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Long-Term Care Financing Options and Retirement Income Security of Minnesota's Elderly

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Issue Briefs published for the Minnesota Long-term Care Financing series have not undergone formal review. It is intended to make the collaborative work between SHADAC and other state-level health policy analysts available to interested parties in preliminary form to encourage discussion and suggestions. Comments are welcome at the address above. Please do not reproduce or cite without permission.

Introduction

As the population of Minnesota ages there is increasing concern about whether older Minnesotans will have sufficient resources to fund their retirement. Costs incurred during retirement include general living expenses as well as health care to supplement basic Medicare coverage and the potential expenses associates with long-term care services. From a personal perspective the concerns about "retirement security" are two-fold: (1) that people are not financially prepared to support their basic retirement expenses, which may span several decades, and (2) that people will be unprepared to cover the additional costs of long-term care if they suffer cognitive decline or become physically disabled as they age.

The concerns over "retirement security" are also a significant state policy issue. State Medicaid programs currently finance almost half of all long-term care expenses and state Medicaid programs have become the default long-term care insurance plan for older people. This is problematic because the number of older people is growing dramatically and, with the impending retirement of the baby boomers between now and 2030, the impact on state Medicaid budgets is likely to be substantial. This is of particular concern because the current administration has proposed new limits on federal financial participation in the financing of Medicaid programs.

This Issue Brief is the second in a two-part series to assess the future needs of Minnesota seniors and state policy approaches to increasing retirement security for future generations. Issue Brief #1, "Retirement Security and Minnesota's Elderly Population," examined whether Minnesotans will have enough money for their retirement and long-term care needs and estimates how many Minnesotans — and more specifically which Minnesotans — are at risk of having insufficient resources to meet their long-term care needs. This second Brief provides a first look at the potential impact of long-term care financing options on decreasing the risk of needing support through the state Medicaid program.

The primary concern that states have in discussing retirement income security is whether people's resources are sufficient to cover long-term care needs as well as general expenses. If people do not have sufficient resources, then "spend-down" is likely, and people considered middle class during their working life impoverish themselves paying for long-term care and become eligible for the Medicaid nursing home and home- and community-based programs. Discussions of retirement security may also be broadened to include whether people will outlive their ability to cover their basic expenses, but for state governments the primary concern is the potential increase in Medicaid expenditures for long-term care.

Retirement Income Security for Americans and Minnesotans

Recent research on retirement income security and the financial planning patterns of baby boomers has contributed to and/or reinforced policy makers' concerns. Although studies vary in aspects of their results and the tone of their overall conclusions, all agree that certain subgroups, such as single women or people who live past 85 years, are unlikely to have

sufficient resources to cover their general and long-term care expenses during retirement. A model developed by the Employee Benefit Research Institute Education & Research Fund (EBRI-ERF) has generated projections that by 2030 the gap between U.S. retiree expenses and resources will be as much as $56 billion. The same model was also used to project what percentage of retirees in subgroups (defined by five-year birth cohorts, household types and income quartiles) are likely to have insufficient retirement resources (VanDerhei and Copeland 2003.

For the Minnesota analysis we combined the EBRI national model with Minnesota demographic data in order to generate projections of the number of Minnesota retirees who will not have sufficient retirement resources and therefore are at risk of relying on Medicaid should they require formal long-term care services. These projections suggest that more than one in five Minnesotans born from 1936 to 1965 — that is 441,000 out of 1.8 million— may not have sufficient resources to maintain their lifestyle and afford an episode of long-term care at some point during their retirement. Although the national model results do not specify *when* during their retirement people will begin to experience a deficit, combining the results with information on the standard retirement age and longevity allows for estimates of the number of people in Minnesota at risk of entering a deficit in any one year. This number is projected to increase from 90,000 in 2005 to over 225,000 by 2021. How these estimates were generated and more detailed results are reported in Issue Brief #1 (Totten and Blewett 2005).

Financing Options and a Framework for Evaluation

Faced with these projections and tight budgets, policy makers are understandably concerned about the potential growth in future Medicaid obligations. In response, federal, state and local governments are considering and implementing policies and programs to encourage people to accumulate more resources for retirement and long-term care through savings and other financial mechanisms, or to help people avoid the need for formal long-term care.

The primary objective of many public policy proposals is to find ways to encourage people to make plans for and pay for their own long-term care. In Minnesota, exploring options has taken the form of a Long-Term Care Financing Reform Initiative including a legislative mandate for a report on several options (Minnesota Department of Human Services 2005). This second brief provides a more detailed analysis of the options listed in the State of Minnesota 2003 long-term care legislation, which called for a study of public and private sector long-term care financing reform options (Laws of MN First Special Session 2003, Ch. 14 Art. 2, Sec. 55). The intent of this brief is to assist policy makers in identifying which options have the greatest potential for achieving the state's policy goals.

We addressed three of the options specifically mentioned in legislation: (1) the Long-Term Care Insurance Partnership Program – similar to what has been adopted in other states – under which the state would encourage the purchase of private long-term care insurance by permitting the insured to retain assets in excess of those otherwise permitted for Medicaid eligibility, if the insured later exhausts the private long-term care insurance benefits; and (2)

using state medical assistance funds to subsidize the purchase of private long-term care insurance by individuals who would be unlikely to purchase it without a subsidy in order to generate long-term Medicaid savings; and (3) in consultation with the Minnesota Department of Human Services, we added an additional option that is being actively discussed at the state level, namely, the reverse housing mortgage option. We also address a fourth option, the family loan and line of credit program, mentioned in the 2003 Minnesota Legislative session.

It should be noted that we did not specifically analyze the option to mandate that insurers add a nursing facility benefit to Medicare supplemental products because: (1) the Department of Human Services has already recommended that this option not be pursued because studies suggest that this option would pose significant problems for the private Medigap market; and (2) the Minnesota Department of Health conducted a related study in January 2000 and concluded that mandating the addition of a nursing facility benefit to Medicare supplemental insurance policies would drive up the cost substantially and likely cause current policy holders to drop their coverage, leading to a potential additional number of elderly spending down to Medicaid coverage (Minnesota Department of Health 2000).

Although encouraging people to plan for their retirement and long-term care needs may represent a general social good, for state governments an important criteria for evaluating any proposed program is measuring its impact on escalating Medicaid costs. State legislatures and others concerned about the impending retirement of the baby boom generation are searching for programs that have a high probability of resulting in savings in Medicaid dollars that exceed any cost increases associated with the program. Using this criterion to assess financing options is rational in that it reflects the objective of many proposed programs; however, it is difficult to do for several reasons.

