Long-Term Care

Principles

- Long-term care programs should be reserved for Georgia's most vulnerable populations.
- Long-term care programs should be designed to avoid "crowding out" private solutions and personal responsibility.

Recommendations

- Seek ways to target publicly funded long-term care (LTC) services to the neediest Georgians. Middle-class and affluent people should prepay for care or repay from their estates.
- Now that the maintenance-of-effort restriction in the Affordable Care Act has expired, Medicaid LTC eligibility criteria should be tightened as much as possible under federal law so as to avoid "crowding out" private sources of LTC financing and encourage a privately financed home- and community-based services infrastructure.
- Seek waivers to eliminate or severely reduce the home equity exemption under Medicaid from its current level of $595,000 in order to encourage the use of home equity conversion to privately fund home care, assisted living and nursing home care.
- Review lien and estate recovery programs under Medicaid, study other states that operate their programs more successfully, and maximize non-tax revenues from this source.

Facts

- Medicaid provides a portion of the payment for 62% of nursing home residents nationwide[1]
- Private LTC insurance market penetration in Georgia is minimal: just 3.9% of the age 40-plus population, compared to 5% nationally.[2]
- Georgia's age 85-plus population is projected to more than quadruple between 2015 and 2050, which is the fourth-highest projected percentage increase in the country.[3]
- Georgia's population of age 65-plus with disabilities is the 16th highest among states. The state's proportion of age 65-plus with dementia is also the 16th highest in the country.[4]
- Nursing facilities in Georgia operate at a loss when it comes to Medicaid residents, but that loss is not as large as the national average. The disparity between Georgia's Medicaid nursing home reimbursement rate and the average private-pay rate is close to the national average.
- Georgia has a larger proportion of family caregivers than the national average. The value of family caregiving in Georgia compared to the state's Medicaid long-term care spending is very high, ranking Georgia No. 7 in the country.
- Georgia has controlled Medicaid expenditures remarkably well but is heavily dependent on provider taxes, which are highly vulnerable to federal government cutbacks.
- Georgia ranks sixth highest in the nation in the percentage of nursing facility residents who rely on Medicaid as the primary payer.

Overview

Georgia faces multi-faceted long-term care problems including:

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[1] Erica L. Reaves and MaryBeth Musumeci, "Medicaid and Long-Term Services and Supports: A Primer," Kaiser Family Foundation, Dec 15, 2015, https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/
[2] Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Tenth Edition 2018," AARP, Washington, DC, 2018, p. A-26, https://www.aarp.org/content/dam/aarp/ppi/2018/08/across-the-states-profiles-of-long-term-services-and-supports-full-report.pdf
[3] *Ibid*. p. A-15.
[4] Ibid. "Profile of Long-Term Services and Supports in Georgia." https://www.aarp.org/content/dam/aarp/ppi/2018/08/georgia-LTSS-profile.pdf

- A rapidly increasing elderly population
- Higher numbers of recipients with disabilities or dementia
- A Medicaid program already strained as the principal long-term care payer
- Dependence on funding from the heavily indebted federal government
- Very little private financing of long-term care to relieve the budgetary pressure on public programs
- Heavy public dependency on social programs and a growing "entitlement mentality"
- The addition of childless, able-bodied Medicaid recipients under the Affordable Care Act, further straining the program's limited resources

Long-term care is expensive whether received in a nursing home, an assisted living facility or in one's own home.[5] The risk of needing some form of long-term care after age 65 is 69%.[6] The catastrophic risk of needing five years or more is 20%.[7] Nevertheless, people often ignore the risk and cost of long-term care. Few save, invest or insure for the possibility of large long-term care expenses in later life.

Georgia's 136,000 citizens over age 85 now will more than quadruple by 2050 at a rate (316%) that is the fourth highest in the nation.

Most people believe Medicare pays for long-term care. It does not. Medicaid long-term care benefits are relatively easy to qualify for financially.[8] Peer-reviewed research indicates that the availability of Medicaid long-term care benefits crowds out private financing and planning.[9] Research also indicates that the rich gain as much or more from Medicaid's long-term care benefits as the poor.[10]

Nationally, long-term care beneficiaries represent only 5.9% of all Medicaid enrollees. However, this group accounts for 41.8% of total Medicaid expenditures through long-term services and support costs.[11]

Georgia's 136,000 citizens over age 85 now will more than quadruple by 2050 at a rate (316%) that is the fourth highest in the nation.[12] Somewhat mitigating the demographic risk, however, is the fact that long-term care costs less in Georgia compared to the national average. For example, charges for a semi-private room in a Georgia nursing home average $181 per day compared to $222 nationally; a private, one-bedroom apartment in an assisted living facility runs $3,077 per month compared to $3,550 nationally. Likewise, home health aides ($18 per hour) and adult day care ($64 per day) cost less in

[5] "[T]he average annual cost of care in the U.S. is $94,170 for a private room in a nursing home; $82,855 for a semi-private room in a nursing home; $41,124 for an assisted living facility and; $18,460 for adult day care. The average annual cost of care received at home was approximately $29,640." Source: John Hancock Life Insurance Company (John Hancock) biennial long-term care (LTC) cost study, press release published July 30, 2013, http://www.johnhancock.com/about/news_details.php?fn=jul3013-text&yr=2013.

[6] Peter Kemper, Harriet L. Komisar, and Lisa Alecxih, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?" *Inquiry*, Vol. 42, Winter 2005/2006, pps. 341-342, http://www.inquiryjournal.org/.

[7] *Ibid*.

