

Apply the LTC Vulnerability Index to Your State: The New Hampshire Example

“Long-Term Care Vulnerability and Potential”

Abstract: Caring for America’s burgeoning older population strains our country’s public health care programs. Private long-term care insurance can and should relieve more of the financial pressure on Medicaid, Medicare and private savings. But private LTCI languishes under current market conditions. How close is long-term care to a breaking point? How likely is it that today’s LTC service delivery and financing systems can endure and for how long? What will replace them if they falter? Will LTCI’s prospects wax or wane? Steve Moses and workshop attendees will interactively analyze the key social, demographic, and economic factors necessary to answer those questions. Together, we’ll review, weigh and score each factor toward the end of better understanding the long-term care crisis, its perils, and potential.

Background paper with source citations:

The Index of Long-Term Care Vulnerability: A National and State Framework

Overview

Long-term care (LTC) is custodial or medical assistance needed for three months or more due to an inability to perform activities of daily living independently. LTC is expensive¹ whether received in a nursing home, an assisted living facility or in one’s own home.² The risk of needing some form of long-term care after age 65 is 69%.³ The catastrophic risk of needing five years or more is 20%.⁴ 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.

¹ National median daily rate for a private nursing home room is \$240; for a semi-private nursing home room is \$212. National median monthly rate for assisted living is \$3,500. National median daily rate for adult day health is \$65. National median hourly rate for home health aide services is \$20; for homemaker services, \$19. Source: Genworth 2014 Cost of Care Survey, Genworth Financial, Inc., April 2014, https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032514_CostofCare_FINAL_nonsecure.pdf.

² Note that Genworth (above) cites median rates whereas John Hancock (following) cites average or mean rates, hence the difference in annualized totals. “[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.

³ 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/>.

⁴ *Ibid.*

Most people, when asked, say they believe Medicare pays for long-term care. It does not. But, its sister program Medicaid does pay for most expensive long-term care.⁵ Contrary to conventional wisdom, Medicaid long-term care benefits are relatively easy to qualify for financially.⁶ Peer reviewed research indicates that the availability of Medicaid long-term care benefits crowds out private financing and planning.⁷ Other reliable research shows that, ironically, the rich gain as much or more from Medicaid's long-term care benefit as the poor.⁸

Even as Medicaid spending grows rapidly, especially for long-term care, states are increasing Medicaid's attractiveness by "rebalancing" toward long-term services and supports (LTSS) provided in the community and away from the more traditional nursing home care. Most people prefer home and community-based services to institutional care, but the common belief that home care saves Medicaid money is dubious.⁹ States also try to save money by expanding managed care to new populations, including the aged, blind and disabled, and even high-risk, high-cost "dual eligibles." But managed care creates serious access and quality challenges, especially for these very vulnerable groups, as advocates for seniors and the disabled often warn.¹⁰

⁵ For a good quick overview of long-term care risk, cost and sources of financing, see David Rousseau, MPH; Jamie Firth; Anne Jankiewicz, "A Short Look at Long-term Care for Seniors," *JAMA*. 2013; 310(8):786. doi:10.1001/jama.2013.17676; <http://jama.jamanetwork.com/article.aspx?articleid=1733726>.

⁶ Income rarely interferes with Medicaid LTC eligibility because most states subtract private medical and long-term care expenses from income before determining income eligibility and, in the rest of the states, Miller income diversion trusts allow applicants to divert excess income temporarily in order to qualify. Virtually unlimited assets are exempt including up to \$814,000 of home equity in some states and \$543,000 in other states. Also exempt under federal rules with no limit are one income producing business, one automobile, term life insurance, personal belongings, home furnishings, prepaid burial funds, and Individual Retirement Accounts (IRAs) if they generate regular outlays as all are required to do after age 70 and a half. For details, see 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>.

⁷ For example: "We examine the interaction of the public Medicaid program with the private market for long-term care insurance and estimate that Medicaid can explain the lack of private insurance purchases for at least two thirds and as much as 90 percent of the wealth distribution, even if comprehensive, actuarially fair private policies were available." Source: 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.

⁸ "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>) based on research by Mariacristina De Nardi, Federal Reserve Bank of Chicago and University College London; Eric French: Federal Reserve Bank of Chicago and University, College London; and John Bailey Jones: SUNY-Albany. Citation: Mariacristina De Nardi, Eric French, and John Bailey Jones, "Medicaid Insurance in Old Age (REVISED June 2013)," Federal Reserve Bank of Chicago, Chicago, Illinois, WP 2012-13, June 2013; http://www.chicagofed.org/webpages/publications/working_papers/2012/wp_13.cfm.

⁹ See Stephen A. Moses, "Briefing Paper #4: Rebalancing Long-Term Care," Center for Long-Term Care Reform, Seattle, Washington, 2011, www.centerltc.com/BriefingPapers/4.htm.

¹⁰ See, for example, Judith Soloman, "Moving 'Dual Eligibles' Into Mandatory Managed Care and Capping Their Federal Funding Would Risk Significant Harm to Poor Seniors and People With Disabilities," Center on Budget and Policy Priorities, Washington, DC, October 10, 2012, <http://www.cbpp.org/files/10-10-12health.pdf> and Stephen A. Moses, "Briefing Paper #5: Dual Eligibles and Long-Term Care: How to

Medicaid already strains state and federal budgets. Many states are about to add thousands of new recipients to Medicaid's rolls through the Affordable Care Act's program expansion. A demographic "Age Wave" is coming soon that will strain Social Security and Medicare immediately and Medicaid, before long. Widespread Medicaid reform measures, such as rebalancing, may or may not save money, but they will make Medicaid LTC financing more popular and sought after. Managed care for high-risk populations may result in unavoidable problems and unanticipated costs.

Long-Term Care Analysis

Much scholarly effort goes into studying problems related to the aging of America. Long-term care is a major target of such research. But LTC has many complicated components, such as risk, cost, care giving, service delivery and financing. These are impacted by many related issues, such as public awareness, the economy's health, government budgets, personal savings, and available financial products. Usually, these components and issues are examined one by one or in small groups, rarely all together. They're studied in silos rather than comprehensively.¹¹

The question most commonly asked is "how can we fix or improve such and such a problem or program?" Unfortunately, many scholars approach the impending long-term care crisis by describing the status quo and proposing improvements. That often leads them to recommend more public financing. But what if public financing of long-term care has caused or exacerbated many of the service delivery and financing problems we face by discouraging responsible planning by private individuals and families? I have answered that question and developed that theme elsewhere.¹²

This paper takes a different approach and asks a different question: Is the current LTC service delivery and financing system sustainable over time in its current form or in its most likely modifications? Or put differently: how vulnerable is long-term care to the vicissitudes of aging demographics, limited financing sources, and consumers' denial of risk? If we keep doing what we've always done (heavy public financing), will we get a different result, and if not, could the dominantly-government-financed long-term care system collapse catastrophically? And if so, shouldn't we consider a fundamentally different approach to LTC service delivery and financing?