For programs related to the financing of long-term care to save Medicaid dollars they must effectively target people who will:

1) need formal long-term care, and
2) who have some means to pay for their own care (or buy insurance) but are likely to spend-down to Medicaid eligibility if or when they need extended care absent the new program.

Furthermore, the nature of long-term care financing requires that the targeted people be identified years before they may need services. For example, plans that involve subsidizing long-term care insurance through either tax credits or direct payments — as a way to encourage more people to purchase insurance — would need to begin when people are young and healthy enough to be insurable, which is usually between 40 and 64, although many companies may sell policies to people up to age 75 who meet certain medical criteria. The insurance then has to be purchased and the premiums paid until the person needs long-term care or dies, which is likely to be 20-45 years later.

Because states generally lack the specific data required to develop models that predict the distribution and income of those likely to use Medicaid in the future, we have used the results of a model developed by the Employee Benefits Research Institute Education and Research Fund (EBRI-ERF). These data were used to indirectly identify the Minnesotans most likely to be at risk of having insufficient retirement resources in the future and estimate those at risk of spending down to Medicaid eligibility. While there are several limitations with the EBRI model, as discussed below, we believe it provides an opportunity to sketch a first-look at estimating the impact of several financing options. It also raises the awareness of the need for better data and modeling assistance incorporating state-specific data that can be used to improve state-level long-term care policy development and analysis.

Using the EBRI Model to identify the target population for long-term care financing proposals

The EBRI model can be used to analyze retirement resource sufficiency in several different ways. In the published summary of its findings three different types of results were reported (VanDerhei and Copeland 2003). These included: (1) a yearly estimate of the deficit between projected retirement expenditures and resources; and (2) estimates of the percentage of retirees projected to have and not have sufficient retirement income and/or wealth. This second type of result served as the basis for the Issue Brief #1 in this two-part series (Totten and Blewett 2005).

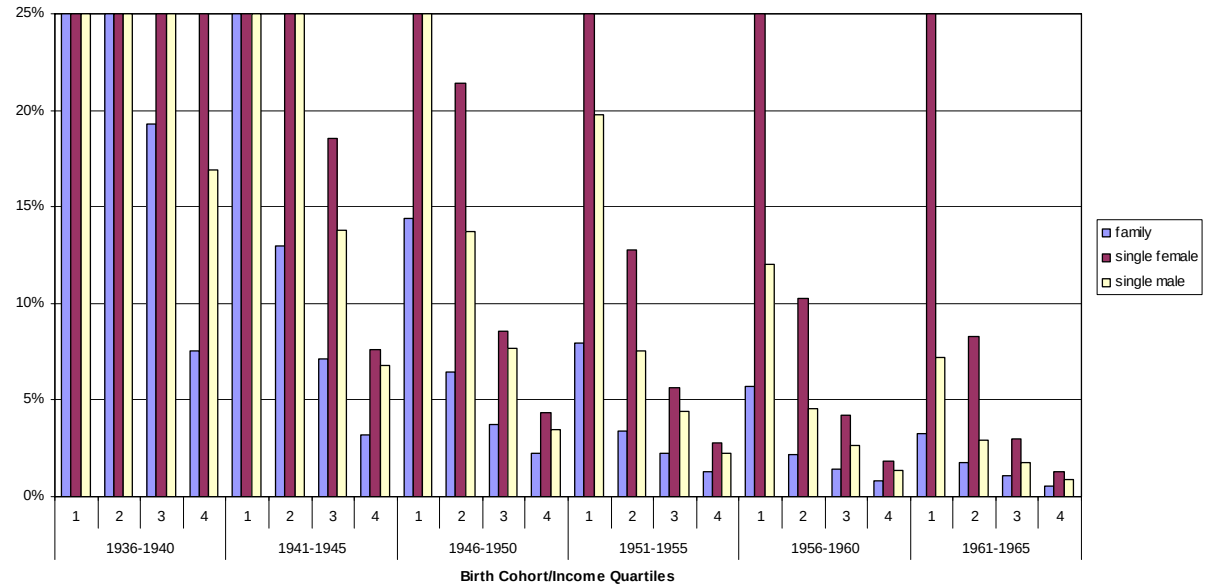
A third type of results included three estimates of how much additional compensation people would have to save every year until retirement in order to have a good chance of covering their retirement and long-term care expenses. The EBRI analysis and all of their projected estimates include a 5% savings assumption across all income categories. These values were calculated for every person in the simulation and then the median values were reported by cohort/martial status/income quartile subgroups[1], providing an estimate of the percentage of retirees with and without sufficient retirement resources.

Results presented in this way are relevant to the analysis of long-term care financing options for two reasons. First, although saving is only one of several possible approaches people could use to fund retirement and long-term care expenses, having estimates of how much different groups of people would need to save allows a direct assessment of the feasibility of increased savings as a means to reduce the future retirement resource deficits. The results of this EBRI analysis[2] for the United States are reproduced in Figure 1.

[1] The 72 EBRI subgroups consist of 6 five-year birth cohorts from 1936-1965, three household types (married, single men, and single women) and the four income quartiles for each birth cohort and household type. (6 birth cohorts x 3 household types x 4 income categories=72 subgroups).

[2] The results reported are based on the assumptions that Social Security does not change and that housing equity is not used. The EBRI analyses were also repeated varying these assumptions.

Figure 1: Percentage of Added Compensation That Must Be Saved Annually Until Retirement For 90% Chance of Covering Basic Estimated Retirement and Health Care Expenses (assumes current Social Security benefits and housing equity is never liquidated)



Source: Preliminary estimates from the 2005 version of the EBRI-ERF Retirement Security Projection Model (VanDerhei and Copeland 2003).

As Figure 1 demonstrates, for a few subgroups in the population a modest (less than 5%) increase in savings is likely to provide retirement security. For many, more than a 5% increase would be required, and for some groups as much as 25% or more of compensation would need to be saved for retirement. Again, these models already assume a 5% savings assumption across all birth cohorts. Given that the savings rate in the United States has been declining, the required savings rate in this model's estimates seems doubtful unless there is a major shift in consumption and savings patterns.

