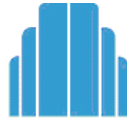


The Index of Long-Term Care Vulnerability: A Case Study in New Jersey

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January 15, 2014

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Preface

The [Common Sense Institute of New Jersey](http://www.csinj.org/) (CSINJ)¹ is a 501(c)(3) non-profit, nonpartisan research institute whose mission is “is to explore and advance public policy alternatives that foster individual liberty, personal responsibility and economic opportunity.” CSINJ contracted with the [Center for Long-Term Care Reform](http://www.centerltc.com/) (CLTCR)²-an independent, non-partisan research institute--to conduct a study of Medicaid and long-term care financing in New Jersey. Field work on this project began July 8, 2013 and concluded July 26, 2013 with a final report due September 30, 2013.

CLTCR president Stephen Moses interviewed people with knowledge and expertise related to long-term care financing in New Jersey including representatives of interest groups with stakes in long-term care service delivery and financing. These individuals are enumerated at the end of this report in the “List of Interviewees.” Each study participant will receive an electronic copy of this report. Anyone else may obtain a copy by request to info@centerltc.com or by downloading it from the Center’s website here: <http://www.centerltc.com/reports.htm>.

Additional research conducted for this study by Mr. Moses included (1) a review of federal Medicaid long-term care eligibility rules as they apply in New Jersey’s eligibility system, (2) review of New Jersey’s state-specific Medicaid eligibility rules, (3) analysis of Medicaid planning techniques used in New Jersey, (4) study of long-term care providers’ perspectives and (5) examination of private LTC financing alternatives such as estate recovery, home equity conversion and long-term care insurance.

Due to heavy workloads related to New Jersey’s implementation of (1) Medicaid expansion under the Affordable Care Act and (2) the state’s Comprehensive Medicaid Waiver, rebalancing, and managed care initiatives, state officials declined to participate in this study. For this reason, we were unable to interview key personnel identified in the study’s proposal and work plan including (1) the Medicaid Director, (2) the long-term care financial eligibility policy specialist, (3) the Medicaid lien and estate recovery program manager, (4) Medicaid long-term care financial eligibility workers and supervisors in a rural, suburban and urban local eligibility office, and (5) officials knowledgeable about New Jersey’s Comprehensive Medicaid Waiver, rebalancing and managed care projects. Consequently, findings and recommendations in this report are based on interviews with non-governmental experts, documentary research, and readily available comparable national and state-level data.

¹ The Common Sense Institute of New Jersey’s website is <http://www.csinj.org/>.

² The Center for Long-Term Care Reform’s website is www.centerltc.com.

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We want to thank everyone who agreed to be interviewed for this study. Special appreciation is due Jerry Cantrell, president of the Common Sense Institute of New Jersey, for his patient and persistent efforts to obtain the cooperation and participation of key state officials for this project.

Executive Summary

Long-term care (LTC) for the elderly is already a large risk and expense for private citizens and public programs. The need for and cost of LTC will increase radically with the aging of the baby-boom generation. Most expensive long-term care, including care provided in nursing homes or by professional aides in family homes for more than nominal durations, is paid for by Medicaid, a means-tested public assistance program.

Medicaid already strains federal and state budgets, including New Jersey's. Yet major initiatives at the federal level and in New Jersey are underway to expand Medicaid coverage in general and to make the program's LTC benefits more attractive, accessible and efficient. New Jersey's "Comprehensive Medicaid Waiver" aspires to achieve those goals by rebalancing care from mostly institutional services to mostly home and community-based services and by turning over management of long-term care for more recipients with higher acuity care needs to managed care organizations.

New Jersey faces multi-faceted long-term care problems including (1) a rapidly increasing elderly population with (2) much higher numbers of disabled or demented people coming soon and (3) Medicaid already strained as the principal LTC payer dependent on (4) funding from the heavily indebted federal government as supplemented by (5) state revenues constrained by recessionary pressures and poor future economic prospects with (6) very little private financing of LTC to relieve the budgetary pressure on public programs in the context of (7) heavy public dependency on social programs already and a growing "entitlement mentality" among the citizenry.

By focusing on improving the state's current long-term care service delivery and financing program instead of taking into account this full range of problems and addressing it, New Jersey runs the risk of modifying a broken LTC system that cannot survive the larger on-coming demographic, economic and social challenges. This report offers a way to take account of these broader challenges by applying an Index of Long-Term Care Vulnerability. It recommends that New Jersey reassess its current LTC initiatives and move in the direction of reducing dependency on public programs while attracting much more private revenue into the LTC financing mix.

National Overview

Long-term care is custodial or medical assistance needed for three months or more due to an inability to perform activities of daily living independently. LTC is expensive whether

received in a nursing home, an assisted living facility or in one's own home.³ The risk of needing some form of long-term care after age 65 is 69%.⁴ The catastrophic risk of needing five years or more is 20%.⁵ 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.

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.⁶ Contrary to conventional wisdom, Medicaid long-term care benefits are relatively easy to qualify for financially.⁷ Peer reviewed research indicates that the availability of Medicaid long-term care benefits crowds out private financing and planning.⁸ Other reliable research shows that, ironically, the rich gain as much or more from Medicaid's long-term care benefit as the poor.⁹

³ “[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.

⁴ 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/>.

⁵ *Ibid.*

⁶ 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>.

⁷ 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 \$802,000 of home equity in some states and \$536,000 in other states. Also exempt under federal rules with no limit are income producing businesses, 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>.

⁸ 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.

⁹ “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.

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.¹⁰ 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.¹¹

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 in New Jersey

Like every state in the country, New Jersey faces an onslaught of frail and infirm elders as the demographic wave of aging baby boomers advances. The Garden State begins with a disadvantage by having 10% more of the population cohort most likely to require long-term care, *i.e.*, people age 85 and older (195,000 or 2.2%, compared to only 2% nationally).¹² The rate of increase for this vulnerable population, however, is somewhat lower in New Jersey than in other states, 58% from 2012 to 2032 and 204% to 2050 (a tripling), compared to 69% and 224% nationally.¹³ Long-term care costs in New Jersey substantially exceed national averages: \$305 per day for a semi-private nursing home room compared to \$222 nationally. A private, one-bedroom apartment in assisted living costs \$4,794 per month in New Jersey versus \$3,550 nationally. Likewise, home health aides (\$22 per hour) and adult day services (\$84 per day) cost more in New Jersey than the national averages, \$21 per hour and \$70 per day, respectively.¹⁴ New Jersey's

¹⁰ 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.

¹¹ 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 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.

¹² 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. 222, <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>.