[8] Stephen A. Moses, "Briefing Paper #2: Medicaid Long-Term Care Eligibility;" Center for Long-Term Care Reform, Seattle, Washington, 2011, http://www.centerltc.com/BriefingPapers/2.htm.

[9] Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," National Bureau of Economic Research, December 2004, cited from the paper's "Abstract," http://www.nber.org/~afinkels/papers/Brown_Finkelstein_Medicaid_Dec_04.pdf.

[10] "Richer people also get on Medicaid!" and "Richer people on Medicaid get big transfers." Source: Testimony August 1, 2013 before the federal Long-Term Care Commission by Eric French (http://www.ltccommission.senate.gov/Eric%20French.pdf)

[11] Nga T. Thach and Joshua M. Wiener, "An Overview of the Long-Term Services and Supports and Medicaid Final Report." Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Washington, D.C., 2018, p.8, https://aspe.hhs.gov/system/files/pdf/259521/LTSSMedicaid.pdf

[12] Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Tenth Edition 2018," AARP, Washington, DC, 2018, p. A-15, https://www.aarp.org/content/dam/aarp/ppi/2018/08/across-the-states-profiles-of-long-term-services-and-supports-full-report.pdf

Georgia than the national averages, $21 per hour and $70 per day, respectively.[13] Georgians appear no more personally concerned about these risks and costs than other Americans. Their private long-term care insurance coverage rate of 3.9% is below the 5% national average for people age 40 and over with private long-term insurance coverage.[14]

In Georgia, as in the rest of the country, Medicaid is the dominant payer for long-term care for the aged, spending $784 million or 76% of $1.02 billion in total for their nursing home care in 2011 and $134 million or 13% on waivered home and community-based services.[15]

Eligibility

Medicaid is a means-tested public assistance program. Eligibility depends on applicants meeting or spending down to apparently draconian income and asset levels. For example, to qualify for Medicaid-financed long-term care in Georgia, individuals must have incomes of $2,349 per month or less and countable assets of no more than $2,000.

But these limits are misleading. Extra income can be transferred into Miller income diversion or qualified income trusts (QITs), allowing people with much higher incomes to qualify. Otherwise countable assets can be converted into virtually unlimited exempt assets, including up to $595,000 of home equity plus one automobile, prepaid burial plans, personal belongings and home furnishings of unlimited value.

As Stephen Moses, President of the Center for Long-Term Care Reform has observed, "Medicaid long-term care income eligibility requires a cash flow problem, *but not low income*."[16] People too wealthy to qualify even under these relatively generous standards often are able to legally reconfigure their income and assets to qualify for long-term care benefits. Common Medicaid planning techniques used in Georgia include asset transfers, promissory notes, annuities and purchase of exempt assets.

Georgia policy-makers have stalled on previous reform efforts to reduce Medicaid long-term care eligibility due to the Maintenance of Effort (MOE) restrictions on Medicaid beneficiaries in the Affordable Care Act. This issue is further exacerbated when the state faces budgetary shortfalls. When eligibility is taken off the table, the state is left with two remaining options to control Medicaid expenditures: Cut services or cut provider reimbursements.

Georgia already limits its optional Medicaid services, and its provider reimbursement levels are low as well. Cutting services hurts the poor especially and cutting reimbursements can damage the quality of care. Tightening eligibility for LTC services so that more prosperous recipients would need to spend more of their own money for their care is the least onerous way to deal with budget shortfalls.

Estate Recovery

If Medicaid allows people to retain substantial wealth while receiving publicly financed LTC benefits, the program should be reimbursed for the cost of their care out of their estates. Otherwise, Medicaid operates as free "inheritance insurance" for their heirs. Georgia's estate recovery program excludes the first $25,000 of an estate from recovery. Given that the average estate recovery in successful states is well below $25,000, it is highly doubtful that Georgia is maximizing non-tax revenue from this source.

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[13] MetLife Mature Market Institute, "The 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs," state by state "Tables," https://www.metlife.com/mmi/research/2012-market-survey-long-term-care-costs.html#tables.

[14] Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Tenth Edition 2018," AARP, Washington, DC, 2018, p. A-26, https://www.aarp.org/content/dam/aarp/ppi/2018/08/across-the-states-profiles-of-long-term-services-and-supports-full-report.pdf

[15] "Data Source: DSS, Claims Incurred July 1, 2010 through June 30, 2011; paid through December 2011 and includes crossovers." Cited in Thompson Reuters, "Georgia Department of Community Health Aged, Blind and Disabled (ABD) Profiles," April 10, 2012, slide #13, http://1.usa.gov/1Sj3ohY.

[16] Stephen A. Moses, "Medicaid and Long-Term Care," Center for Long-Term Care Reform, Seattle, Washington, 2020, p. 23, http://www.centerltc.com/pubs/Medicaid_and_Long-Term_Care.pdf

Home equity conversion

In the absence of Medicaid's home equity exemption – $595,000 in Georgia – more people would use their home equity to pay for long-term care before becoming dependent on Medicaid. Reverse mortgages enable people age 62 and over to extract equity from their homes while continuing to live in them. That money could fund home- and community-based services privately. But the reverse mortgage option ends where mobility, morbidity or mortality begins. Such mortgages become due and payable when the elder mortgagee becomes too ill to remain, moves out, dies or sells.

As an alternative, families who want to retain the elders' home could pitch in to help pay for home care, assisted living or nursing facility care, providing in essence an informal family-based reverse mortgage. Many variations would be possible, but the current policy that exempts a huge amount of home equity discourages personal responsibility from a purely financial standpoint.