The Index of Long-Term Care Vulnerability

To answer those questions, I propose to look closely at the following variables individually and in combination based on national and state-level data (New Hampshire):

Save Medicaid LTC \$30 Billion Per Year *and* Pay for the 'Doc Fix,'" Center for Long-term Care Reform, Seattle, Washington, 2011, www.centerltc.com/BriefingPapers/5.htm.

¹¹ For a fuller development of this theme, see Stephen A. Moses, "Opinion: The Elephant, the Blind Men, and Long-Term Care," *National Underwriter LTC E-Wire*, Vol. 2, No. 3, February 2003, <http://www.centerltc.com/pubs/Articles/Elephant.htm>.

¹² Stephen A. Moses, "The History of Long-Term Care Financing, or How We Got Into This Mess," Center for Long-Term Care Reform, Seattle, Washington, 2011, <http://www.centerltc.com/BriefingPapers/1.htm>.

- How many older people are coming in the next few decades?
- How sick will they be?
- How viable is Medicaid as a long-term care payer?
- How reliable is federal revenue on which Medicaid mostly depends?
- How reliable is state revenue on which Medicaid secondarily depends?
- How much private-pay revenue is available to relieve LTC financing pressure on Medicaid?
- How strong is dependency on public programs (*i.e.*, the entitlement mentality)?

With clear answers to these questions, it should be possible to estimate, or at least shed light on, the likely outcome of current and probable future long-term care service delivery and financing policies. Fortunately, we have a lot of data and analysis readily available to answer these questions. So, we shall address them one by one. Thereafter we can array the questions and answers in a “Table of Long-Term Vulnerability,” apply weights and scores, and thereby appraise the national and state-by-state sustainability of existing and likely future LTC service delivery and financing systems.

How many older people coming?

This is the question of aging demographics. People 85 years of age and older are the most likely cohort to require long-term care. According to AARP, a good “barometer for the potential demand for long-term services and supports (LTSS) is the growth in the population age 85 and older, which is expected to increase by 69 percent between 2012 and 2032 and more than triple (+224%) between 2012 and 2050. People age 85 or older not only have much higher rates of disability, but they are also much more likely to be widowed and without someone to provide assistance with daily activities.”¹³

| <u>People age 85+</u> | <u>United States</u> ¹⁴ | <u>New Hampshire</u> ¹⁵ |
|-----------------------|------------------------------------|------------------------------------|
| Number in 2012 | 6,426,000 (2.0%) | 28,000 (2.1%) |
| 2012 to 2032 increase | 69% | 77% |
| 2012 to 2050 increase | 224% | 267% |

A state’s long-term care vulnerability is higher if its age 85 plus population growth is higher than the national average and lower, if lower.

¹³ Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, “Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012,” AARP, Washington, DC, 2012, p. 7, <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

¹⁴ *Ibid*, p. 36.

¹⁵ *Ibid.*, p. 216.

New Hampshire’s expected age 85 population growth is much higher than the national average. In fact, between 2012 and 2050, New Hampshire’s proportion of population 85 years of age or older is expected to move from 23rd in the country to number 1.¹⁶

Assign a weight and score in the Table of Long-Term Care Vulnerability.

2. How sick are they?

This question bears on the aging population’s health condition. The proportion of people age 65 plus with disabilities and the number of LTC facility residents with dementia (a major cause of long-term care) factor critically into the consideration of how likely the aging population is to need and receive long-term care.

| <u>People age 65+ with disabilities, 2010</u> | <u>United States</u> ¹⁸ | <u>New Hampshire</u> ¹⁷ | |
|---|------------------------------------|------------------------------------|-----------------|
| | | <u>Percent</u> | <u>Rank</u> |
| a. Self-care difficulty | 8.8% | 5.9% | 47 |
| b. Cognitive difficulty | 9.5% | 6.1% | 51 |
| c. Any disability | 37% | 32% | 48 |
| <u>Nursing facility residents with dementia, 2010</u> | 46% ¹⁹ | 55% | 1 ²⁰ |

A state’s long-term care vulnerability is higher if it has more people age 65 plus with disabilities and more nursing facility residents with dementia, less if less.

New Hampshire presents a puzzle. The state ranks near the bottom nationally in the proportion of older people with disabilities. But it is number one nationwide in the percentage of nursing facility residents with dementia.

Assign a weight and score for this factor in the Table of Long-Term Care Vulnerability.

3. How viable is Medicaid as a long-term care payer?

Because Medicaid is the dominant payor for high-cost long-term care in the United States, its current status and likely future viability factors vitally into the question of whether or not the long-term care system now in place can survive. Medicaid’s LTC viability breaks down into several sub-factors.

| <u>Expenditure trends</u> | <u>United States</u> | <u>New Hampshire</u> | |
|---------------------------|----------------------|----------------------|-------------|
| | | <u>Percent</u> | <u>Rank</u> |

¹⁶ *Ibid.*

¹⁷ *Ibid.*, p. 223.

¹⁸ *Ibid.*, p. 37.

¹⁹ *Ibid.*, p. 40.

²⁰ *Ibid.*, p. 220.

| | | | |
|---|-----------------------------|-----|------------------|
| Percent of budget for Medicaid ²¹ | 15.8% | 33% | 1 |
| Medicaid LTSS spending change for older people and adults with physical disabilities 2004 to 2009 | +28% ²² | 31% | 15 ²³ |
| Medicaid nursing facility spending change 2004 to 2009 | +12% ²⁴ | 23% | 10 ²⁵ |
| Medicaid HCBS spending change for older people and adults with physical disabilities 2004 to 2009 | +70% ²⁶ | 80% | 18 ²⁷ |
| Medicaid HCBS change as a % of LTSS spending for older people and adults with physical disabilities 2004-2009 | +9% ²⁸ | +5% | 29 ²⁹ |
| Federal Medical Assistance Percentage (FMAP) | 50% (minimum) ³⁰ | 50% | NA |

A state's long-term care vulnerability is higher if its rate on the preceding factors (except FMAP) is higher than the national rate; lower, if lower. A higher FMAP indicates a state's lower economic prosperity, but it is a positive factor because it means the state can garner more federal funds from the same investment of state funds. Expanded HCBS spending is deemed a negative factor because it makes Medicaid a more attractive LTC payer, and discourages private home care financing, private LTC savings or insurance and free care provided by families, friends or charities.³¹

New Hampshire has the lowest possible Federal Medical Assistance Percentage, 50%, which means the state has to raise one dollar in state funds to get one dollar in federal Medicaid funds. New Hampshire has the highest percentage of its state general fund

²¹ *State Health Facts*, The Henry J. Kaiser Family Foundation, "Distribution of State General Fund Expenditures," <http://kff.org/other/state-indicator/distribution-of-general-fund-spending/>.

²² Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012," AARP, Washington, DC, 2012, p. 41; <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

²³ *Ibid.*, p. 221.

²⁴ *Ibid.*

²⁵ *Ibid.*, p. 221.

²⁶ *Ibid.*

²⁷ *Ibid.*, p. 221.

²⁸ *Ibid.*

²⁹ *Ibid.*

³⁰ *State Health Facts*, The Henry J. Kaiser Family Foundation, "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," <http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/>.

³¹ For further explanation, see Stephen A. Moses, "Briefing Paper #4: Rebalancing Long-Term Care," Center for Long-Term Care Reform, Seattle, Washington, 2011, www.centerltc.com/BriefingPapers/4.htm.

expenditures going to Medicaid, 33%. New Hampshire ranked above average in most of the key measures of long-term care spending increases in the five year period between 2004 and 2009. Nursing facility spending nearly doubled the national rate (23% compared to 12%, rank 10) and HCBS spending increased faster than the national rate (80% compared to 70%, rank 18), but because of New Hampshire’s disproportionately high increase in nursing facility spending, its HCBS spending as a percentage of total LTC spending increased at only slightly more than half of the national rate (5% compared to 9%, rank 29).

| <u>Other Medicaid sub-factors</u> | <u>United States</u> | <u>New Hampshire</u> |
|--|--|-------------------------|
| Medicaid expansion under ACA? | 27 yes; 21 no; 3 undecided as of August 27, 2014 ³² | Yes, expanding |
| Medicaid LTC eligibility and Medicaid planning (Rank on range from less easy to more easy) | Easy ³³ | Less easy ³⁴ |
| Low reimbursement vulnerability (shortfall per SNF bed day) | \$22.34 ³⁵ | \$57.38 ³⁶ |
| Cost shifting: Medicaid nursing home rate as percentage of private pay rate | 92.2% ³⁷ | 74.1% ³⁸ |

A state’s long-term care vulnerability is higher if it (1) expands Medicaid under the ACA, (2) if its financial eligibility for Medicaid LTC benefits is more lenient, (3) if its nursing home reimbursement shortfall is higher, or (4) if its Medicaid institutional reimbursement rate is lower compared to its private-pay rate. Federal Medicaid LTC financial eligibility is deemed “easy” because income rarely obstructs eligibility, exempt assets are practically unlimited, and artificial self-improvement through legal Medicaid planning techniques is readily available.³⁹

³² *State Health Facts*, The Henry J. Kaiser Family Foundation, “Status of State Action on the Medicaid Expansion Decision, as of September 3, 2013,” <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

³³ See footnote #6 for why Medicaid LTC financial eligibility is relatively “easy.”

³⁴ New Hampshire is a 209-B state which allows its Medicaid program to have stricter financial eligibility rules than are allowed under SSI regulations elsewhere in the country.

³⁵ “A Report on Shortfalls in Medicaid Funding for Nursing Center Care,” ELJAY, LLC for the American Health Care Association, December 2012, p. 1, http://www.ahcancal.org/research_data/funding/Documents/FINAL%20Medicaid%20Underfunding%20for%20Nursing%20Home%20Care%20Report.pdf.

³⁶ *Ibid.*, p. 8.

³⁷ Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, “Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012,” AARP, Washington, DC, 2012, p. 39; <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>. Based on a Medicaid rate of \$178 and a private-pay rate of \$193.

³⁸ *Ibid.*, p. 219.

³⁹ For details, see footnote #6 and Stephen A. Moses, “Briefing Paper #2: Medicaid Long-Term Care Eligibility,” Center for Long-Term Care Reform, Seattle, Washington, <http://www.centerlrc.com/BriefingPapers/2.htm>.

New Hampshire ranks poorly on all these factors except LTC eligibility. It is expanding Medicaid under the ACA; it has the highest Medicaid SNF reimbursement shortfall in the country by far; and its reimbursement rate is only 74.1% compared to the national average of 92.2%. New Hampshire is a 209-B state so it has the potential to apply stricter eligibility criteria than most other states, but we lack a study including interviews with eligibility workers to show definitely whether New Hampshire as a more strict or less strict LTC eligibility system.

| <u>Dual eligibles vulnerability</u> ⁴⁰ | <u>United States</u> | <u>New Hampshire</u> |
|---|----------------------|----------------------|
| Dual eligibles as share of all Medicaid enrollees | 15% ⁴¹ | 19% ⁴² |
| Duals as share of all aged and disabled enrollees | 60% ⁴³ | 73% ⁴⁴ |
| Dual eligibles spending as % of total Medicaid | 39% ⁴⁵ | 49% ⁴⁶ |

A state's long-term care vulnerability is higher if it has more high-cost dual eligibles and higher spending for dual eligibles; otherwise, lower.

New Hampshire's dual eligibles vulnerability is exceptionally high. Only two states, Connecticut and Wisconsin, spend a higher percentage of Medicaid on duals. New Hampshire is also substantially higher than the national average in duals as a share of all Medicaid enrollees and as a share of aged and disabled enrollees.

| <u>Rebalancing vulnerability</u> | <u>United States</u> | <u>New Hampshire</u> | |
|----------------------------------|----------------------|----------------------|------------------|
| | | <u>Number</u> | <u>Rank</u> |
| Family Caregivers #/1000 | 137 ⁴⁷ | 138 ⁴⁸ | 24 ⁴⁹ |

⁴⁰ The nine million elderly or disabled individuals eligible for both Medicare and Medicaid are by far the most expensive beneficiaries of both programs costing \$250 billion in 2009 for health care benefits.

Source: Congressional Budget Office, "Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies," June 2013, p. 1, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44308_DualEligibles.pdf

⁴¹ Katherine Young, Rachel Garfield, MaryBeth Musumeci, Lisa Clemans-Cope, and Emily Lawton, "Medicaid's Role for Dual Eligible Beneficiaries," The Henry J. Kaiser Family Foundation, April 2012, Table 2: Dual Eligibles and Full Dual Eligibles by State, 2008, p. 5, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7846-03.pdf>.