¹³ *Ibid.*

¹⁴ MetLife Mature Market Institute, "The 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs," state by state "Tables," <https://www.metlife.com/mmi/research/2012-market-survey-long-term-care-costs.html#tables>.

population age 65-plus with disabilities is slightly lower and its proportion of nursing facility residents with dementia is slightly less compared to the rest of the country.¹⁵ New Jerseyans' private long-term care insurance take up rate of 4.3% is slightly below the 4.5% national average for people age 40 and over who have the coverage.¹⁶

As in all states, Medicaid is the dominant payer for long-term care in New Jersey. Medicaid consumes nearly one-quarter, 23.3%, of the state's general fund expenditures, close to the national average of 23.7% and second only in the state budget to elementary and secondary education (24.4%).¹⁷ New Jersey's Medicaid expenditures in the period 2007 to 2010 increased at a relatively moderate annual rate of 4.7% compared to the 6.8% average for the U.S.¹⁸ In Fiscal Year 2011, New Jersey spent a considerably higher proportion of its Medicaid funds on long-term care (37.1%) versus acute care (50.9%) compared to the national average of 30.2% for LTC vs. 65.6% for acute care.¹⁹ In the same year, New Jersey spent more of its total Medicaid long-term care funds (\$3.928 billion) on nursing facilities (50.6%) than on home health and personal care (30.0%) compared to the national averages, 41.5% and 44.7%, respectively.²⁰

New Jersey has opted to expand its Medicaid program under the Patient Protection and Affordable Care Act.²¹ According to the Governor's Fiscal Year 2014 Budget Summary titled "New Jersey: Recover, Rebuild, Restore":

Governor Christie is taking action to expand health care coverage for New Jersey's most vulnerable citizens through Medicaid. New Jersey already has one of the most expansive and generous Medicaid programs in the nation Recognizing the Christie Administration's vision for bold and innovative Medicaid reform, New Jersey has received approval of its Comprehensive Medicaid Waiver. . . . New Jersey is one of very few states across the country that advanced Medicaid reform **without affecting eligibility**, imposing co-pays or cutting optional services.²²

¹⁵ Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012," AARP, Washington, DC, 2012, pps. 223, 226, <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>.

¹⁶ *Ibid.*, p. 223.

¹⁷ *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/>.

¹⁸ *State Health Facts*, The Henry J. Kaiser Family Foundation, "Average Annual Growth in Medicaid Spending," <http://kff.org/medicaid/state-indicator/growth-in-medicaid-spending/>.

¹⁹ *State Health Facts*, The Henry J. Kaiser Family Foundation, "Distribution of Medicaid Spending by Service," <http://kff.org/medicaid/state-indicator/spending-by-service/>.

²⁰ *State Health Facts*, The Henry J. Kaiser Family Foundation, "Distribution of Medicaid Spending on Long Term Care," <http://kff.org/medicaid/state-indicator/spending-on-long-term-care/>.

²¹ "Patient Protection and Affordable Care Act," *Wikipedia*, http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act

²² Chris Christie, Governor and Kim Guadagno, Lt. Governor, "The Fiscal Year 2014 Budget, New Jersey: Recover, Rebuild, Restore, Budget Summary," February 26, 2013, p. 30, <http://www.state.nj.us/treasury/omb/publications/14bib/BIB.pdf>, emphasis added.

Clearly, New Jersey is building the future of its long-term care service delivery and financing system on an expanding Medicaid program growing in numbers of recipients and expenditures. The state's Comprehensive Medicaid Waiver reforms Medicaid to rebalance care from dominantly institutional settings to home and community-based care while encompassing more of the state's most vulnerable recipients, those who are dually eligible for Medicaid and Medicare, in managed care--explicitly "without affecting eligibility." It bears consideration, which follows, whether this is a sustainable strategy for the decades ahead.

Who Qualifies for Medicaid Long-Term Care in New Jersey?

Medicaid is a means-tested public assistance program commonly referred to as "welfare." Most people assume that Medicaid covers only "low-income," financially destitute recipients who have no, or very few, remaining assets. It is not hard to understand why that belief persists. Medicaid's federal and state laws and regulations seem to say as much. But the reality is very different and extraordinarily complicated.

New Jersey has a "medically needy" system for determining income eligibility for Medicaid LTC benefits. This means that eligibility workers who receive and evaluate applications for the program deduct private medical and long-term care expenses from an applicant's income before asking whether the individual has a low enough income to qualify. Consequently, income is almost never an obstacle to eligibility for Medicaid long-term care benefits and people with relatively high incomes can qualify under the "medically needy" standard. They only need to have medical and LTC expenses high enough. In other words, one does not need to be "low income" to qualify for Medicaid's most expensive benefit. One only needs to have a cash flow problem after paying privately for such expenses each month. For example, with the average monthly cost of nursing home care exceeding \$100,000 in New Jersey, citizens of the state with incomes below that level, and potentially above it if they have other health care expenses, routinely qualify based on income for Medicaid LTC benefits.

But what about assets, the other financial eligibility criterion? You will often hear that Medicaid applicants must spend down their life's savings for private long-term care until they reach the impoverishment eligibility level of only \$2,000 remaining. Actually, it does not matter how excess countable assets are disposed of to arrive at that seemingly draconian level as long as they are not given away for less than fair market value for the purpose of qualifying for assistance. Law journal articles have recommended taking a world cruise, throwing a big party, or converting countable assets into exempt resources in order to "spend down" to the required level. When expensive long-term care becomes necessary, New Jerseyans tend to learn how this system works, especially the most savvy affluent citizens.

Furthermore, the \$2,000 limit on "countable assets" itself is nearly meaningless. Assets exempted from consideration are for all intents and purposes unlimited. When the Deficit Reduction Act of 2005 placed the first limit ever on exempt home equity offering state legislatures the choice between a \$500,000 or \$750,000, New Jersey opted for the higher

amount which has since increased with inflation to \$802,000. Moreover, most assets that are exempt for purposes of determining financial eligibility for Medicaid LTC benefits are exempt with no limit on the amount. These include an income-producing business, one automobile, prepaid burial plans, term life insurance, personal belongings, home furnishings and even Individual Retirement Accounts, assuming the IRA is generating a periodic flow of funds to the recipient which is mandatory after age 70 and a half.²³ Otherwise countable assets that might put an applicant over the \$2,000 limit are easily, and legally under Medicaid rules, converted to exempt assets by remodeling or redecorating, purchasing a more expensive home, or buying a new car, *etc.*

On top of these already generous income and asset limits, people otherwise still too affluent to qualify consult legal specialists called “Medicaid planners” to access more sophisticated techniques of artificial self-improvement. These include the use of “Medicaid-friendly annuities,” life estates, special trusts, life care contracts, promissory notes, reverse half-a-loaf strategies, and many more. An internet search for “Medicaid Planning in New Jersey” will generate many pages of advertisements for such services. Here’s one example:

A proper Medicaid Plan can protect your assets from the increasing costs of long-term care expenses or nursing home care. . . . It is key to start your Medicaid Planning early. The cost of nursing home care can exceed \$10,000 per month, and in some regions may considerably exceed that amount. How does one pay for such an expense, or even plan for such contingencies? . . . The major alternative to private pay is therefore, Medicaid. By carefully designing a thorough Medicaid plan, security can be ensured for the spouse and a legacy preserved for surviving children. . . . The rules of eligibility for Medicaid are strict. To help a person navigate these rules, an attorney with expertise and knowledge of Medicaid Planning becomes essential. . . . Our attorneys literally wrote the book on Medicaid Planning in New Jersey.²⁴

Most people do not think about long-term care until they or a loved one need it. Poor people, unaccustomed to financial advice from financial planners, CPAs or lawyers, often see their meager savings wiped out by high LTC expenses before they find their way to Medicaid. More affluent people, with better financial advice, learn early about how to qualify for Medicaid. They often ask, however, what kind of care their loved ones will receive if they become dependent on Medicaid, which has a dismal reputation for problems of access, quality, low reimbursement, discrimination, and institutional bias. Indeed, legislators and policy makers ask the same question when confronted with the reality that prosperous people routinely qualify for Medicaid. “Why would anyone deliberately plan to go on Medicaid?”, they inquire.

²³ 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>.

²⁴ Begley Law Group, “Medicaid Planning: New Jersey Medicaid Planning Attorneys,” <http://www.begleylawyer.com/practice-areas/medicaid-planning/>, cited September 23, 2013.

The answer is that Medicaid planners routinely advise their well-to-do clients to hold back “key money” so they can buy their way into the best LTC facilities. Nursing homes and assisted living facilities desperately need private payers whom they charge often half again as much as Medicaid pays for the same service. They “cost shift” in this manner in order to balance losses from their mostly Medicaid residents. They roll out the red carpet for private payers. Once a client is well-established in the nicest facility, the lawyer flips a legal switch, and converts the resident to Medicaid, thus reducing the provider’s income for the care. State and federal laws prohibit LTC facilities from expelling a resident because his or her source of payment changes. Thus, ironically, wealthier people gain access to the best care Medicaid has to offer. Unfortunately, poor people do not have “key money” so they end up in the mostly Medicaid facilities, which because of their dependency on the program’s low reimbursement levels, have earned Medicaid’s less than stellar reputation.

Rebalancing and Managed Care

New Jersey Medicaid has whole-heartedly adopted rebalancing and managed care, two major nationwide initiatives actively promoted by the federal Centers for Medicare and Medicaid Services (CMS) to improve publicly financed long-term care. Rebalancing from institutional to home and community-based services (HCBS) seeks to provide care in the most appropriate, least institutional settings preferred by recipients and to save money. Managed care endeavors to coordinate care delivery more efficiently, to integrate formerly disparate revenue sources such as Medicare and Medicaid, and to save money.

On October 2, 2012, CMS approved New Jersey’s Comprehensive Medicaid Waiver that “will transition the delivery of Medicaid-funded long-term services and supports (LTSS) from a fee-for-service model to a managed care model” and provide a “wide variety of services designed to allow beneficiaries to remain at home” with the “ability to self-direct such services.”²⁵ New Jersey’s Medicaid program is currently fully engaged in implementing these new programs. While hopes are high that the new approaches to LTC service delivery and financing will improve access, quality and desirability of Medicaid’s services, senior advocates and long-term care providers remain very concerned. For example, according to the National Seniors Citizens Law Center:

Requiring high-needs beneficiaries to enroll in programs that do not have a track record of successfully providing LTSS exposes beneficiaries to risks, especially during the transition to the new program. If the MCOs [Managed Care Organizations] offer a truly person-centered experience, beneficiaries will enroll without being forced to do so.²⁶

²⁵ National Senior Citizens Law Center, “Medicaid Managed Long-Term Services and Supports: A Review and Analysis of Recent CMS Waiver Approvals in New Jersey and New York,” Special Report, March 2013, pps. 1, 2, <http://www.nslc.org/wp-content/uploads/2013/03/MLTSS-NY-NJ-Final-030113.pdf>.

²⁶ *Ibid.*, p. 5.

The advocates also worry that transitioning currently institutionalized Medicaid recipients into home care or diverting new recipients into non-institutional settings may jeopardize quality care especially when severe spending restrictions apply:

Limiting . . . the provision of these services to cases where the cost of alternative services is less than the cost of a nursing facility ignores the many reasons other than cost for providing services in the community.²⁷

They urge:

CMS should require that states establish and fund independent advocacy entities to provide MCO enrollees with support in obtaining services, negotiating, and pursuing grievances and appeals, and to formally represent enrollees as necessary.²⁸

Nor are senior advocates the only observers concerned about New Jersey's massive and mandatory transition of Medicaid's frailest and most infirm recipients into new care settings managed by large managed care companies lacking experience with such high-needs patients. Long-term care providers, who depend on Medicaid for much of their operating revenue, are extremely worried as well.

LTC Providers' Perspective

When asked what is their profession's biggest concern, long-term care providers usually answer first "low Medicaid reimbursement combined with heavy regulation." In New Jersey, the answer was different. Unqualifiedly, interviewees representing nursing homes and assisted living facilities on both the for-profit and not-for-profit sides of the business said their biggest concern was "tremendous angst about the roll out of managed care for Medicaid recipients."

Long-term care providers worry that big managed care organizations will use their influence in the market to crowd out small providers, impair access to care in rural areas and cut quality by reducing reimbursements. Providers mobilized to mitigate these perceived dangers. They lobbied for and won a concession that in the first two years of the new program any provider willing to accept the conditions and reimbursement levels of the program could participate. But after that, what happens? Providers worry that without a data-driven system to set reimbursement rates and after the any-willing-provider protection expires, they and the people they serve will be at the mercy of huge MCOs driven to control costs by any means available.

"Our biggest unresolved problem in the entire system is one of eligibility determination," said Paul Langevin, president of the Health Care Association of New Jersey. He complained that Medicaid long-term care eligibility in the state is determined in "21 counties in 21 different ways and 21 different time frames." Residents run up huge bills

²⁷ *Ibid.*, p. 14.

²⁸ *Ibid.*, p. 20.

while their Medicaid applications are under consideration for months. If they are found to be ineligible, as often happens, the nursing facility is left without compensation. Removing such residents is not possible because of “safe transfer” rules. Other adequate venues are unavailable. How, providers ask, will big managed care organizations deal with this problem? Will they have the wherewithal or willingness to provide uncompensated care? Will home care providers? Doubtful in both cases.

Michele Kent, president and CEO, of LeadingAge New Jersey (formerly the New Jersey Association of Homes and Services for the Aging-NJAHS), opined that “I think the current trend in NJ to shift to HCBS is a good one, notwithstanding the savings the state expects. The jury is out on that.” Most people who work in the business of long-term care services are dubious of claims that providing home and community-based services instead of institutional care will save Medicaid money. When MCOs are under contract to provide such services at a constrained rate, care quality and access may suffer, although everyone hopes that will not happen. Ms. Kent thinks her members should realize that “Medicaid and Medicare are unsustainable” and that LTC providers should align themselves in a “messenger model” like an IPA (Independent Practice Association) to strengthen their position in competing with big, powerful managed care organizations.