However, the utility of these results extends beyond determining whether savings is a feasible means of achieving retirement security and financing long-term care. These results can also be used to categorize people according to their level of risk of having insufficient retirement resources. The categories created in this manner can then be used to evaluate various financing options in terms of their potential to improve the retirement security prospects of those most at risk. This application of the EBRI model relies on an assessment of the feasibility of the estimated level of additional savings needed to achieve retirement security. We use this assessment as a proxy to predict the risk of an individual experiencing a funding deficit and therefore requiring Medicaid support for formal long-term care needs at some time during retirement.

Minnesotans at Risk of Not Having Enough Retirement Resources: Income Insecurity

To use the EBRI results to identify target groups for long-term care financing programs, a system of evaluating the feasibility of increased savings needs to be established. For this

analysis, the subgroups were distributed among three categories based on an assessment of whether a person in a given income quartile would be able to save above a given percentage of all future compensation. The three categories were constructed based on the assumption that as income increases, the amount that a person could reasonably be expected to save also increases. The relative risk refers to the risk of not having sufficient retirement resources to cover retirement expenses. Those at very high risk and a subset of the people with moderate to high risk are at risk of spending all of their resources and becoming eligible for Medicaid. The categories were defined and created as follows:

Category Definitions for Risk of Income Insecurity by Required Savings Level to Achieve Income Security

Category I - **Very High Risk**: Very significant increase in savings required for income security Over 10% additional savings for the lowest and 2nd income quartiles Over 15% additional savings for the 3rd income quartile Over 20% additional savings for the highest income quartile
Category II - **Moderate to High Risk**: Significant increase in savings required for income security. 5-10% additional savings for the lowest and 2nd income quartiles 5-15% additional savings for the 3rd income quartile 5-20% additional savings for the highest income quartile
Category III - **Low to Moderate Risk:** Moderate increase in savings required for income security 5% additional savings or less, for all income quartiles

Note: "additional savings" refers to savings in addition to current savings efforts.

The results of EBRI's estimations of the median percentage of additional savings using Minnesota demographic data are arranged according to these three risk categories in Table 1. The subgroups are sorted in Table 1 according to the results of the simulation and assumes no change in Social Security benefits and that housing equity is not liquidated.

Table 1: Minnesotans born from 1936 to 1965, by risk category based on ability to save sufficient funds for retirement

Key:

Color = marital status	
$	Single Women (yellow)
$	Single Men (green)
$	Married (blue)

$ = income quartile	
$	lowest income quartile
$$	2nd income quartile
$$$	3rd income quartile
$$$$	highest income quartile

	Risk Categories Based on Ability to Save Sufficient Funds for Retirement		
Age in 2000	I Very High Risk	II Moderate to High Risk	III Low to Moderate Risk
60-64	$ $$ $$$ $$$$ $ $$ $$$ $$$$ $ $$ $$$ $$$$		
55-59	$ $$ $$$ $$$$ $ $$ $$$ $$$$ $ $$ $$$ $$$$		
50-54	$ $$ $$$ $$$$ $ $$ $$$ $$$$ $ $$ $$$ $$$$		
45-49	$ $$ $$$ $$$$ $ $$ $$$ $$$$ $ $$ $$$ $$$$		
40-44	$ $$ $$$ $$$$ $ $$ $$$ $$$$ $ $$ $$$ $$$$		
34-39	$ $$ $$$ $$$$ $ $$ $$$ $$$$ $ $$ $$$ $$$$		

These results parallel those reported in the first Issue Brief in this series. Single women are more likely to be in the very high risk category and only the youngest and wealthiest single women are at low risk. Married couples are also better off than either single men or single women. Because this model was created to estimate the impact of savings, the younger cohorts are at lower risk because their savings have more time to accumulate. Nevertheless, people in the lowest income quartile are almost uniformly at moderate to very high risk because large amounts of their compensation would need to be saved to ensure retirement security. Table 1 is reproduced in Appendix A with the addition of the number of Minnesotans in each subgroup.

The creation of three risk categories as opposed to some other number of categories is somewhat arbitrary, but was chosen to approximate other work in this field (Knickman and Snell 2002; Knickman, et al. 2003) which has divided retirees into: (1) people likely to be able to pay for all their long-term care needs (the financially independent); (2) those likely to be eligible

for public support for any long-term care needs (the Medicaid bound), and (3) people likely to "spend-down" or be able to afford some long-term care services, but would exhaust their resources if long-term care is needed for an extended period (the "Tweeners").

Table 2 presents the number of Minnesotans estimated to be in each of these three categories. While these numbers may seem dire, they are actually better then either national estimates for 2000 or projections for 2030 derived from the Knickman long-term care financing model.

Table 2: Projections of Minnesotans expected to be at risk of not having enough retirement resources to meet expected expenditures including long-term care

Risk Category	Number in Minnesota (born 1936-1965)	% of Minnesota Population (born 1936-1965)
Very High Risk	533,450	29%
Moderate to High Risk	326,360	17%
Low to Moderate Risk	1,013,920	54%
Total	1,873,730	100%

The results from these two models are compared in Table 3 and may be driven by the differences between Minnesota and the national population as well as how the categories were created. It is interesting to note that while the number estimated at risk of income insecurity is the same for those at high risk of spending down to Medicaid, the distribution between the higher income categories is quite different. The disparate results are due to the ways in which the models were developed and assumptions made as to how to divide populations into discrete categories. Clearly more work needs to be done to understand these models and refine them to help states develop their long-term care program options.

Table 3: Comparison of Minnesota projections to Knickman-Lewin Model

EBRI-based Minnesota Estimate % of Minnesotans born between 1936 and 1965		Knickman-Lewin Model	2030
Very High Risk	29%	Medicaid Bound	29%
Moderate to High Risk	17%	Tweeners	33%
Low to Moderate Risk	54%	Financially Independent	38%

Programs to Reduce the Number of Minnesotans at Risk

We use this classification as a starting point in efforts to document what characterizes the Minnesotans in each category, which can in turn be used to aid in evaluations of public programs designed to increase the number of Minnesotans with sufficient retirement resources and decrease the number of people who might need to rely on Medicaid or other public programs for their long-term care needs. For example, additional information is available from the US Census Bureau on home ownership and the value of the houses people own. This information can be used to evaluate the viability of reverse mortgages as a financing mechanism for long-term care. In the following section, the risk categories defined in this Issue Brief are combined with additional data about Minnesotans, as well as information from other studies, in order to evaluate the potential of four program options to reach Minnesotans at high and moderate risk of having insufficient retirement resources.

