initiatives such as those in South Carolina and Florida – which focus on consumer-driven decisions and are aligned with the Bush administration’s views on fostering an ownership society – are at the center of active debate: on the one hand, proponents of shifting Medicaid to a market-driven model support a defined dollar contribution model; in contrast, there are those policymakers at both the federal and state levels who strongly oppose reform that changes Medicaid from a guaranteed benefit to a defined contribution.

Throughout the Medicaid program’s 40-year history states have used various types of waivers in order to try a variety of changes affecting program coverage and costs. For example, Section 1115 waivers “give states federal approval to alter the way they provide coverage and/or deliver services to the low-income population outside of the federal standards and options and still receive federal matching funds” (Artiga and Mann, March 2005).<sup>9</sup> The new Section 1115 waiver initiative released in 2001 may provide lessons in the context of the broader debate over Medicaid restructuring since, in exchange for the increased flexibility provided through waivers, states must accept a cap on federal financing and therefore have even greater incentive to use waivers as a tool to reduce program spending rather than expand coverage. Since





2001, seventeen states have had comprehensive Section 1115 waivers approved; some have focused on reducing or changing coverage and/or eligibility in order to relieve state fiscal pressures.

## MEDICAID AND LTC REFORM

Embedded within the larger context of overall Medicaid program reform is the issue of Medicaid LTC reform. By default, Medicaid has become the insurance coverage program for those in America who do not have coverage for long-term care. At present, Medicaid covers 43 percent of all long-term care, and the 25 percent of Medicaid beneficiaries who receive Medicaid long-term care coverage constitute 70 percent of Medicaid expenditures. Long-term care costs, projected to increase exponentially as the baby boomers age, are an important focus of the ongoing debate about Medicaid reform. Another important statistic for long-term care policymakers is that long-term care coverage and insurance is not solely for the elderly – four out of ten people receiving LTC are between the ages of 18 and 64.

One of the four objectives that the NGA recommendations are organized around is “Slowing the Growth of Medicaid Long-Term Care.” The long-term care policy reforms include asset policy reforms and the development of certain types of incentives such as tax credits, e.g.:

- Increasing penalties for those who transfer assets to acquire Medicaid eligibility<sup>10</sup>
- Restricting the types of assets that can be transferred
- Limiting the amount and types of funds that can be sheltered in an annuity, trust or promissory note
- Using home equity to pay for long-term care by requiring recipients who own homes to secure reverse mortgages,<sup>11, 12</sup> or allowing state governments to place liens on the homes to reimburse Medicaid for the cost of care<sup>13</sup>
- Offering incentives such as tax credits or deductions to encourage individuals to privately purchase long-term care insurance.

NGA’s overall recommendation is to encourage individuals and their families to self-finance care rather than rely on Medicaid for long-term care services.

At the recent National Academy for State Health Policy annual conference (August 7-9, 2005), a number of roundtable discussions, breakout sessions and intensives focused on various aspects of Medicaid reform. Several states, including Vermont and Pennsylvania, presented on their current specific efforts directed towards Medicaid long-term care reform. Representatives from the states of Oregon and Washington also discussed their current status as “pioneers” in restructuring their LTC systems of care with a specific focus on supporting expansion of community-based alternatives for the elderly and disabled with long-term care health and social needs. One common suggestion regarding state reform initiatives was to allow states to modify their income and asset tests in order to allow applicants seeking community care – who are likely to use up their assets quickly in a nursing facility – to be eligible for community care.

Two recent initiatives undertaken by the states of Pennsylvania and Vermont focus on changes regarding eligibility, benefits and financing. The director of Pennsylvania’s Long-Term Living Reform Project reported that the state is looking at options such as long-term care global budgeting and estate recovery strategies. Overall, state government administrators are focusing on consumer-driven values and working collaboratively between and among all state agencies and external stakeholders. Vermont’s innovative 1115 Long-Term Care Waiver Proposal aims to create a more balanced system by offering consumer







choice and equal access to community-based and institutional settings appropriate to individual care needs, as well as balancing eligibility, benefits and financing of services. For an in-depth look at state strategies regarding Medicaid LTC reform, reference is made to the final report released by the *Making Medicaid Work for the 21st Century* project, a year-long effort undertaken by the National Academy for State Health Policy (NASHP) to develop recommendations that would improve the Medicaid program ([http://www.nashp.org/Files/Making\\_Medicaid\\_Work\\_for\\_the\\_21st\\_Century.pdf](http://www.nashp.org/Files/Making_Medicaid_Work_for_the_21st_Century.pdf)).