New Jersey’s Medicaid reimbursement rate for skilled nursing facilities, although very high compared to rates paid in other states, is actually far below the cost of providing the care: \$41.83 per bed day less than allowable costs projected for 2012.²⁹ LTC providers depend on higher reimbursements from the Medicare program which is highly vulnerable to future cuts and from a dwindling supply of private payers to make up for shortfalls in Medicaid reimbursement. There is little wonder why they doubt the ability of huge MCOs and smaller home care providers to improve care *and* cut costs.

Private Long-Term Care Financing

There are four ways in which the pressure on Medicaid to finance long-term care could be relieved by additional private financing, none of which figure prominently in New Jersey.

1. **Asset spend down:** As explained above in the section on Medicaid long-term care financial eligibility, relatively easy income and asset rules, most of which are mandated by federal law and regulation, make access to Medicaid-financed long-term care attainable for most applicants without significant expenditure of private funds. The home equity exemption of \$802,000 in New Jersey (far exceeding the \$536,000 limit in most other states) is a major factor, but Medicaid planning techniques of artificial self-impoverishment also contribute substantially. Further exacerbating the problem in New Jersey is the fact that the state’s Comprehensive Medicaid Waiver “permits self-attestation that assets or resources have not been transferred for individuals who have

²⁹ “A Report on Shortfalls in Medicaid Funding for Nursing Center Care,” ELJAY, LLC for the American Health Care Association, December 2012, p. 8, http://www.ahcancal.org/research_data/funding/Documents/FINAL%20Medicaid%20Underfunding%20for%20Nursing%20Home%20Care%20Report.pdf.

income that is equal to or below 100% of the Federal Poverty Level (FPL) and are applying for institutional or Home and Community Based Services.”³⁰ People with low income but high or divested assets will be able to gain access to Medicaid benefits by unverified “self-attestation.” On the one hand, middle class and affluent people believe they should not be excluded from public LTC benefits simply because they were responsible citizens who accumulated adequate retirement income and savings. Therein lies the political sensitivity of the issue. But on the other hand, how does anyone benefit if public programs prove inadequate in the long run to fund access to quality care in appropriate venues of care for everyone, poor and rich alike?

2. Estate recovery: Arguably, if Medicaid allows people to retain substantial wealth while receiving publicly financed LTC benefits, they ought to reimburse Medicaid for the cost of their care out of their estates. Otherwise, Medicaid operates as free inheritance insurance for their heirs. That was the principle embodied in the Omnibus Budget Reconciliation Act of 1993 which made Medicaid estate recovery mandatory as a condition of receiving any federal matching funds for the program. New Jersey does have a Medicaid estate recovery program, but we were unable to ascertain its current collections and costs of recovery due to the state agency’s decision not to participate in this study. State-level data on estate recoveries has not been published by the federal government since 2005 (based on 2004 data), at which time New Jersey recovered \$8,329,882 or .6% of its Medicaid nursing home expenditures from the estates of deceased recipients, below the national average of .8%.³¹ If New Jersey had recovered at the same rate as the most effective estate recovery state, Oregon at 5.8% of nursing home expenditures, it would have collected an additional \$76,954,272 in non-tax revenue that could have offset tax-based revenue. The author recently published a report detailing collections and listing best practices in leading estate recovery states titled “Maximizing NonTax Revenues from MaineCare Estate Recoveries.”³²

3. Home equity conversion: The single biggest asset aging people possess is their homes. Two-thirds of New Jerseyans (66.6%) own their homes which have a median value of \$349,100, close to double the national average of \$186,200.³³ In the absence of Medicaid’s home equity exemption, \$802,000 in New Jersey, many more people would use their home equity to pay for long-term care before becoming dependent on Medicaid. Reverse mortgages enable people age 62 and over to extract equity from their homes while continuing to live in them. That extra money could be used to fund home and community-based services privately. But the reverse mortgage option ends where mobility, morbidity, or mortality begin. Such mortgages become due and payable when

³⁰ State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services, Medicaid Communication No. 13-02 to County Welfare Agency Directors, March 15, 2013.

³¹ 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, <http://aspe.hhs.gov/daltcp/Reports/estreccol.pdf>.

³² Stephen A. Moses, “Maximizing NonTax Revenues from MaineCare Estate Recoveries,” Center for Long-Term Care Reform,” Seattle, Washington and the Maine Heritage Policy Center, Portland, Maine, 2013, <http://www.centerltc.com/pubs/Maine2013.pdf>.

³³ United States Census Bureau, “State and County Quick Facts,” <http://quickfacts.census.gov/qfd/states/34000.html>.

the elder mortgagee becomes too ill to remain, moves out, dies or sells. Alternatively, families who want to retain the elder's home could pitch in to help pay for home care, assisted living or nursing facility care, providing in essence an informal family-based reverse mortgage. Many variations would be possible, but current public policy exempting a huge amount of home equity, more than double the median home value in New Jersey, discourage all such options from a purely financial standpoint. There are other reasons, however, to consider home equity conversion for funding long-term care. As one of our interviewees in another state said in her "elevator speech" about reverse mortgages: "If you take a reverse mortgage to pay for your long-term care instead of qualifying for Medicaid, it gives you ultimate consumer control. You get to purchase as much or as little as you need, which is very difficult to do under Medicaid. You can pay a neighbor to bring your dinner. It helps you maintain as much as you can of your dignity and independence."³⁴

4. Private long-term care insurance: Private LTC insurance market penetration in New Jersey, at 4.3% of the age 40 plus population, approaches the 4.5% national average.³⁵ The state encourages the purchase of private LTC insurance and participates in the federally promoted "LTC Partnership Program." That program incentivizes the purchase of LTC insurance by granting purchasers of partnership policies who actually use their benefits a forgiveness of Medicaid's spend down requirement equal to the amount of coverage used. For example, a beneficiary who collected \$100,000 in LTC benefits from a partnership-qualified policy would be able to qualify for New Jersey's Medicaid LTC benefits while retaining \$102,000 in otherwise countable assets instead of the usual \$2,000 limit. Interviewees representing the LTC insurance industry said New Jersey does not do enough to promote the LTC Partnership Program or to educate the public about the need to plan for long-term care costs. "The average person doesn't have a clue," they said. "People know they have to have health insurance. If they don't, there's no way out. But they don't hear horror stories about long-term care. It's not on their radar screens. Most people have no idea of the risk. They face no peer pressure to prepare." A discussion of the many factors inhibiting the market for private LTC insurance, including lower lapse and interest rates than originally expected and higher claims, is beyond the scope of this report. But it is apposite to observe that demand for private insurance protection against the risk and cost of long-term care might be greater if Medicaid LTC benefits were not so easy to obtain after the insurable event occurs.