⁴² *Ibid.*

⁴³ *Ibid.*

⁴⁴ *Ibid.*

⁴⁵ Katherine Young, Rachel Garfield, MaryBeth Musumeci, Lisa Clemans-Cope, and Emily Lawton, "Medicaid's Role for Dual Eligible Beneficiaries," The Henry J. Kaiser Family Foundation, April 2012, Table 4a Medicaid Expenditures for Dual Eligibles by State, 2008, p. 8, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7846-03.pdf>

⁴⁶ *Ibid.*

⁴⁷ Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012," AARP, Washington, DC, 2012, p. 37; <http://www.aarp.org/home->

| | | | |
|-------------------------|-----------------------|-----------------------|------------------|
| Value in \$Million/1000 | \$1,460 ⁵⁰ | \$1,680 ⁵¹ | 6 ⁵² |
| Ratio | 3.8 ⁵³ | 3.9 ⁵⁴ | 29 ⁵⁵ |

A state’s long-term care vulnerability is higher if it has fewer “free” family caregivers or lower family caregiving value contributed toward providing LTC services.⁵⁶

New Hampshire scores roughly average on total family caregivers and on the ratio of their value. The state is high, sixth in the nation, on value of family caregiving.

Rebalancing also tends to increase overall Medicaid expenditures for long-term care, but these cost factors were captured above under “expenditure trends” above.⁵⁷

| <u>Managed care vulnerability</u> | <u>United States</u> | <u>New Hampshire</u> |
|---|-------------------------|----------------------|
| Managed care for aged, blind and disabled recipients? | Expanding ⁵⁸ | None ⁵⁹ |
| Managed care for “dual eligibles”? | Expanding ⁶⁰ | None ⁶¹ |

A state’s long-term care vulnerability is higher if it is expanding managed care to higher acuity long-term care recipients, especially the “dual eligibles.”⁶²

[garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html](http://www.aarp.org/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html).

⁴⁸ *Ibid.*, p. 217.

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*

⁵¹ *Ibid.*

⁵² *Ibid.*

⁵³ *Ibid.*

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*

⁵⁶ "Americans should expect an enormous shortage in caregivers for older people in the coming decades, with a dearth of friends and family members available to care for the baby-boom generation as it ages, according to a report released Monday by AARP." Source: Tara Bahrapour, "Huge shortage of caregivers looms for baby boomers, report says," *The Washington Post*, August 5, 2013, http://www.washingtonpost.com/national/health-science/huge-shortage-of-caregivers-looms-for-baby-boomers-report-says/2013/08/25/665fb2aa-0ab1-11e3-b87c-476db8ac34cd_story.html.

⁵⁷ For details, see Stephen A. Moses, "Briefing Paper #4: Rebalancing Long-Term Care," Center for Long-Term Care Reform, Seattle, Washington, 2011, www.centerlrc.com/BriefingPapers/4.htm.

⁵⁸ "Managed Care," Medicaid.gov, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html>.

⁵⁹ *State Health Facts*, The Henry J. Kaiser Family Foundation, "Medicaid Managed Care Enrollment," <http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/>.

⁶⁰ *Ibid.*

⁶¹ *State Health Facts*, The Henry J. Kaiser Family Foundation, "Dual Eligible Enrollment in Medicaid Managed Care, by Plan Type," <http://kff.org/medicaid/state-indicator/dual-eligible-enrollment-in-medicaid-managed-care-by-plan-type/>.

⁶² See Judith Soloman, "Moving 'Dual Eligibles' Into Mandatory Managed Care and Capping Their Federal Funding Would Risk Significant Harm to Poor Seniors and People With Disabilities," Center on Budget and Policy Priorities, Washington, DC, October 10, 2012, <http://www.cbpp.org/files/10-10->

According to cited sources, New Hampshire has not begun to move Medicaid recipients into managed care.

Assign a weight and score for New Hampshire Medicaid’s viability as a LTC payor in the Table of Long-Term Care Vulnerability.

4. How reliable is federal revenue on which Medicaid mostly depends?

| | <u>United States</u> | <u>New Hampshire</u> | |
|--|--------------------------------------|------------------------------------|------------------|
| | | <u>Number</u> | <u>Rank</u> |
| Total Medicaid spending (2009) | \$368,330,000,000 ⁶³ | \$1,328,000 ⁶⁴ | 43 ⁶⁵ |
| Five year % increase (2004-2009) | 29% ⁶⁶ | 16% ⁶⁷ | 16 ⁶⁸ |
| FY2012: Fed./State shares of Medicaid ⁶⁹ | 57% federal; 43% state | 50% /50% ⁷⁰ | |
| Dependency on “provider taxes” ⁷¹ | Every state but Alaska ⁷² | 2, at least 1 > 3.5% ⁷³ | |
| Social Security role in sustaining Medicaid (2014 infinite-horizon unfunded liability) ⁷⁴ | \$24.9 trillion ⁷⁵ | Vulnerable ⁷⁶ | |

12health.pdf and Stephen A. Moses, “Briefing Paper #5: Dual Eligibles and Long-Term Care: How to Save Medicaid LTC \$30 Billion Per Year and Pay for the ‘Doc Fix,’” Center for Long-term Care Reform, Seattle, Washington, 2011, www.centerlrc.com/BriefingPapers/5.htm.

⁶³ Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, “Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012,” AARP, Washington, DC, 2012, p. 41, <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

⁶⁴ *Ibid.*, p. 218.

⁶⁵ *Ibid.*

⁶⁶ *Ibid.*, p. 41.

⁶⁷ *Ibid.*, p. 221.

⁶⁸ *Ibid.*

⁶⁹ *State Health Facts*, The Henry J. Kaiser Family Foundation, “Federal and State Share of Medicaid Spending,” <http://kff.org/medicaid/state-indicator/federalstate-share-of-spending/>.

⁷⁰ Source provides no rank, only an alphabetical list of states.

⁷¹ To raise extra state funds in order to leverage up more federal Medicaid funds, all states but Alaska tax medical and long-term care providers. States may or may not reimburse providers for such “taxes.” Provider taxes are highly vulnerable to cuts: “Recent federal deficit reduction discussions have suggested gradually lowering the safe harbor threshold from 6.0 percent to 3.5 percent of net patient revenues. States have indicated that nearly 6 in 10 provider taxes currently in use by states are above that threshold.”

Source: The Henry J. Kaiser Family Foundation, “Quick Take: Medicaid Provider Taxes and Federal Deficit Reduction Efforts,” January 10, 2013, <http://kff.org/medicaid/fact-sheet/medicaid-provider-taxes-and-federal-deficit-reduction-efforts-2/>.

⁷² *Ibid.*

⁷³ *Ibid.* New Hampshire has two provider taxes at least one of which exceeds the 3.5% net patient revenue threshold so is vulnerable to a cut previously proposed.