## LONG-TERM CARE INSURANCE – ISSUES AND CHALLENGES

A common thread in both federal and state recommendations regarding LTC reform is to encourage personal responsibility and purchasing of some form of long-term care insurance. America's Health Insurance Plans (AHIP) reports that 7 million Americans – or one in 10 middle-aged or older Americans – has privately purchased long-term care insurance and currently more than 5,000 employers offer LTC insurance to their employees ([www.ahip.org](http://www.ahip.org)). Historically, the LTC insurance industry has been challenged by the non-standardization of coverage products and price swings in premium costs. As states have moved to enact consumer protection safeguards and accurate pricing policies, many companies have left the LTC market in recent years (Coombes, 2005).<sup>14</sup> Two additional major barriers to individuals' purchasing LTC insurance are that many available LTC insurance plans are prohibitively costly, and when not indexed to inflation can fail to provide enough coverage to prevent people from outliving their savings.<sup>15</sup> Nationwide, approximately 362,000 individuals bought new policies in 2004, down 38 percent from 585,000 in 2000 (*ibid.*).

Approximately 100 companies are currently selling LTC insurance, down from 127 in 2001.<sup>16</sup> The AHIP trade group notes, however, that the industry's pricing has begun to stabilize over the last two years.<sup>17</sup> As a result, more companies are entering the LTC market and offering a more innovative range of insurance products. For example, in the beginning of August 2005 Blue Cross Blue Shield of Michigan announced plans to create a subsidiary that will offer policies that cover long-term care services for individuals, including assisted living and nursing homes.

In its June 2005 "Hot Topic" alert, the Changes in Health Care Financing and Organization (HCFO) program highlighted the issue of Medicaid reform among the states. In their analysis, HCFO staff summarized potential Medicaid reform solutions related to long-term care coverage and costs which are consonant with the National Governors Association recommendations. HCFO's recommendations included supporting public education to encourage contributing individual finances to purchasing LTC insurance coverage; placing restrictions on – or imposing penalties for – asset transfers used to render people eligible for Medicaid coverage; and fostering incentives to encourage individuals to obtain LTC insurance.

A bill currently being considered by the Senate Committee on Banking, Housing, and Urban Affairs that would establish an Interagency Council on Meeting the Housing and Service Needs of Seniors (HCFO, June 2005). The Council would emphasize collaboration and create more uniform regulations and application language, so the elderly could obtain the combination of health, housing, transportation and other services needed to "age in place" and remain in the community (U.S. Senate Committee on Banking, Housing, and Urban Affairs, S. 705, To establish the Interagency Council on Meeting the Housing and Service Needs of Seniors, introduced April 5, 2005.). The bill is in response to concerns that each of the potential policy reforms also need to include certain consumer protections.

At this point state policymakers are taking the lead in addressing the critical need to address the financing of long-term care services for their elderly and disabled citizens. There are many unknowns as to the impact and effect of long-term care reform proposals and the future of public and private financing for long-term care. Although policymakers and stakeholders may have different approaches to addressing the issue, there is certain consensus that the growth of Medicaid long-term care expenditures must be slowed and innovative options must be explored for the future.





## APPENDIX I

### **LONG-TERM CARE FACTS ABOUT NEW JERSEY<sup>18</sup>**

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.<sup>19</sup>
- 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.<sup>20</sup>
- 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.<sup>21</sup>
- 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.<sup>22</sup>
- 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.<sup>23</sup>

#### **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.<sup>24</sup>





## 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 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.
- 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.<sup>25</sup>
- 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.<sup>26</sup>