Outlook

Given the current status and likely development of New Jersey's long-term care service delivery and financing system as described above, what are its likely prospects for sustainability in the future? How vulnerable is the system to future demographic,

³⁴ Interview August 19, 2013 with Catherine Ivy, Executive Director, National Association of Social Workers (NASW) Georgia Chapter, Atlanta, Georgia.

³⁵ 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. 223, <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>.

economic and social shocks? Following below is a proposed method to answer those questions in any state and an application of the method specifically to New Jersey.

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 altogether. They're studied in silos rather than comprehensively.³⁶ 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 in "The History of Long-Term Care Financing, or How We Got Into This Mess."³⁷

This report 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 data and state-level data in a series of state-specific papers:

1. How many older people are coming in the next few decades?
2. How sick will they be?
3. How viable is Medicaid as a long-term care payer?
4. How reliable is federal revenue on which Medicaid mostly depends?

³⁶ 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>.

³⁷ 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>.

5. How reliable is state revenue on which Medicaid secondarily depends?
6. How much private-pay revenue is available to relieve LTC financing pressure on Medicaid?
7. How strong is dependency on public programs (*i.e.*, the entitlement mentality)?

With clear answers to these questions, it should be possible to predict, or at least, estimate the outcome of current and likely long-term care service delivery and financing policies. Fortunately, we have a lot of data and analysis readily available to answer these questions.³⁸ So, we shall address them one by one. Thereafter we can array the questions and answers in a “Table of Long-Term Care Vulnerability,” apply weights and scores, and thereby estimate the national and state-by-state sustainability of existing and likely future LTC service delivery and financing systems. A blank Table of Long-Term Care Vulnerability and one filled out for New Jersey applying the author’s own weights and scores are included as embedded objects in the electronic version of this report.

1. 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.”³⁹

<u>People age 85+</u>	<u>United States</u> ⁴⁰	<u>New Jersey</u> ⁴¹
Number in 2012	6,426,000 (2.0%)	195,000 (2.2%)
2012 to 2032 increase	69%	58%
2012 to 2050 increase	224%	206%

New Jersey’s age 85+ population was only slightly larger proportionately than the national average as of 2012. It will likely increase by more than half through 2032

³⁸ Note that data included in the Table of Long-Term Care Vulnerability may not correspond exactly with data supplied earlier in this report which were based on current state-specific information. The reason for such possible discrepancies is that we have drawn on data sources for the Index of Long-Term Care Vulnerability which provide information that is consistent across all states but which may not be as current. This was necessary to make possible comparisons of long-term care vulnerability across states.

³⁹ 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>.

⁴⁰ *Ibid.*, p. 36..

⁴¹ *Ibid.*, p. 222.

and is expected to triple by 2050.⁴² Though high, these rates are less than the national averages.

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. 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> ⁴³	<u>New Jersey</u> ⁴⁴	
		<u>Percent</u>	<u>Rank</u>
a. Self-care difficulty	8.8%	8.3%	21
b. Cognitive difficulty	9.5%	8.3%	34
c. Any disability	37%	33%	42
<u>Nursing facility residents with dementia, 2010</u>	46% ⁴⁵	44%	37 ⁴⁶

New Jersey’s incidence of disabilities among people age 65 plus and the state’s proportion of nursing facility residents with dementia are all below the national averages.

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. 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 payer for high-cost long-term care in the United States, its current status and likely future viability factors vitally into the question of

⁴² *Ibid.*

⁴³ 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>.

⁴⁴ *Ibid.*, p. 223.

⁴⁵ 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. 40; <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>.

⁴⁶ *Ibid.*, p. 226.

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 Jersey</u>
Percent of budget for Medicaid ⁴⁷	23.7%	23.3%
Medicaid LTSS spending change for older people and adults with physical disabilities 2004 to 2009	+28% ⁴⁸	29%, 16th ⁴⁹
Medicaid nursing facility spending change 2004 to 2009	+12% ⁵⁰	34%, 3rd ⁵¹
Medicaid HCBS spending change for older people and adults with physical disabilities 2004 to 2009	+70% ⁵²	13%, 47th ⁵³
Medicaid HCBS change as a % of LTSS spending for older people and adults with physical disabilities 2004-2009	+9% ⁵⁴	-3%, 48th ⁵⁵
Federal Medical Assistance Percentage (FMAP)	50% (minimum) ⁵⁶	50% ⁵⁷

New Jersey spends a slightly lower percentage of its state budget on Medicaid than the national average. Nursing facility spending in the state increased dramatically in the 2004 to 2009 period at the third highest rate in the country. On the other hand, New Jersey Medicaid’s HCBS spending for older people and adults with physical disabilities increased at the 47th slowest rate in the country and actually decreased 3% as a percentage of LTSS spending on the same population. New Jersey’s Medicaid match equals the federal minimum.

⁴⁷ *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/>.

⁴⁸ 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>.

⁴⁹ *Ibid.*, p. 227.

⁵⁰ *Ibid.*

⁵¹ *Ibid.*

⁵² *Ibid.*

⁵³ *Ibid.*

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*

⁵⁶ *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/>.

⁵⁷ *Ibid.*

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.⁵⁸

<u>Other Medicaid sub-factors</u>	<u>United States</u>	<u>New Jersey</u>
Medicaid expansion under ACA?	26 yes; 22 no; 3 undecided ⁵⁹	Yes a/o 9/16/13
Medicaid LTC eligibility and Medicaid planning (Rank on range from less easy to more easy)	Easy ⁶⁰	More easy ⁶¹
Low reimbursement vulnerability (shortfall per SNF bed day)	\$22.34 ⁶²	\$41.83 ⁶³
Cost shifting: Medicaid nursing home rate as percentage of private pay rate	92.2% ⁶⁴	72.3% ⁶⁵

On ACA Medicaid expansion, New Jersey "is moving forward at this time."⁶⁶ Medicaid LTC financial eligibility is relatively easy to attain in New Jersey. The state's home equity exemption is \$802,000, the federal maximum, and Medicaid planning advice is readily available. New Jersey's Medicaid reimbursement rate

⁵⁸ 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.

⁵⁹ *State Health Facts*, The Henry J. Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision, as of September 16, 2013," <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

⁶⁰ See footnote #7 for why Medicaid LTC financial eligibility is relatively "easy."

⁶¹ See the section "Who Qualifies for Medicaid Long-Term Care in New Jersey?" for why eligibility is "more easy" in New Jersey.

⁶² "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.

⁶³ *Ibid.*, p. 8.

⁶⁴ 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.

⁶⁵ *Ibid.*, p. 225.