⁷⁴ Although Social Security does not pay directly for long-term care, Medicaid does require LTC recipients to contribute most of their income, including Social Security benefits, to offset the cost of their care. If and

| | | |
|--|--|-------------------------------|
| Medicare role in sustaining Medicaid (2013 infinite-horizon unfunded liability) ⁷⁷ | \$43.0 trillion ⁷⁸ | Vulnerable ⁷⁹ |
| Federal debt | \$17.7 trillion ⁸⁰ (as of August 27, 2014) | Less Vulnerable ⁸¹ |

On average, nearly two-thirds of Medicaid spending comes from federal financing. Therefore, a state's long-term care vulnerability is higher if it is relatively more dependent on federal funds; otherwise, less.

New Hampshire's Medicaid expenditures grew much more slowly than the national average in the 2004-2009 review period. The state is less dependent on provider taxes than some other states, but at least one of its two taxes exceeds the 3.5% threshold deemed vulnerable to future cuts in federal matching funds. Social Security benefit reductions or decreases in Medicare LTC provider reimbursement levels would severely impact New Hampshire's ability to fund its long-term care safety net, as would any deficit-related federal revenue retrenchment. The state is marginally less vulnerable to cutbacks in federal funding because of its relatively low FMAP (50%).

when Social Security needs to cut back benefit payments by 23% as it has warned, the extra cost will fall directly on state Medicaid programs and LTC providers.

⁷⁵“Table VI.F1 shows that the OASDI open group unfunded obligation over the infinite horizon is \$24.9 trillion in present value, which is \$14.3 trillion larger than for the 75-year period.” Source: The 2014 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, p. 191, <http://www.ssa.gov/OACT/TR/2014/tr2014.pdf>.

⁷⁶ Potential cuts to Social Security benefits would not directly hurt New Hampshire's Medicaid recipients who have to contribute most of their income to offset Medicaid's cost for their care. Rather such cuts would reduce patient revenue to long-term care providers thus reducing their reimbursement and/or increasing Medicaid's expenditures, a potentially devastating result financially for providers and Medicaid.

⁷⁷ Medicare does not pay directly for long-term care as its benefits are mostly limited to short-term sub-acute care and rehabilitation. Nevertheless, Medicare does pay much more generously than Medicaid for skilled nursing care and home care. Long-term care providers depend heavily on higher Medicare reimbursements to offset their losses on Medicaid. Cuts to Medicare nursing home reimbursements which are frequently proposed by the Medicare Payment Advisory Commission (MedPAC) would be devastating to Medicaid long-term care providers.

⁷⁸ John C. Goodman and Laurence J. Kotlikoff, "Medicare by the Scary Numbers," *Wall Street Journal*, June 24, 2013, <http://online.wsj.com/article/SB10001424127887323393804578555461959256572.html>. Actually, Medicare's unfunded liability may be much worse: “Looking indefinitely into the future, the unfunded liability is \$43 trillion-almost three times the size of today's economy. Based on more plausible assumptions, such as those reflected in the ‘alternative’ scenario for Medicare produced by the Congressional Budget Office in June 2012, the long-term shortfall is more than \$100 trillion.”

⁷⁹ Reduction in or loss of Medicare's currently generous long-term care reimbursement rates would impact providers severely and immediately, possibly causing withdrawals from Medicaid participation and/or closures.

⁸⁰ U.S. National Debt Clock as of August 27, 2014, <http://www.usdebtclock.org/>.

⁸¹ New Hampshire's relatively low FMAP makes the state somewhat less vulnerable to potential loss of federal funding than other states with higher FMAPs.

Assign a weight and score in the Table of Long-Term Care Vulnerability for the reliability of federal funding to support New Hampshire’s Medicaid long-term care program.

**5. How reliable is state revenue on which Medicaid secondarily depends?
State economies must generate sufficient revenue to support LTC financing.**

Following several very difficult fiscal years since the Great Recession: “State budgets are expected to continue their trend of moderate growth in fiscal 2015 according to governors’ spending proposals. Consistent year-over-year growth has helped states achieve relative budget stability, but progress remains slow for many states. With each passing year of slow improvement, more and more states are moving beyond recession induced declines and returning to spending and revenue growth. According to executive budgets, general fund spending is projected to increase by 2.9 percent in fiscal 2015.”⁸²

Rich States, Poor States “Economic Competitiveness Index”⁸³

| | | <u>New Hampshire Rank</u> |
|--|-------------------------------|---------------------------|
| Economic Performance Rank | From Texas #1 to Michigan #50 | 34 |
| Economic Outlook Rank | From Utah #1 to New York #50 | 32 |
| <i>Forbes</i> Best States for Business and Careers ⁸⁴ | From Virginia #1 to Maine #50 | 31 |

“Fiscal Policy Report Card,”⁸⁵

| | | |
|---|---|-------------------|
| Grades state Governors from A to F on their fiscal policies | From Sam Brownback (R), Kansas, 69, A To Pat Quinn (D), Illinois, 16, F | John Lynch, 62, B |
|---|---|-------------------|

Mercatus “Freedom Index”⁸⁶

| | | |
|---|--|--------|
| Combined personal/economic rank; change from 2009 | From #1, North Dakota; +4 To #50, New York; 0 change | #4, -2 |
|---|--|--------|

| | | |
|------------------------------|--------------------------------|----------|
| Tax Foundation ⁸⁷ | U.S. Average: 9.8%; Range: #1, | 44, 8.0% |
|------------------------------|--------------------------------|----------|

⁸² Fiscal Survey of States, Spring 2014, National Association of State Budget Officers, Spring 2014, <http://www.nasbo.org/fiscal-survey-of-states-spring-2014>.

⁸³ Arthur B. Laffer, Stephen Moore, and Jonathan Williams, *Rich States, Poor States: ALEC-Laffer State Economic Competitiveness Index*, Table 1: ALEC-Laffer State Economic Outlook Rankings, 2014 and Table 2: ALEC-Laffer State Economic Performance Rankings, 2002-2012, American Legislative Exchange Council, 2014, <http://www.alec.org/publications/rich-states-poor-states/>.

⁸⁴ “The Best States for Business and Careers,” *Forbes*, September 2013, <http://www.forbes.com/best-states-for-business/>.

⁸⁵ Chris Edwards, “Fiscal Policy Report Card on America’s Governors, 2012,” Cato Institute, Washington, DC, Table 1: Overall Grades for the Governors, pps. 3-4, 2012, <http://www.cato.org/pubs/wtpapers/GRC2012.pdf>. “This report grades governors on their fiscal policies from a limited-government perspective. The governors receiving an ‘A’ are those who cut taxes and spending the most, while the governors receiving an ‘F’ raised taxes and spending the most. The grading mechanism is based on seven variables, including two spending variables, one revenue variable, and four tax rate variables.” (p. 3)

⁸⁶ Mercatus Center, “Freedom in the 50 States,” list view, <http://freedominthe50states.org/>.