Estimating the impact of programs is difficult. We discuss each of the options but provide additional detail on estimates of impact on two of these options where the most data is available: long-term care insurance tax incentives and reverse mortgages. We caution readers that these are initial assessments based on Minnesota projections of future income of retirees, assumptions of use and need of long-term care services, and Medicaid eligibility based on the research literature. Changing the assumptions and the inputs to the model will produce different estimates. We urge caution and encourage more detailed research to refine our initial assessment.

Four Options that Aim to Improve Retirement Income Security

Option 1: Long-Term Care Insurance Partnership Program

"Partnership" in the context of long-term care financing refers to a specific program in place in four states (New York, Connecticut, Indiana and California). Begun in 1988 with the sponsorship of The Robert Wood Johnson Foundation, the partnerships were designed to encourage long-term care planning and specifically the purchase of long-term care insurance. The "partnership" is between people who agree to buy private long-term care insurance and the state that agrees to exclude some wealth from the eligibility determination for Medicaid if the need for care extends beyond the insurance coverage.

The requirements for "qualifying" long-term insurance policies and how Medicaid eligibility is calculated vary across the participating states. In Connecticut and California a dollar-for-dollar model is used. In these states if a person purchases coverage for $100,000 worth of care and needs care over and above this amount, they will be able to keep $100,000 worth of assets and still qualify for Medicaid. In New York all assets are excluded from Medicaid eligibility determination (but income must be spent on care) if the benefits are exhausted from a policy that covers three years of nursing home care, six years of home care, or a combination of the

two. Indiana uses a hybrid model in which policies below an amount set by the state are matched dollar for dollar and policies above that amount allow total asset protection. During the 2005 session the Minnesota Legislature authorized establishment of a hybrid model of the long-term care partnership program after necessary enabling legislation is passed at the federal level.

Although the programs vary across the states, the underlying idea is the same: the individual carries at least the required amount of long-term care insurance, then Medicaid serves as catastrophic coverage after the insurance benefit is used; individuals do not need to impoverish themselves to qualify. The potential benefit for the states with these programs is that private insurance is covering the initial cost of long-term care, some of which might have been paid for by Medicaid absent the program. For individuals, the investment in long-term care insurance is rewarded by a guarantee that some assets can be maintained for a spouse, left to children, or distributed as they want regardless of the need for care.

There are several advantages to this approach for states. First, there are very few administrative costs involved. The state role is limited to setting the standards for qualifying policies and honoring the exemption if and when a person qualifies. Perhaps most importantly, the state does not need to either appropriate funds up front nor immediately lose income as it would for other policy options such as family loans, tax incentives for insurance premiums, or reverse mortgages.

Partnerships have not expanded beyond the four original states due to a change in federal law that was included in OBRA 1993. Under this law states are not allowed to waive the estate recovery requirement for Medicaid. This means assets could only be excluded while a person is alive, effectively negating much of the motivation for participating in a partnership plan. For this reason other states have not pursued implementing a partnership, although several state legislatures have proposed or passed legislation asking the federal government to repeal this provision of OBRA 1993 and authorizing the implementation of a partnership program if and when federal law is changed.

Another barrier to the expansion of the partnership model is that it, like any state-based program, is not transportable to other states. A participant in Connecticut's program who retires to Florida would need to return to Connecticut when and if Medicaid coverage was needed in order to benefit. An initial step in removing this barrier was taken by two of the current partnership states by establishing reciprocity. This sets an example that could be used to remove this barrier if partnerships are expanded in the future.

Cost Savings to the Partnership Model

Determining the benefit for states in terms of realizing Medicaid savings is less straight forward. Medicaid savings requires that at least some of the care covered by the insurance benefits would have been paid by Medicaid. People who participate in these partnership programs must have sufficient income to pay their long-term care insurance premiums and

some wealth such that they are motivated to protect their assets. Given this, it is unlikely that most would qualify for Medicaid when they initially require long-term care services. The primary savings to the state would come in terms of delaying spend down to Medicaid eligibility. If they would have spent down to Medicaid in a shorter time than the insurance benefits period, then the state Medicaid programs would still realize a savings equal to this difference.

While existing partnerships are limited to long-term care insurance, there is nothing intrinsic to the model that would keep it from being used with reverse mortgages or any other long-term care financing mechanism. The key element of the partnerships is that private financing for a period of long-term care is supplemented by public financing if extended care is needed. If the federal law was changed, various forms of partnerships are likely to be developed by the states. For example "partnerships" could be designed where the initial private financing is from a reverse mortgage and then any remaining home equity would not be used to determine Medicaid eligibility or be due from the estate after the Medicaid recipient has died. Another variation on the partnership model has been proposed by the Elder Law Section of the New York State Bar Association. The proposed "LTC Compact" would require a person to pledge to spend $300,000 or half of their total assets on long-term care, whichever is lower. After this is expended, Medicaid would cover any additional long-term care needed. In this type of a program, any mechanism could be used to reach the required private pay ceiling, including an insurance policy, reverse mortgage, liquidation of assets, and/or income (Holubinka 2005).

Experience with the partnership program is still limited in that most participants have yet to reach the age when long-term care is likely to be needed. However, based on our current understanding of need for long-term care services, the structure of these programs appears to support the anticipated future need. For example, although a significant portion of people who live to 65 years will require some long-term care during their remaining life, most require care for short (less than 1 year) or moderate (1 to 3 years) periods. Partnership programs encourage individuals to arrange private financing for these short-term needs by having the state assume responsibility for those needing extended care. As a result, the individual is faced with a more predictable risk of managing short-term care by using an affordable private financing option. The state's participation reduces or eliminates the individual's risk of having insufficient resources to manage long-term care needs.

Option 2: Tax Incentives and Subsidized Long-Term Care Insurance Options

One group of programs that have been implemented to some degree, and continue to be considered by both federal and state governments aim to make long-term care insurance less expensive through either tax incentives or subsidies. The rationale is that lowering the cost of long-term care insurance will encourage more people to purchase coverage; and more people with long-term care insurance will result in fewer people requiring Medicaid for long-term care.

Overview of Tax Incentive Options

Although tax deductions, tax credits and premium subsidies all effectively reduce premiums, they differ in terms of who is most affected and the overall impact on public long-term care financing. Tax deductions, which allow people to reduce their taxable income, provide a greater benefit to people with higher incomes who are taxed at higher rates. Conversely, tax credits – which are usually a fixed amount (currently $100 in Minnesota) – offset a higher proportion of the tax burden of people with lower incomes versus higher incomes. However, both of these tax mechanisms require that a person pay premiums up front and receive the benefit at some point in the future. A subsidy helps people who may not have the cash flow – from either income or assets – to pay the full premium, and then wait for the tax benefit.