⁶⁶ *State Health Facts*, The Henry J. Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision, as of September 16, 2013," <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>. Cited as of September 22, 2013.

shortfall for skilled nursing facilities is nearly double the national average. It is less than three-fourths of the private-pay rate.

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.⁶⁷

<u>Dual eligibles vulnerability</u> ⁶⁸	<u>United States</u>	<u>New Jersey</u>
Dual eligibles as share of all Medicaid enrollees	15% ⁶⁹	21% ⁷⁰
Duals as share of all aged and disabled enrollees	60% ⁷¹	65% ⁷²
Dual eligibles spending as % of total Medicaid	39% ⁷³	49% ⁷⁴

New Jersey is one of only six states where duals comprise 21% or more of the Medicaid caseload. Duals are also a higher percentage of aged and disabled recipients in New Jersey compared to the U.S. as a whole. Only three other states (CT, ND and WI) spend a larger share of Medicaid expenditures on dual eligibles than new Jersey.⁷⁵

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.

⁶⁷ For details, see footnote #7 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>.

⁶⁸ 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

⁶⁹ 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>.

⁷⁰ *Ibid.*

⁷¹ *Ibid.*

⁷² *Ibid.*

⁷³ 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>

⁷⁴ *Ibid.*

⁷⁵ *Ibid.*

<u>Rebalancing vulnerability</u>	<u>United States</u>		<u>New Jersey</u>	
	<u>Number</u>	<u>Rank</u>	<u>Number</u>	<u>Rank</u>
Family Caregivers #/1000, Rank	137 ⁷⁶	25 ⁷⁷	137 ⁷⁸	28 ⁷⁹
Value in \$Million/1000, Rank	\$1,460 ⁸⁰	25 ⁸¹	\$1,520 ⁸²	25 ⁸³
Ratio, Rank	3.8 ⁸⁴	25 ⁸⁵	3.5 ⁸⁶	31 ⁸⁷

New Jersey ranks near the national average on caregiver measures.

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.⁸⁸

Rebalancing also tends to increase overall Medicaid expenditures for long-term care, but these cost factors were captured under "expenditure trends" above.⁸⁹

<u>Managed care vulnerability</u>	<u>United States</u>	<u>New Jersey</u>
Managed care for aged, blind and disabled recipients?	Expanding	Expanding
Managed care for "dual eligibles"?	Expanding	Expanding

New Jersey plans an aggressive program to expand managed care for ABD and dual eligible Medicaid recipients.

⁷⁶ 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>.

⁷⁷ *Ibid.*, national average.

⁷⁸ *Ibid.*, p. 223.

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

⁸¹ *Ibid.*, national average.

⁸² *Ibid.*, p. 223.

⁸³ *Ibid.*

⁸⁴ *Ibid.*

⁸⁵ *Ibid.*, national average,

⁸⁶ *Ibid.*, p. 223.

⁸⁷ *Ibid.*

⁸⁸ "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.

⁸⁹ 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.

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."⁹⁰

Assign a weight and score for Medicaid's viability as a LTC payer 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 Jersey</u>	
		<u>Number</u>	<u>Rank</u>
Total Medicaid spending (2009)	\$368,330M ⁹¹	\$9,928M	11
Five year % increase (2004-2009)	29% ⁹²	24%	37
Federal and state shares of Medicaid ⁹³	63.7% federal; 36.3% state	44.2%	
Dependency on "provider taxes" ⁹⁴	Every state but Alaska ⁹⁵	4 or more taxes, 1 or more over 3.5% ⁹⁶	
Social Security role in sustaining Medicaid (2013 infinite-horizon unfunded liability) ⁹⁷	\$23.1 trillion ⁹⁸	Vulnerable ⁹⁹	

⁹⁰ 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/10-10-12health.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.centerltc.com/BriefingPapers/5.htm.

⁹¹ 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. 227, <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>.

⁹² *Ibid.*

⁹³ *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/>.

⁹⁴ 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/>.

⁹⁵ *Ibid.*

⁹⁶ *Ibid.*, Figure 1 and Figure 3.

⁹⁷ 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) ¹⁰⁰	\$43.0 trillion ¹⁰¹	Vulnerable ¹⁰²
Federal debt ¹⁰³	\$16.7 trillion ¹⁰⁴	Vulnerable ¹⁰⁵

New Jersey's total Medicaid spending grew considerably less rapidly than the national average during the 2004 to 2009 period. But the state is markedly more dependent on provider taxes than most. Only 13 states and DC depend on four or more provider taxes. Social Security benefit reductions or decreases in Medicare LTC provider reimbursement levels would severely impact New Jersey's ability to fund its long-term care safety net, as would any deficit-related federal revenue retrenchment.

when Social Security needs to cut back benefit payments by 24% as it has warned, the extra cost will fall directly on state Medicaid programs and LTC providers.

⁹⁸ Laurence Kotlikoff, "[Why the Government Needs to Budget over the Infinite Horizon](http://finance.yahoo.com/blogs/the-exchange/why-government-needs-budget-over-infinite-horizon-002610882.html)," *Yahoo! Finance*, June 13, 2013, <http://finance.yahoo.com/blogs/the-exchange/why-government-needs-budget-over-infinite-horizon-002610882.html>.

⁹⁹ Potential cuts to Social Security benefits would not hurt New Jersey'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.

¹⁰⁰ 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.

¹⁰¹ 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."

¹⁰² 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.

¹⁰³ "In 2013, federal spending approached \$3.5 trillion and the deficit dropped to 'only' \$642 billion. Some are using this small improvement in the nation's fiscal situation to avoid further budget tightening. But as the figures and graphics in this report show, this is the wrong conclusion to draw. Following four years of trillion-dollar deficits, the national debt will still reach nearly \$17 trillion and exceed 100 percent of gross domestic product (GDP) at the end of the year." Source: Romina Boccia, Alison Acosta Fraser and Emily Goff, "Federal Spending by the Numbers, 2013: Government Spending Trends in Graphics, Tables, and Key Points," Special Report #140 on Budget and Spending, Heritage Foundation, Washington, DC, August 20, 2013, <http://www.heritage.org/research/reports/2013/08/federal-spending-by-the-numbers-2013>.

¹⁰⁴ U.S. National Debt Clock as of September 22, 2013, http://www.brillig.com/debt_clock/.

¹⁰⁵ While New Jersey is relatively less dependent on federal funding than most Medicaid states, its heavy use of vulnerable provider taxes is worrisome.

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.

Assign a weight and score in the Table of Long-Term Care Vulnerability for the reliability of federal funding to support 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.