State-Local Tax Burden NY, 12.6% to #50, WY, 6.9%

State Budget Shortfalls (2013)⁸⁸ 30+DC Yes Yes, 19.9%

A state's long-term care vulnerability is higher if it ranks lower on these measures of economic performance, outlook, business climate, freedom and budget.

New Hampshire ranks below average on ALEC's "economic competitive index" and *Forbes'* "Best States for Business and Careers." But the state's former governor received a good grade (B) on Cato's "Fiscal Policy Report Card." New Hampshire ranked very high on the Mercatus Freedom Index (#4) and showed a relatively low tax burden on the Tax Foundation's State-Local Tax Burden listing. New Hampshire's budget shortfall was resolved by the end of the year.

Assign a weight and score in the Table of Long-Term Care Vulnerability for the reliability of New Hampshire's economy to support its Medicaid long-term care program.

6. How much private pay is available to relieve LTC financing pressure on Medicaid?

| | <u>United States</u> | <u>New Hampshire</u> |
|---|--|---|
| Asset spend down potential ⁸⁹ | Higher if easy eligibility can become less easy. ⁹⁰ | Yes, after MOE. 209-B state ⁹¹ |
| Estate recoveries (2004 data) ⁹² | | |

⁸⁷ Tax Foundation, "State and Local Tax Burdens: All States, One Year, 1977 – 2011," "2011: State-Local Tax Burden Compared to U.S. Average Real Dollars," October 23, 2012,

<http://taxfoundation.org/article/state-and-local-tax-burdens-all-states-one-year-1977-2011>.

⁸⁸ *State Health Facts*, The Henry J. Kaiser Family Foundation, "State Budget Shortfalls, SFY2013,"

<http://kff.org/other/state-indicator/state-budget-shortfalls-sfy13/?state=NH>.

⁸⁹ "Nearly half of all Americans will outlive their assets, dying with practically no money at all. Even more worrisome, that's true even among households that met the traditional standards for secure retirement income. Economic factors and changes in employer pensions and in economic reality have made it much harder to stretch income and assets so they last, especially as people live longer." Source: Michael Hiltzik, "A crisis for the very old: They're outliving their assets," *Los Angeles Times*, July 16, 2013, <http://www.latimes.com/business/la-fi-hiltzik-20130717,0,2211926.column>.

⁹⁰ The Affordable Care Act's "maintenance of effort" (MOE) requirement prevented states from making Medicaid eligibility rules stricter than they were when the Act became law on March 23, 2010. This requirement expired for adults on January 1, 2014. Maine, Rhode Island, Wisconsin and Vermont intended to reduce eligibility this year. Source: Phil Galewitz, "Amid Health Law Expansion, Some States Trim Medicaid Rolls," *Kaiser Health News*, August 18, 2013, <http://www.kaiserhealthnews.org/Stories/2013/August/19/medicaid-cuts-in-four-states.aspx>.

⁹¹ For more details on Medicaid long-term care eligibility rules, see "Key Medicaid Information for New Hampshire for 2014," *ElderLawAnswers*, <http://www.elderlawanswers.com/key-medicaid-information-for-new-hampshire-for-2014-12209>.

⁹² U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, "Medicaid Estate Recovery Collections," Policy Brief No. 6, September 2005, p. 8, <http://aspe.hhs.gov/daltcp/Reports/estreccol.pdf>.

| | | |
|--|---|----------------------|
| Total | \$361,766,396 | \$4,362,641 |
| As a % of SNF spending | U.S. Average: .8% | |
| Range | From 5.8% (OR) ⁹³ to 0.0% (GA) | 1.6% |
| Estate recoveries (2011 data) ⁹⁴ | | |
| Total | \$497,905,382 | \$4,933,904 |
| As a % of SNF spending | U.S. Average: .95% | |
| Range | From 5.4% (ID) to 0.0% (MI) | 1.6% |
| Home equity for LTC financing | | |
| Medicaid home equity exemption ⁹⁵ | \$543,000 to \$814,000 (2014) | \$543,000 |
| Private long-term care insurance | | |
| LTCI market penetration | | |
| Private LTCI policies | 6,485,598 ⁹⁶ | 32,516 ⁹⁷ |
| Policies per 1000 population | 45 ⁹⁸ | 48 ⁹⁹ |
| LTC partnership ¹⁰⁰ | 31 states approved | Yes ¹⁰¹ |
| LTCI tax incentives ¹⁰² | 36 states and DC | No ¹⁰³ |

A state's long-term care vulnerability is higher if it (1) has and maintains relatively easy Medicaid long-term care financial eligibility standards, (2) recovers relatively less from former recipients' and their spouses' estates, (3) has a higher home equity exemption level, and (4) has less and/or does less to encourage private long-term care insurance.

⁹³ The estate recovery table gives Arizona's collections as a percent of nursing home spending as 10.4%, but footnotes it thus: "Arizona's estate recovery collections, as a percentage of nursing home spending, are not comparable to any other state because comprehensive prepaid managed care contracts dominate the state's Medicaid program, and nursing home care provided under these contracts is not identified separately for reporting purposes."

⁹⁴ This data is based on a Department of Health and Human Services Inspector General report that has not yet been made public.

⁹⁵ Medicaid had no cap on home equity until the Deficit Reduction Act of 2005 which required states to limit the home equity exemption to \$500,000 or \$750,000. As of 2013, those limits have increased to \$536,000 to \$802,000.

⁹⁶ Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012," AARP, Washington, DC, 2012, p. 37, <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

⁹⁷ *Ibid.*, p. 217.

⁹⁸ *Ibid.*

⁹⁹ *Ibid.*

¹⁰⁰ American Association for Long-Term Care Insurance, "What States Have Approved Long-Term Care Partnership Insurance For Sale?," <http://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php#approved>.

¹⁰¹ "Key Medicaid Information for New Hampshire for 2014," *ElderLawAnswers*, <http://www.elderlawanswers.com/key-medicaid-information-for-new-hampshire-for-2014-12209>.

¹⁰² David Baer and Ellen O'Brien, AARP Public Policy Institute, "Federal and State Income Tax Incentives for Private Long-Term Care Insurance," #2009-19, November 2010, Table 5: Structure of State Tax Incentives for Long-Term Care (LTC) Insurance, 2007, p. 10, <http://assets.aarp.org/rgcenter/ppi/econ-sec/2009-19-tax-incentives.pdf>.