Another difference that mitigates the impact of these approaches is that each may have varying effects on different age cohorts or at different stages of a person's life. Tax deductions may encourage younger people to buy insurance, but provide a smaller benefit when a person retires and has less income. Tax credits, on the other hand, are more beneficial for someone continuing a policy who has experienced a decline in income, whether due to retirement or some other reason. The tax credit in this situation is an incentive not to let a policy lapse. A subsidy for someone who purchased a policy and has difficulty maintaining the premium payments functions in the same way, but could provide the funds when the premium payment is due, thereby averting lapse by those with lower incomes or more precarious finances. People who lapse due to lack of income are more likely to also qualify for Medicaid should they need extended long-term care. This difference was pronounced in one simulation study and led the authors to conclude, "tax credits are better suited to assist lower income and elderly individuals maintain their policy and tax deductions are better suited to stimulate the long-term care insurance market among the wealthier, working-age population" (Frakt and Pizer 2001).

Other arguments in support of favorable tax treatment for long-term care insurance, either deductions or credits, are that they would provide a "signaling effect" and that they would lead to growth in the market and increased quality of the insurance products offered. The "signaling effect" is the idea that government action would raise awareness and focus attention on the need for long-term care planning (Cohen and Weinrobe 2000), thereby creating a sizeable market. A larger market for long-term care insurance would allow insurers to offer a wider variety of products at lower premiums. However, these benefits are difficult to quantify and therefore it is difficult to determine if they would offset the costs of tax credits, deductions or subsidies, or if other educational approaches or efforts to improve long-term care insurance products might be more cost-effective.

Challenges in Evaluating the Impact of Premium Reduction Programs

Evaluating any of these programs in which the government would pay now, either through subsidies or foregone revenue, and benefit at some time in the future requires the consideration of the time value of money, recent changes in the long-term care insurance market, and the extent to which these policies can be targeted to reach people at risk of needing Medicaid support to meet their long-term care needs.

Put simplistically, considering the time value of money means that one dollar in the future is worth less than one dollar today. Exactly how much less depends on how far into the future the benefit will be realized and the discount rate that is used. The impact of the delay between the cost and benefit can be illustrated for any of the premium cost reduction policies. For example, one simulation of the impact of making long-term care insurance premiums completely deductible from federally taxable income estimated that the cost per policyholder would be $2,850 while the Medicaid savings would be $4,258. Applying a discount rate of 6% to these values and assuming that the savings are realized, on average, 12 years in the future, the cost becomes $2,111 and the savings $2,243 for a real saving of $1.06 of Medicaid savings for every $1 spent or forgone (Cohen and Weinrobe 2000). This estimate is for the total savings to Medicaid, including both federal and state government. The savings for a particular state will depend on the federal/state matching rate for Medicaid and the Medicaid payment rates for long-term care services.

The utility of some of these simulations based on data from the late 1990s and the first two years of this decade is limited to some extent by recent changes in the economy and their impact on long-term care insurance. Lower than expected rates of return on investments and limited experience with long-term care products have resulted in significant premium increases in recent years. At the same time, long-term care costs have been increasing, but at slower rates then acute care costs in Medicaid (O'Brien and Elias 2004). In this situation larger tax credits or the creation of subsidies may only serve to offset the increases in lapse rates likely to accompany the increase in the cost of insurance. Moreover, if the costs of programs to reduce long-term care insurance premiums are increasing faster then the benefit received (which is the cost of the avoided Medicaid support), the net impact on state expenditures is reduced. While the current situation must be considered, some in the long-term care insurance industry have suggested that the recent premium increases are a one-time adjustment and that the cost of long-term care will continue to rise at a slower and more predictable rate, creating a situation where the cost and benefits of reducing long-term care premiums for a state government are more straightforward.

However, the most difficult aspect of evaluating programs that reduce premiums is that while increasing the number of people who purchase long-term care insurance and helping people maintain their long-term care insurance policies may produce a general social good, there are only resulting Medicaid savings if certain conditions are met. These conditions are:

1. the purchasers of long-term care insurance require long-term care services at some point in the future;
2. the purchasers who need long-term care keep their insurance policies in force by continuously paying their premiums;
3. absent long-term care insurance, these purchasers would have become eligible for Medicaid; and

4. the long-term care needed and used by these purchasers would have been covered by Medicaid (Frakt and Pizer 2001).

Finally, assessing the use of Medical Assistance funds to subsidize the purchase of long-term care insurance by individuals who would be unlikely to purchase it without a direct subsidy is also difficult to assess. There is first the need to target the subsidy to those at "high risk" of spending down to Medicaid and again, Medicaid savings are achieved if only the four conditions above are met. With the addition of the subsidy, there is an additional burden on demonstrated savings as there is now on the upfront cost of the Medical Assistance premium subsidy.

A specific issue is timing, and how to project who would likely be Medicaid eligible in the future. In addition, the target population will by definition, not be Medicaid eligible when the subsidy begins. This provides an added upfront cost to the Medicaid program that will need to be recouped to demonstrate the effectiveness of such a program. Another issue is that the subsidy must be large enough to induce take-up and for low-income populations in the long-term care insurance market this could be substantial.

Finally, in a voluntary program, only some of the population participates although program participation could be limited by some type of eligibility criteria. Consider the example of a tax subsidy for long-term care insurance for the same 4 types of people.

Example of a Tax Subsidy for Long-term Care Insurance

Type of Person (w/o program)	Upfront Cost to State	Benefit to Person	Medicaid savings for State w/ program
Never needs long-term care	Amount of tax subsidy	Amount of tax subsidy	Loss – amount of tax subsidy
Long-term care total private pay (e.g., does not spend down)	Amount of tax subsidy	Amount of tax subsidy and the long-term care covered by insurance that would have been private pay out-of-pocket	Loss – amount of tax subsidy
Long-term care mixed private pay and Medicaid (after spend down)	Amount of tax subsidy	Amount of tax subsidy and the long-term care covered by insurance that would have been private pay out-of-pocket	Savings from private payment of long-term care from insurance that would have been a Medicaid expense minus the value of the tax subsidy
Long-term care Medicaid only (immediate eligibility due to income).	Amount of tax subsidy	Amount of tax subsidy	Loss – value of long-term care covered by insurance minus the amount of tax subsidy

In this case, the state is at risk of spending Medicaid dollars up-front for a subsidy that might be poorly targeted. That is, only a few people will ever need long-term care financing. For many, they will never need their long-term care insurance policy and thus there is virtually no savings to the state. For a state to save Medicaid dollars over time, the amount saved on the people who would have used Medicaid has to be greater than the amount lost on the tax subsidy for all

types of people. In these types of programs, people are going to self select according to their estimation of whether they will get the long-term care benefit and the general conclusion in economics is that people are better at self-selecting than the state will ever be at forcing selection through any mechanism because of information asymmetry (people know more about their own situation than the State does and can use this information to make a more informed decision.)