Overview

"State revenues in 2013 are up 5.3 percent from this time last year, but state officials are worried the gains will dissipate in 2014 . . . State revenues in the current fiscal year got a boost from taxpayers who accelerated tax payments on their capital gains to avoid any fallout from the impending 'fiscal cliff.'"¹⁰⁶

“Five years after the 2008 financial crisis sent the U.S. economy into a tailspin, only a handful of states are charging full steam ahead.”¹⁰⁷

“The effects of the worst economic downturn since the Great Depression are forcing changes on state governments and the U.S. economy that could linger for decades.”¹⁰⁸

State Specific

<i>Rich States, Poor States</i> “Economic Competitiveness Index” ¹⁰⁹		<u>New Jersey</u>
		<u>Rank</u>
Economic Performance Rank	From Wyoming #1 to Michigan #50	45
Economic Outlook Rank	From Utah #1 to New York #50	42

¹⁰⁶ Maggie Clark, “States Pessimistic About Revenues In 2014,” *Stateline*, August 13, 2013, http://www.pewstates.org/projects/stateline/headlines/states-pessimistic-about-revenues-in-2014-85899497318?utm_campaign=2013-08-14-stateline-daily.html&utm_medium=email&utm_source=Eloqua&elq=f72a55085fe642ada6d8aaa930074ae0&elqCampaignId=146.

¹⁰⁷ Pamela M. Prah, “Five Years After Crash, States Still Picking Up Pieces,” *Stateline*, September 4, 2013, http://www.pewstates.org/projects/stateline/headlines/five-years-after-crash-states-still-picking-up-pieces-85899502301?utm_campaign=2013-09-04-Stateline-Daily.htm&utm_medium=email&utm_source=Eloqua.

¹⁰⁸ Jake Grovum, “Lasting Effects from Financial Crash Mean New Normal in States,” *Stateline*, September 5, 2013, http://www-origin.pewstates.org/projects/stateline/headlines/lasting-effects-from-financial-crash-mean-new-normal-in-states-85899502664?utm_campaign=2013-09-05-Stateline-Daily.htm&utm_medium=email&utm_source=Eloqua#sthash.kTZm0rQ7.s1AiAodc.dpuf.

¹⁰⁹ Arthur B. Laffer, Stephen Moore, and Jonathan Williams, *Rich States, Poor States: ALEC-Laffer State Economic Competitiveness Index*, Table 15: ALEC-Laffer State Economic Outlook Rankings, p. 56 and 2012 and Table 16: ALEC-Laffer State Economic Performance Rankings, 2000-2010, p. 57, American Legislative Exchange Council, 2012, http://www.alec.org/docs/RSPS_5th_Edition.pdf.

<i>Forbes</i> Best States for Business and Careers ¹¹⁰	From Utah #1 to Maine #50	36
“Fiscal Policy Report Card,” ¹¹¹ 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	Chris Christie (R), score 58, grade B
Mercatus “Freedom Index” ¹¹² Combined personal/economic rank; change from 2009	From #1, North Dakota; +4 To #50, New York; 0% change	#48, 0% change
Tax Foundation ¹¹³ State-Local Tax Burden	U.S. Average: 9.9%; Range: #1, New York, 12.8% to #50, Alaska, 7.0%	#2, 12.4%
State Budget Shortfalls (2013) ¹¹⁴	30+DC Yes	Yes, \$506M

New Jersey ranks poorly on all the measures of economic performance and outlook, although the current governor scores fairly high.

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.

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

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

United States

New Jersey

¹¹⁰ “The Best States for Business and Careers,” *Forbes*, December 2012, <http://www.forbes.com/best-states-for-business/list/>.

¹¹¹ 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)

¹¹² Mercatus Center, “Freedom in the 50 States,” list view, <http://freedominthe50states.org/>.

¹¹³ Tax Foundation, “State and Local Tax Burdens: All States, One Year, 1977 – 2010,” “Table: 2010 State-Local Tax Burden Compared to U.S. Average,” October 23, 2012, <http://taxfoundation.org/article/state-and-local-tax-burdens-all-states-one-year-1977-2010>

¹¹⁴ *State Health Facts*, The Henry J. Kaiser Family Foundation, “State Budget Shortfalls, SFY2013,” <http://kff.org/other/state-indicator/state-budget-shortfalls-sfy13/?state=NJ>.

Asset spend down potential ¹¹⁵	Higher if easy eligibility can become less easy. ¹¹⁶	Yes, after MOE ends. ¹¹⁷
Estate recoveries (2004, latest data) ¹¹⁸		
Total	Total: \$361,766,396	\$ 8,329,882
As a % of nursing home spending	U.S. Average: .8%	.6%
Range	From 5.8% (Oregon) ¹¹⁹ to 0.0% (Georgia)	
Home equity for LTC financing		
Medicaid home equity exemption ¹²⁰	From \$536,000 to \$802,000 as of 2013	\$802,000
Private long-term care insurance		
LTCI market penetration		
Private LTCI policies	6,485,598 ¹²¹	184,611 ¹²²
Policies per 1000 population	45 ¹²³	43, Rank 26
LTC partnership ¹²⁴	31 states approved	Yes

¹¹⁵ "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>.

¹¹⁶ The Affordable Care Act's "maintenance of effort" requirement currently prevents states from making Medicaid eligibility rules stricter than they were when the Act became law on March 23, 2010. This requirement is due to expire January 1, 2014. Maine, Rhode Island, Wisconsin and Vermont intend to reduce eligibility next 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>.

¹¹⁷ For example, New Jersey legislators could reduce the state's home equity exemption from the federal maximum (\$802,000) to the federal minimum (\$536,000) when the Maintenance of Effort rule no longer applies.

¹¹⁸ 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>.

¹¹⁹ 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."

¹²⁰ 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.

¹²¹ 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>.

¹²² *Ibid.*, p. 223.

¹²³ *Ibid.*

LTCI tax incentives¹²⁵

36 states and DC

Unique deduction only¹²⁶

New Jersey scores poorly to average on all of these criteria of potential relief from private LTC financing sources. Easy access to Medicaid LTC benefits after care is needed and a very large home equity exemption militate against the likelihood that New Jerseyans will save, invest or insure for long-term care or, having failed to do so, utilize their home equity to fund care privately by means of reverse mortgages or outright sales.

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.

Assign a weight and score in the Table of Long-Term Care Vulnerability for a state'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 Jersey</u>
Births financed by Medicaid (2010) ¹²⁷	47.8%	28.1%
Range:	From 69% in Louisiana to 24% in Hawaii	

Supplemental Nutrition Assistance Program (Food Stamps), 2012¹²⁸

¹²⁴ 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>.

¹²⁵ 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>.

¹²⁶ "Taxpayers can subtract medical and dental expenses (including long-term care insurance premiums) that are in excess of 2% of their New Jersey gross income. Taxpayers can claim a self-employed health insurance deduction (including long-term care insurance premiums) similar to the federal deduction." No tax credit. *Ibid.*, p. 31.

¹²⁷ 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).