¹⁰³ *Ibid.*, p. 9.

New Hampshire has very generous Medicaid long-term care eligibility rules, but it is a 209-B state so could be more restrictive if it so chose after expiration of the “maintenance of effort” rule. The state does a mediocre job of estate recovery and did not improve between 2004 and 2011. New Hampshire wisely set its home equity exemption at the lower \$543,000 level allowed by federal law. The state does have a long-term care insurance partnership program but does not have a state tax incentive for purchase of the product. New Hampshire has proposed a rate cap on LTCL.¹⁰⁴

Assign a weight and score in the Table of Long-Term Care Vulnerability for New Hampshire’s likelihood of generating private LTC financing to relieve the cost burden on Medicaid.

7. How strong is dependency on public programs (entitlement mentality) cradle to grave?

| | <u>United States</u> | <u>New Hampshire</u> |
|--|---------------------------|----------------------|
| Births financed by Medicaid (2010) ¹⁰⁵ | 47.8% | |
| Range: | From 69% (LA) to 24% (HI) | 29.9% ¹⁰⁶ |
| Supplemental Nutrition Assistance Program (Food Stamps), 2012 ¹⁰⁷ | | |
| Participants (ave. per month) | 47,636,090 | 117,315 |
| Percent of population ¹⁰⁸ | 14.9% | 8.9% |
| Total annual benefits (FY2013) | \$76,066,279,984 | \$162,970,800 |
| Ave. benefit per person per month: | \$133.41 | \$115.76 |
| Welfare exceeds minimum wage ¹⁰⁹ in . . . | 35 states and | \$19.11 |

¹⁰⁴ NH Insurance Department Extends Public Comment Period for Proposed Long-Term Care Rule Changes, *InsuranceNewsNet*, August 7, 2014, <http://insurancenewsnet.com/oarticle/2014/08/07/nh-insurance-department-extends-public-comment-period-for-proposed-long-term-car-a-541064.html#.UPdR010xIY>. “The suggested revisions to the current state rule governing long term care would cap premium increases at 50 percent for consumers age 50 or younger and thereafter lower the allowable percentage increase almost each year by 1 percent, so that policyholders who are 90 and older would face a maximum annual premium increase of just 2 percent.”

¹⁰⁵ Anne Rossier Markus, JD, PhD, MHS, *et al.*, “Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform,” *Women’s Health Issues*, Vol. 23, Issue 5, September 2013, Table: State-Based Medicaid Birth Estimates, [http://www.whijournal.com/article/S1049-3867\(13\)00055-8/fulltext#sec3.1](http://www.whijournal.com/article/S1049-3867(13)00055-8/fulltext#sec3.1).

¹⁰⁶ *Ibid.*

¹⁰⁷ United States Department of Agriculture, Food and Nutrition Service, Program Data, Supplemental Nutrition Assistance Program, Annual State Level Data: FY 2009-2013, <http://www.fns.usda.gov/pd/snapmain.htm>.

¹⁰⁸ United States population as of August 7, 2014: 318,892,103. Source: United States Census Bureau, “U.S. and World Population Clock, <http://www.census.gov/popclock/>. For state populations: United States Census Bureau, “State and County Quick Facts,” <http://quickfacts.census.gov/qfd/index.html>.

¹⁰⁹ “If one looks at this as an hourly wage (as shown in Table 3), it is easy to see that welfare pays more than a minimum-wage job in 33 states-in many cases, significantly more. In fact, in a dozen states and the

ranges from \$5.36/hr. in Idaho to \$29.13 in Hawaii

Rank: 9

Social Security Disability Insurance \$143.4 billion, trust fund
depleted in 2016¹¹⁰

SSDI replaces work¹¹¹

SSDI Beneficiaries, Ages 18-64¹¹² 9,306,256 49,925

Percent of population¹¹³ 2.9% 3.8%

Unfunded pension liabilities of state and local governments \$3 trillion¹¹⁴ Funding ratio: 56.2%
\$4.5 billion¹¹⁵

To fully fund would require: \$1,385 tax increase per household per year for 30 years¹¹⁶ \$1,010 tax increase per household per year for 30 years¹¹⁷

District of Columbia, welfare pays more than \$15 per hour." Source: Michael Tanner and Charles Hughes, "The Work vs. Welfare Trade-Off, 2013: An Analysis of the Total Level of Welfare Benefits by State," Cato Institute, Washington, DC, 2013, Table 3 Hourly Wage Equivalents, pps. 8-9, http://object.cato.org/sites/cato.org/files/pubs/pdf/the_work_versus_welfare_trade-off_2013_wp.pdf.

¹¹⁰ "DI Trust Fund reserves expressed as a percent of annual cost (the trust fund ratio) declined to 62 percent at the beginning of 2014, and the Trustees project trust fund depletion late in 2016, the same year projected in the last Trustees Report." Source: "A Summary of the 2014 Annual Reports: Social Security and Medicare Boards of Trustees," Social Security Administration, <http://www.ssa.gov/oact/trsum/>. See Table 2: Program Cost (in Billions) for cost figure.

¹¹¹ "The program's expenditures have doubled over the last decade, reaching an estimated \$144 billion this year. Spending has risen so rapidly that SSDI's trust fund is projected to be depleted just three years from now. . . . The result is that people capable of working are instead opting for the disability rolls when confronted with employment challenges." Source: Tad DeHaven, "The Rising Cost of Social Security Disability Insurance," Policy Analysis No. 733, Cato Institute, August 6, 2013, p. 1, http://object.cato.org/sites/cato.org/files/pubs/pdf/pa733_web.pdf.

¹¹² *State Health Facts*, The Henry J. Kaiser Family Foundation, "Total Disabled Social Security Disability Insurance (SSDI) Beneficiaries, Ages 18-64," <http://kff.org/medicare/state-indicator/total-disabled-social-security-disability-insurance-ssdi-beneficiaries-ages-18-64/>.

¹¹³ United States population as of August 7, 2014: 318,892,103. Source: United States Census Bureau, "U.S. and World Population Clock," <http://www.census.gov/popclock/>. For state populations: United States Census Bureau, "State and County Quick Facts," <http://quickfacts.census.gov/qfd/index.html>.

¹¹⁴ Jeffrey A. Miron, "State and Local Pension Liabilities," Cato Institute, July 17, 2013, <http://www.cato.org/blog/state-local-pension-liabilities>.