In summary, the use of Medicaid subsidy for the purchase of long-term care insurance policies is difficult to design to assure a cost-savings to the Medicaid program.

Option 3: Reverse Mortgages

A reverse mortgage allows older (62 years or older) homeowners to access the equity in their home while continuing to live in it and delay repayment on the home until the homeowners leave permanently and the house is sold. The proceeds from a reverse mortgage can be in a monthly payment, a line of credit, or a lump sum and can be used for any purpose. When the home is sold the loan balance, interest and other costs are paid out of the proceeds.

Increasing the use of reverse mortgages for long-term care is receiving more attention because home equity represents a major asset for many older Americans. Currently the value of a person's home is not considered for Medicaid eligibility, but a state can require the estate of a person who has received Medicaid services to repay the cost of the services used. If people voluntarily used their home equity to cover long-term care expenses, estate recovery by states would not be necessary. Perhaps more importantly, the person needing long-term care services would have more control over the types of services purchased and their price. Money could be used for services that are not usually paid for by Medicaid, such as extensive home modifications. Additionally, services could be purchased in ways that might be more cost-effective than how they are frequently purchased under Medicaid programs. For example, hiring a personal care aide directly or paying a relative to deliver certain services is likely to be less expensive than the average Medicaid home health care payment.

The use of reverse mortgages has the potential to change the dynamic of when private and public money is used for long-term care. Such a change could be advantageous for both individuals and the state. For individuals, a reverse mortgage for long-term care could provide additional control and flexibility— purchases from personal funds can be made as the individual prefers, rather than conform to Medicaid requirements. From the state's perspective, reverse mortgages may allow individuals to pay privately for services for enough time that they either never need Medicaid or use Medicaid for a shorter period of time. Additionally, if a person voluntarily uses their home equity before qualifying for Medicaid the state may avoid some of the costs associated with estate recovery.

A national study by the National Council on Aging estimated that of the 13.2 million candidates for reverse mortgages, about 5.2 million (39%) are either already receiving Medicaid or are at financial risk of needing Medicaid. The study also estimated that if 4% of eligible households were to take out reverse mortgages to pay for services in their homes, Medicaid would save $3.3 billion a year nationally. High rates of home ownership in Minnesota make it likely that this option would be viable for a significant proportion of people at risk. Additional information on the potential impact of using Minnesota data on home ownership is included in Appendix B.

Despite these advantages, a barrier to the use of reverse mortgages is the relatively high upfront costs for this type of loan. Loan origination fees – required as they are with a conventional mortgage – are often 2% of the loan value, and mortgage insurance is also required. For example, a $50,000 loan may involve fees of over $5,000, of which $3,000 is the origination fee and mortgage insurance. States might be able to encourage the use of reverse mortgages by finding ways to reduce or subsidize these fees. Both Rhode Island and New Jersey have been able to lower fees by processing the loans through their housing authorities and requiring lower loan origination fees. Montana has lowered the cost of reverse mortgages by running their own program, which allows them to set the fees at what they believe are appropriate levels.

Finally, there is some concern about reverse mortgage funds being used for purchases other than long-term care, thereby depleting an individual's resources to pay for needed long-term care. This issue may be addressed by limiting the types of purchases made with the reverse mortgage funds to long-term care items and services.

Option 4: Family Loan Program

Overview

A family loan program is a financing mechanism that facilitates payment by others, usually (but not limited to) children, for an older person's long-term care. Basically, one or more family members apply for an unsecured line of credit. This credit is used to pay the difference between the cost of long-term care – often in assisted living or a nursing home – and the elder resident's income. The payments from the line of credit are made directly to the provider and the borrower makes a lower monthly payment over a longer period of time (often 3 to 5 years). See Figure 2 for a visual description of the family loan.

These loans are currently available in five states (Virginia, Maryland, Missouri, Kansas, and Tennessee) and could be used in Minnesota if a private lender was interested in this line of business. No changes in existing law or policy would be needed for this type of program to be offered in its current form. An expansion of this program would depend on the interest in this area by private financial institutions.

Any state role in a family loan program would represent a new initiative. The state could attempt to determine why financial institutions would or would not be interested in this product. If such an effort identified legal or regulatory barriers, these could be addressed by the

legislature or agencies. Another larger role would be for the state to support these types of loans directly if the primary barrier is that this line of business is not perceived to be profitable. These could take the form of default guarantees, subsidized interest rates, or making the interest rates deductible for the borrower. Interest rate deductions would reduce the cost of the loans for family members, but would not necessarily support the entry of lenders into this market. Guarantees against defaults and interest rate subsidies have been proposed as a means to make this type of loan viable for financial institutions.

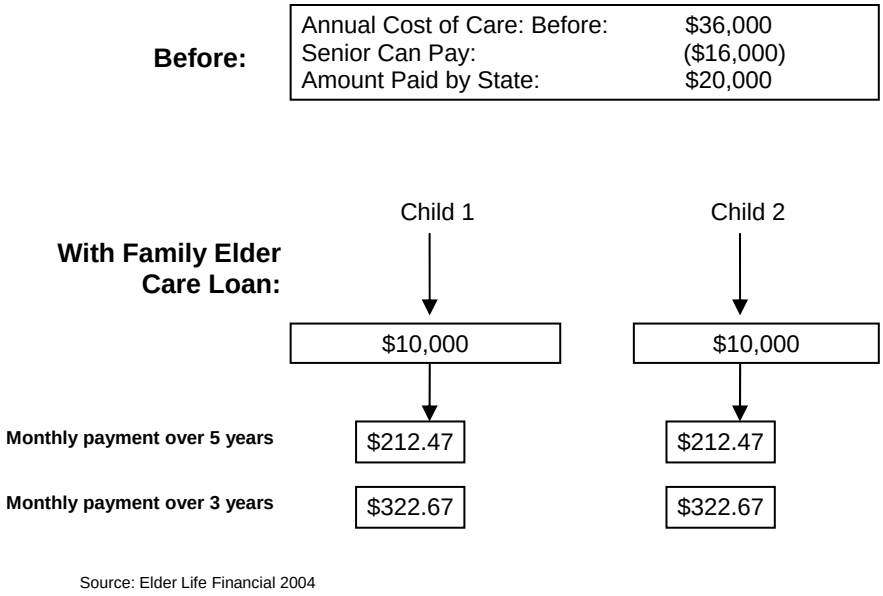
Implications for Long-term Care Financing