## ENDNOTES AND REFERENCES

- <sup>1</sup> Reference is made to the Issue Brief prepared for the New Jersey Policy Forum, May 9, 2005.
- <sup>2</sup> The entire brief can be accessed at: [http://www.forumsinstitute.org/pubs/nj/may\\_05.pdf](http://www.forumsinstitute.org/pubs/nj/may_05.pdf).
- <sup>3</sup> 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. At this point, partnership policies represent less than 11 percent of all long-term care insurance policies sold in the four states.
- <sup>4</sup> The Pepper Commission, U.S. Bipartisan Commission on Comprehensive Health Care, *A Call For Action: Final Report*, September 1990.
- <sup>5</sup> April 27, 2005.
- <sup>6</sup> The federal government and the states jointly fund Medicaid, with the federal share ranging from 50 percent to 77 percent of the costs. New Jersey shares a 50-50 match with the federal government for its Medicaid program.
- <sup>7</sup> HCFO “Hot Topics” Alert, June 2005 (<http://www.hcfo.net/topic0605.htm#8>).
- <sup>8</sup> See “Federal Medicaid Commission Likely to Rely on Governors’ Recommendations,” *Cover the Uninsured Week*, News Summary, August 8, 2005. ([www.covertheuninsuredweek.org](http://www.covertheuninsuredweek.org)).
- <sup>9</sup> See as cited by Artiga and Mann, March 2005: Office of the Secretary of Administration and the Office of the Secretary of Human Services, “Saving Medicaid, The Douglas Administration’s Plan for Saving the Vermont Medicaid System,” January 19, 2005; Bush, J., Governor, “Florida Medicaid Modernization Proposal,” January 11, 2005; Stephan, J.A., Commissioner, New Hampshire Department of Health and Human Services, “New Hampshire’s GraniteCare, Recommendations to Modernize Medicaid,” November 10, 2004; and Sanford, M., Governor, “South Carolina Medicaid Choice: A Waiver Concept to Bring a Consumer Directed, Market Based Environment into Medicaid,” (undated).
- <sup>10</sup> The most popular idea is to slow eligibility by extending the look-back period, during which older people can give away or shelter assets and not be penalized when applying for Medicaid. At present, the look-back period is three years; reformers are promoting that period to be extended to five years. (See: Gross, J. “In effort to pare Medicaid, long-term care is focus.” *The New York Times*, June 27, 2005.)
- <sup>11</sup> The National Council on Aging estimates that 48 percent of America’s 13.2 million households age 62 and older could get \$72,128 on average from reverse mortgages, and “in total, an estimated \$953 billion could be available from reverse mortgages for immediate long-term care needs and to promote aging in place.”
- <sup>12</sup> Robertson, T. “More retirees pay the bills with reverse mortgages,” *The Boston Globe*, April 25, 2005. Reverse mortgages allow seniors “to convert a portion of the equity in their homes into cash without selling their home. The mortgage is not due until they move or die, when proceeds from the sale of the property can be used to satisfy the loan.” But “the loans have high upfront costs, and interest rates can exceed those of conventional mortgages.”
- <sup>13</sup> The NGA August 2005 report points out: “According to the U.S. Census Bureau, 81 percent of seniors own their homes and 73 percent own them free and clear. This represents \$1.9 trillion in untapped home equity that is currently exempted from Medicaid’s calculations.”
- <sup>14</sup> Coombes, A. “Insurers Struggle with Long-Term Care,” *The Wall Street Journal*, June 15, 2005.
- <sup>15</sup> Gross, J. “In effort to pare Medicaid rolls, long-term care is the focus,” *The New York Times*, June 27, 2005.
- <sup>16</sup> Since 2000, half of the leading carriers – companies with annual sales of \$10 million or more – no longer sell the LTC product, including CAN Financial Corp., Aegon NV, Fortis and TIAA-CREF (Coombes, 2005).
- <sup>17</sup> See, Moos, B. “Long-term care insurance; care-giving policies becoming a retirement must for many.” *The Dallas Morning News*, August 15, 2005. [www.dallasnews.com](http://www.dallasnews.com).
- <sup>18</sup> Summarized from Robert Friedland, “Financing Long-Term Care in New Jersey and Across the Nation,” May 9, 2005.
- <sup>19</sup> Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, *Behavioral Health Risk Factor Surveillance System Online Prevention Data, 1995-2003*, <http://www.cdc.gov/brfss/>.
- <sup>20</sup> U.S. Bureau of the Census (2005) *Statistical Abstract of the United States: 2004-2005* (Table no. 184) (Washington, DC: U.S. Bureau of the Census).
- <sup>21</sup> Gibson, M. J., Gregory, S. R., Houser, A. N., & Fox-Grage, W. (2004) *Across the States: Profiles of Long-Term Care* (Washington, DC: AARP, Public Policy Institute).
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