¹¹⁵ "Public pensions in New Hampshire," *BallotPedia*, undated, http://ballotpedia.org/Public_pensions_in_New_Hampshire. "A 2012 report from the Pew Center on the States noted that New Hampshire's pension system was funded at 59 percent at the close of fiscal year 2010, well below the 80 percent funding level experts recommend. Consequently, Pew designated the state's pension system as cause for 'serious concern.' [5] The system currently has an unfunded liability of over \$4.5 billion and a funding ratio of 56.2 percent."

¹¹⁶ "We calculate increases in contributions required to achieve full funding of state and local pension systems in the U.S. over 30 years. Without policy changes, contributions would have to increase by 2.5 times, reaching 14.1% of the total own-revenue generated by state and local governments. This represents a tax increase of \$1,385 per household per year, around half of which goes to pay down legacy liabilities while half funds the cost of new promises." Source: Robert Novy-Marx and Joshua D. Rauh, "The Revenue Demands of Public Employee Pension Promises," Working Paper 18489, National Bureau of Economic Research, October 2012, <http://www.nber.org/papers/w18489>.

¹¹⁷ *Ibid.*, Table 4--Required Increases for Full Funding by State, No Policy Change, p. 48.

after people need long-term care has crowded out private LTC financing alternatives such as home equity conversion and private long-term care insurance. Low Medicaid reimbursement has diminished care access and quality for poor and affluent alike. Medicaid consumes a larger and larger proportion of state budgets and tends to crowd out other spending priorities. Expansion of Medicaid eligibility under the Affordable Care Act (aka ObamaCare) will exacerbate all these problems.

To survive as the principal funder of long-term care, Medicaid is heavily dependent on federal (57%) and state (43%) funds. The ratio is 50/50 for New Hampshire. But the availability of sufficient federal funds in the future is dubious. Federal debt is huge and growing, nearly \$18 trillion. Infinite horizon unfunded liabilities of Social Security and Medicare are \$68 trillion. Federal Medicaid lacks even the artifice of a borrowed “trust fund” to obscure its unlimited general fund liability. Federal reserve policy has expanded the money supply tremendously and forced interest rates to near-zero creating a huge risk of higher, possibly hyper-inflation. Aging boomers have not saved enough. Low interest rates reduce their retirement incomes, making them more dependent on safety net programs that threaten to explode in cost. State funds needed to match the federal funds are also vulnerable. Each new economic bubble bursting—most recently the dot.com (2000) and housing (2008) busts—has brought worsening recessions that devastate state tax revenues. Economists worry that the latest bubble, inflated by extremely loose monetary and fiscal (spending) policy, will bring on a much worse downturn than the Great Recession.

If the Age Wave and financing pressures are too great for Medicaid to sustain long-term care financing, where can the country and states like New Hampshire turn? Unfortunately, potential private sources of LTC financing have been largely crowded out by the relatively easy access to Medicaid in the past. Medicaid income and asset eligibility rules make it easy for people with substantial wealth to qualify. Mandatory estate recovery goes largely unenforced. Medicaid’s outsized home equity exemption eliminates reverse mortgages as a major source of LTC funding. A main reason so few people purchase private LTC insurance is that for the past 49 years Americans have been able to ignore the risk and cost of LTC, wait to see if they need extended care and, if they do, qualify easily for public financing while protecting most or all of their estates. This perverse incentive has discouraged responsible LTC planning and impeded the market for private insurance products that could have relieved the financial pressure on Medicaid.

Underscoring all these practical problems is a broader socio-political malaise. Over the past eight decades more and more Americans have become dependent on government programs. Arguably, a growing entitlement mentality has substantially impaired the country’s traditional reliance on personal responsibility, self-sufficiency, independence, and freedom, the building blocks of our earlier economic success. Welfare (Medicaid) pays for nearly half of all births in the U.S., though only 30% in New Hampshire. Food stamps sustain 15% of Americans; 9% of New Hampshire residents. Welfare pays more than work in 35 states, over \$19 per hour in New Hampshire, the ninth most generous state. The nearly bankrupt Social Security Disability Income (SSDI) program has been found to crowd out work. SSDI supports 3% of Americans, nearly 4% in New Hampshire. State

and local pensions, on which many depend, are unfunded \$3 trillion nationally, \$3 billion in New Hampshire. Fully funding them would require tax increases of \$1,385 per household per year for 30 years nationally; \$1,010 in New Hampshire, which has pre-funded only 56.2% of its pension liability. Medicaid is the primary payor for 63% of nursing home residents; 64% in New Hampshire and upwards of 80% of all Medicaid nursing home residents have prepaid burial insurance funded by assets exempted from the program's resource spend down requirements. This cradle-to-grave public safety net creates a moral hazard, "a situation in which a party is more likely to take risks because the costs that could result will not be borne by the party taking the risk."¹²¹

Conclusion

From the foregoing analysis, it is hard to reach any other conclusion than to expect the current long-term care service delivery and financing system to face severe, possibly fatal challenges as the Age Wave crests and crashes on America. Absent extraordinary improvements in the national and state economies generating huge new revenues to support large and growing public programs and pensions, it is difficult to see how those programs' and pensions' promises will be met. A sensible conclusion is that long-term care scholarship should angle away from narrow, marginal reforms of specific LTC service and financing problems toward comprehensive analysis and potentially radical restructuring with much heavier reliance on private planning and individual responsibility.

The future prospects for private long-term care insurance are excellent. When economic conditions compel Medicaid and Medicare to back off from LTC financing, real asset spend down will rapidly increase; spend down of home equity to fund LTC will skyrocket; and as retirement savings and home equity are consumed to pay for long-term care, more and more people will begin to plan early and insure privately for that risk and cost. LTC insurance will become a mainstream financial planning product, losing its reputation as the "poor relative" of insurance. Demand will increase. Distribution will improve. Innovative marketing ideas, such as Paul Forte's American Long-Term Care Insurance Program will succeed. We'll see a resurgence of traditional LTC insurance products, but new products, especially equity-based hybrid plans will proliferate and grow exponentially. Good times ahead!

Appendix: Table of Long-Term Care Vulnerability

We have created an Excel worksheet to allow the user to apply weights to each of the seven categories of long-term care vulnerability and to assign scores within each of the sub-categories. In time, we hope to have such worksheets available for every state in the country, making it possible to compare states' long-term care vulnerability according to standard, objective criteria as weighted subjectively by individual users based on their own systemic knowledge, analysis, and opinion.

¹²¹ Wikipedia definition of "moral hazard," http://en.wikipedia.org/wiki/Moral_hazard.

Click <http://centerltc.com/pubs/TLTCV-Blank.xls> to open the worksheet in your web browser. You may save the resulting worksheet--reflecting your entries in each field--to your own computer without changing the original worksheet hosted on the Center for Long-Term Care Reform's website.