Because family elder care loans are not currently available it is difficult to predict whether Minnesotans would use this program and whether such use would reduce Medicaid obligations. As family members are not compelled to financially support their parents by law or culture, family members' willingness and ability to pay have to be considered. Data and research on the baby boomers and their retirement prospects rarely include information on the income and current debt of family members. Also it is generally not possible to link adult children to retirees in available data because they typically live in different households and the data is neither collected nor coded in ways that allow these types of links.

The idea of a subsidized elder loan program has been compared by some to the student loan program. The comparison is accurate in that such a loan would make something that is difficult to afford obtainable, by making inexpensive loans available that would spread out the payments. However, there are some differences that are important to note. Student loan borrowers have an extended period of time to pay back the loan during the years when their earnings are likely to be increasing. The adult children of elderly family members who need long-term care are likely to be retired or nearing retirement themselves and may have declining incomes or fewer years of earnings available to repay the loan. In this case the elder care loan could become difficult to pay over time and the borrowers may need to reduce other expenditures such as savings for their own retirement.

These difficulties may be preempted by loan approval procedures that limit the amount of credit the family could access. However if the granted credit lines are low, they may not be sufficient to cover the long-term care cost of a parent who needs care and financial assistance for more than a short time. The lines of credit granted in the states where this program is currently offered have ranged from $3,000 to $50,000. How long this would last would depend on the income the elder is able to contribute and how long the care is required. Given the high cost of assisted living and nursing homes, it seems likely that this program is most effective at meeting a relatively short-term need (e.g., the total cost for a short stay or a portion of the cost for a stay not more than 1 or 2 years). This is reinforced by the sample scenario reproduced in Figure 2, in which two children split the balance of the cost of one year of care and have 3 or 5 years to make reasonable payments. If the parent needed this support for two, three, or five years, the credit may not be enough or the payments may be too high.

Figure 2: Family Loan Example



Source: Elder Life Financial 2004

While family loans may not be a viable approach to funding extended long-term care needs, they may be a very valuable intermediate solution. Often an elder's assets cannot be liquidated easily even when he or she wants to use them for long-term care. In such cases, the family may be able to take the loan as a "bridge" financing measure to cover costs for a short time. For example, the loan could pay for care while a house is repaired and sold, and then the loan could be repaid from the sale. In other cases care may only be needed for a year or less, either because there is an expectation of improvement or the elder has a terminal condition, and a family loan would be preferable to using other lines of credit or applying for public assistance.

Another issue to consider is the cost of a subsidized loan program. Such a program could be run either through private lenders or directly by a government entity. The Federal government established a direct lending program for student loans in 1993 in order to reduce the costs of this very expensive program. One estimate is that the subsidized student loans made through private lenders cost the government $11 *more* per $100 loaned than the same loans made via the Department of Education (Burd 2005). The 2005 budget of the United States Government reports subsidy rates and administrative costs that, combined, place the cost of a guaranteed loan at $1,706 for every $10,000 (Shireman 2004). This experience with the student loan program suggests that establishing a subsidized elder care loan system would be costly for a state, either in terms of the subsidies or in terms of setting up the infrastructure for a direct loan program.

Summary

States continue to look for new financing initiatives to address the growing number of aging baby boomers. Our analysis has highlighted the concern that as many as 28 percent of the baby boomers in Minnesota will be at risk of not having enough income to cover their retirement expenses. We have identified the characteristics of Minnesotans that are in the high-risk category and likely to end up on Medicaid. This is a significant concern to the state as it considers its future financing obligations.

We analyzed the four financing options against their potential to reach the target population which in turn affects the ability of that option to have a significant impact on future Medicaid costs. Two options, the family loan program and the tax incentives, are clearly targeted to those with low to moderate risk of needing help in meeting their retirement and long-term care needs and evidence to date indicate that they will have minimal impact on future Medicaid costs. There is new evidence to suggest that a reverse mortgage program has potential to target a segment of the at-risk population with a significant estimated impact on future Medicaid savings. Finally, while there is only limited experience with the partnership program, we believe with appropriate targeting and outreach it could potentially meet the same subset of the target population as could be reached through reverse mortgages.

States will need to consider a combination of public-private strategies to effectively address the ballooning number of aging baby boomers who are at potential risk of needing Medicaid support in their retirement years. Part of this strategy must be an effective campaign to educate individuals about the growing gap between retirement resources, the risk of needing long-term care and all the health and long-term care costs associated with retirement. This two-part Issue Brief series helps to begin this process of education and program development in the State of Minnesota, and this preliminary analysis suggests that the state should pursue the long-term care insurance partnership program and reverse mortgage options as potential vehicles for addressing future long-term care financing needs.

Appendices

Appendix A: Retirement Security Risk Category Projections

Table A.1: Minnesotans born from 1936 to 1965, by risk category based on ability to save sufficient funds for retirement

Key:

Color = marital status		$ = income quartile	
$	Single Women (yellow)	$	lowest income quartile
$	Single Men (green)	$$	2nd income quartile
$	Married (blue)	$$$	3rd income quartile
		$$$$	highest income quartile