Participants (ave. per month)	46,609,072	826,134
Percent of population ¹²⁹	14.8%	9.3%
Total annual benefits	\$74,619,344,626	\$1,321,101,694
Ave. benefit per person per month	\$133.41	\$133.26
Welfare exceeds minimum wage ¹³⁰ in . . . 35 states and ranges	from \$5.36/hr. in Idaho	\$20.89
	to \$29.13 in Hawaii	Rank: 6
Social Security Disability Insurance (SSDI) replaces work ¹³¹	\$144 billion, trust fund depleted in three years	
SSDI Beneficiaries, Ages 18-64 ¹³²	9,082,367	211,385
Percent of population ¹³³	2.9%	2.4%
Unfunded pension liabilities of state and local governments	\$3 trillion ¹³⁴	
To fully fund would require:	\$1,385 tax increase per household per year for 30 years ¹³⁵	\$2,000 tax increase per household per year for 30 years

¹²⁸ United States Department of Agriculture, Food and Nutrition Service, Program Data, Supplemental Nutrition Assistance Program, Annual State Level Data: FY 2008-2012, <http://www.fns.usda.gov/pd/snapmain.htm>.

¹²⁹ United States population as of September 10, 2013: 316,646,460. 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>.

¹³⁰ "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 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.

¹³¹ "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.

¹³² *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-ssdi-beneficiaries/>

¹³³ United States population as of September 10, 2013: 316,646,460. 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>.

¹³⁴ Jeffrey A. Miron, "State and Local Pension Liabilities," Cato Institute, July 17, 2013, <http://www.cato.org/blog/state-local-pension-liabilities>.

¹³⁵ "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*

		<u>Percent</u>	<u>Rank</u>
Nursing facility residents with . . . ¹³⁶			
Medicaid as primary payer,	63%	63%	21
Medicare as primary payer,	14%	18%	5
Other as primary payer	22%	19%	36
Medicaid recipients with prepaid burial plans that avoid spend down requirements	Approx. 80% ¹³⁷		Unknown

New Jersey ranks well on some of the measures of entitlement mentality and poorly on others. The proportion of births financed by Medicaid in New Jersey is substantially below the national average. Likewise, food stamp and SSDI dependency are low by comparison. On the other hand, welfare benefits exceed the minimum wage in New Jersey reaching \$20.89 per hour equivalency; the state ranks sixth highest nationally. Likewise, New Jersey's unfunded pension liabilities far exceed other states' and would require annual tax increases for 30 years 44% higher than the national average for full funding.

A state's long-term care vulnerability is higher to the extent its pension liabilities are unfunded and if its citizens are relatively more dependent on publicly funded safety net programs.

Assign a weight and score in the Table of Long-Term Care Vulnerability for a state's unfunded pension liabilities and its citizens' social welfare dependency.

Conclusion: National and New Jersey

From the foregoing analysis and the following "Table of Long-Term Care Vulnerability," 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 and public policy should angle away from narrow, marginal reforms of specific LTC service and financing programs toward comprehensive analysis and potentially radical restructuring with much heavier reliance on private planning and individual responsibility.

Demands of Public Employee Pension Promises," Working Paper 18489, National Bureau of Economic Research, October 2012, <http://www.nber.org/papers/w18489>.

¹³⁶ 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. 40, <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>.

¹³⁷ Author's estimate based on interviews with scores of Medicaid long-term care financial eligibility workers, supervisors, and state policy specialists in dozens of states.

Recommendations

1. In light of the on-coming wave of aging baby-boomers, many of whom will become frail and infirm, and recognizing that Medicaid is not a viable LTC funding source for the long term, New Jersey officials, legislators and policy makers should re-evaluate their decision to rely more and more heavily on Medicaid to fund long-term care.
2. Instead of making Medicaid long-term care more desirable by rebalancing to home and community-based care “*without affecting eligibility*,” the state should seek ways to target scarce public resources to the neediest New Jerseyans and to eliminate access to publicly funded benefits by middle-class and affluent people without their either prepaying for care or repaying from their estates.
3. To avoid “crowding out” alternative private sources of long-term care financing and in order to encourage a privately financed home and community-based services infrastructure, New Jersey should tighten Medicaid LTC eligibility criteria as much as possible under federal law as soon as the maintenance of effort restriction in the Affordable Care Act expires.
4. Especially, the state should seek waivers to enable it to eliminate or severely reduce the home equity exemption under Medicaid from its current level of \$802,000 in order to encourage the use of home equity conversion to fund home care, assisted living, and nursing home care privately.
5. New Jersey should review its lien and estate recovery program under Medicaid, study other states that operate their programs more successfully, and seek laws, regulations and judicial interpretations to maximize non-tax revenues from this source.
6. With the sovereign debt of the United States at \$17 trillion and the combined infinite-horizon unfunded liabilities of Social Security (\$23.1 T) and Medicare (\$43.0 T) being \$66.1 trillion, New Jersey should begin to wean the state off dependency on federal funds instead of reaching for more and more.
7. Gradually but persistently the state should move away from publicly funded entitlement programs like Medicaid that increase a spreading “entitlement mentality” and sap its citizens’ sense of personal responsibility.

Appendix: Table of Long-Term Care Vulnerability

The following Excel worksheet allows 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. First assign weights to each variable reflecting your judgment of its importance. The worksheet will automatically calculate the maximum number of points you may assign within that variable. Assign points for the U.S. and your state based on data sources provided in this report or based on other data consistent across the country.

Table of Long-Term Care Vulnerability generic worksheet:



TLTCV 092513.xls

For example, the author has completed the following “Table of Long-Term Care Vulnerability” for the U.S. and New Jersey. 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.

Table of Long-Term Care Vulnerability for New Jersey as completed by the author:



TLTCV 092513 New
Jersey.xls

Please consider this worksheet a “beta” version under development.

List of Interviewees

Donald W. Cash CPA, CFP, Donald W. Cash Insurance Advisors
Freehold, New Jersey

Ron Citron ChFC, CLU, Ron Citron & Associates, Verona, New Jersey

Thomas M. Dorner, Director of Reimbursement and Information Services, Health Care
Association of New Jersey, Hamilton, New Jersey

Michael Fitzpatrick, President, LTC Partnership, LLC, Morristown, New Jersey

Michael E. Fitzpatrick, Founder, The LTC Partnership, LLC, New Vernon, New Jersey

Rochelle Forster, CFP®, CDFP™, MBA, R.I.C.H. Planning Group, LLC., Woodbridge,
New Jersey

John W. Indyk, Vice President, Health Care Association of New Jersey, Hamilton, New
Jersey

Michele M. Kent, President, CEO, LeadingAge New Jersey, Princeton, New Jersey

Paul R. Langevin, President, Health Care Association of New Jersey, Hamilton, New
Jersey

Dave Saltzman, Dave Saltzman Insurance, Princeton, New Jersey

Robert W. Schwaneberg, Policy Adviser, Office of the Governor, State of New Jersey,
Trenton, New Jersey