	Risk Categories Based on Ability to Save Sufficient Funds for Retirement		
Age in 2000	**I** **Savings unlikely to be feasible**	**II** **Substantial Increases in Savings Required**	**III** **5% or less savings increase = retirement income sufficiency**
60-64	$ 6,650 $$ 6,370 $$$ 6,930 $$$$ 6,660 $ 4,100 $$ 4,040 $$$ 4,050 $$$$ 4,300 $ 32,750 $$ 33,040 $$$ 33,270	$$$$ 33,050	
55-59	$ 7,630 $$ 7,550 $$$ 7,910 $ 5,580 $$ 5,350 $$$ 5,560 $ 42,910 $$ 42,780	$$$$ 7,710 $$$$ 5,820 $$$ 41,280	$$$$ 45,350
50-54	$ 10,420 $$ 10,450 $ 8,810 $$ 8,770 $ 55,320	$$$ 10,530 $$$$ 10,470 $$$ 8,850 $$ 55,300	$$$$ 8,820 $$$ 55,320 $$$$ 55,390
45-49	$ 12,260 $$ 12,270 $ 11,450 $ 64,900	$$$ 12,250 $$ 11,670 $$$ 11,580	$$$$ 12,300 $$$$ 11,600 $$ 66,330 $$$ 65,570 $$$$ 65,770
40-44	$ 14,100 $$ 14,110 $ 14,200	$$$ 14,020 $$ 15,000 $ 73,690	$$$$ 14,220 $$$ 14,630 $$$$ 14,750 $$ 73,680 $$$ 70,380 $$$$ 77,090
35-39	$ 14,400 $$ 14,590	$ 15,150	$$$ 14,470 $$$$ 14,550 $$ 14,580 $$$ 17,060 $$$$ 15,720 $ 71,590 $$ 71,510 $$$ 70,190 $$$$ 73,080

Appendix B: Reverse Mortgage Impact Estimation

Impact of Reverse Mortgages on Risk of Retirement Income Security

The potential impact of reverse mortgages on the retirement income security of Minnesotans is evaluated in two different ways. First, as part of the EBRI research, the amount of savings required was also modeled assuming that people used their home equity as needed, meaning that as soon as their retirement and long-term care expenses exceeded their income and other assets. As expected, this improves the financial situation for some people. Table B.1 replicates the distribution of Minnesotans into risk categories if the value of housing is included in the model. Using housing value has a positive impact because using housing equity reduces the risk of retirement income insecurity for three of the 72 subgroups used in the EBRI analysis.

Table B.1: Change in risk of retirement income insecurity when housing equity is used when needed, Minnesotans born between 1936 and 1965

Risk Category	Number and Percent of Minnesotans (born 1936-1965)		Number and Percent of Minnesotans (born 1936-1965) if housing equity is used when needed		Difference
Very High Risk	533,450	29%	464,250	25%	-69,200
Moderate to High	326,360	17%	383,980	21%	57,620
Low to Moderate Risk	1,013,920	54%	1,025,500	55%	11,580
Total	1,873,730	100%	1,873,730	100%	

Another way to evaluate the potential impact of reverse mortgages is to determine what percentage of the population — specifically what subgroups of the population — actually own a home that has enough value to offset a significant amount of long-term care costs. Given that Minnesotans have a high rate of home ownership, it is likely that the use of a national model results in an underestimate of the potential impact of reverse mortgages.

To generate another estimate that incorporates the rate of homeownership and housing values in Minnesota, data from the 2000 Census were used to establish counts of the EBRI groups (based on age, household type and income quartile) with at least 75% homeowners and in which 66% of these homeowners had properties valued at $100,000 or more. These values were chosen based on the judgment that this rate of homeownership and value would be high enough to shift the entire subgroup into the next better risk category.

This analysis, shown in Table B.2, suggests that many homeowners in Minnesota would move from the higher risk categories to lower risk categories if these criteria were applied. This supports the assumption that housing is a significant asset for many middle class individuals and if it is accessed, either through reverse mortgages or through other means, the risk of requiring Medicaid is reduced. The percentage of homeowners and the percentage with homes valued at $100,000 or more are presented for each of the EBRI groups in Table B.3.

Table B.2: Change in risk of retirement income security when home ownership and value* are considered, Minnesotans born between 1936 and 1965

Risk Category	Number and Percent of Minnesotans (born 1936-1965)		Number and Percent of Minnesotans (born 1936-1965) with home ownership qualification added*		Difference
Very High Risk	533,450	29%	526,790	28%	-6,660
Moderate to High Risk	326,360	17%	161,010	9%	-165,350
Low to Moderate Risk	1,013,920	54%	1,185,930	63%	172,010
Total	1,873,730	100%	1,873,730	100%	

* At least 75% of risk category owns a home, and at least 66% of these homeowners have a house valued at $100,000 or more.

However, while the use of the EBRI national data probably underestimates the impact of using housing equity, this housing data results in an overestimate because it is unknown what percentage of these people would qualify for a reverse mortgage and what the value of the loan would be. The National Council on Aging recently released a report that uses a methodology likely to be more accurate because it is based on actual mortgage lending practices. The estimates in the report are for the nation, but NCOA plans to produce some regional and state estimates in the near future, possibly by early 2006 (Stucki 2005).

Table B.3: Home ownership and home values greater than $100,000 by EBRI Category, Minnesotans born between 1936 and 1965

Large/Bold = greater than 75% home ownership and greater than 66% of home values over $100,000

Age in 2000		Lowest Income Quartile		2nd Income Quartile		3rd Income Quartile		Highest Income Quartile	
		Own	> $100,000	Own	> $100,000	Own	> $100,000	Own	> $100,000
60-64	Single Women	63%	35%	72%	39%	81%	50%	**86%**	**70%**
	Single Men	65%	29%	74%	36%	79%	54%	83%	55%
	Married	94%	60%	94%	59%	96%	64%	**97%**	**82%**
55-59	Single Women	60%	38%	70%	35%	81%	58%	**88%**	**67%**
	Single Men	65%	32%	64%	45%	82%	43%	**83%**	**68%**
	Married	93%	63%	93%	61%	**97%**	**69%**	**97%**	**87%**
50-54	Single Women	55%	37%	70%	39%	83%	52%	**89%**	**71%**
	Single Men	59%	39%	69%	40%	78%	55%	**82%**	**78%**
	Married	91%	63%	94%	64%	97%	74%	**98%**	**91%**
45-49	Single Women	52%	37%	66%	38%	78%	48%	**92%**	**72%**
	Single Men	57%	33%	72%	39%	75%	47%	**80%**	**73%**
	Married	89%	65%	93%	63%	**97%**	**74%**	**98%**	**90%**
40-44	Single Women	51%	36%	58%	37%	74%	50%	**84%**	**74%**
	Single Men	60%	41%	66%	35%	72%	50%	**80%**	**75%**
	Married	**89%**	**66%**	92%	59%	**95%**	**74%**	**97%**	**90%**
35-39	Single Women	45%	33%	60%	43%	71%	53%	**80%**	**75%**
	Single Men	52%	39%	63%	39%	69%	53%	**76%**	**77%**
	Married	**86%**	**68%**	88%	60%	**93%**	**75%**	**96%**	**91%**

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