

Improving Long-Term Care in Wisconsin

Policy Report No. 361

by Pamela Villarreal

November 2014

Over the next few years, the population of 85-year-olds in Wisconsin will grow more than 3 percent a year, faster than the U.S. average of around 2 percent. This means an increasing need for long-term care and future challenges in funding it.

Executive Summary

Medicaid, the state/federal health care program for the poor, covers a variety of health services, including long-term care (either in a nursing home facility or through at-home visits) for those whose income and asset thresholds are low enough to qualify for Medicaid. Approximately 80,000 Wisconsinites are receiving some form of long-term care, and that number is expected to grow more than 2 percent annually. In fiscal year 2014, 40 percent of state Medicaid expenditures in Wisconsin were spent on long-term care, even though only 7 percent of Medicaid enrollees were receiving long-term care services.

About 15 percent of Wisconsin residents age 65 and over are in a nursing home, compared to the national average of 13 percent. Wisconsin is facing some challenges that will result in future growth in Medicaid long-term care expenditures.

Public/Private Partnerships. Wisconsin has a public/private partnership program that encourages individuals to purchase private long-term care insurance in exchange for asset protection before qualifying for Medicaid. Wisconsin's program is the dollar-for-dollar model; for every dollar of long-term care coverage an individual purchases, that amount of assets is protected from spend-down requirements in the event the individual exhausts the coverage on his/her private long-term care policy. The amount of asset protection is also the amount the insurer pays out in long-term care benefits. But the Medicaid public/private partnership is not as effective as it could be because it focuses on preserving assets, not income.

Asset Recovery. Federal law requires that "states must recover, at a minimum, all property and assets that pass from a deceased person to his or her heirs under state probate law," except in the event it is not cost effective for the state to do so. In 2013, the Wisconsin legislature expanded the property Medicaid could recover to pay for long-term care costs. The general premise in expanding the asset recovery program was that taxpayers should



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ISBN #1-56808-243-6
www.ncpa.org/pub/st361

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not be required to pay long-term care costs simply because beneficiaries wish to pass their estate on to their heirs.

Recommendations to Reform Long-Term Care.

Following are some recommendations to further manage the increasing cost of long term care while providing services to residents who truly need them.

At the federal level, allow states to establish their own home equity limits, or none at all, for Medicaid eligibility. The current minimum and maximum home equity exemptions of \$543,000 and \$814,000 are large enough that almost anybody who is asset rich and cash poor can qualify for Medicaid. Instead, state legislatures should be allowed to establish their own, lower home equity limits, based on the median home price in the state and the distribution of assets among the residents' income quintiles.

Allow Medicaid to require and support reverse mortgages as an alternative to asset recovery. One option that could replace asset recovery after the death of the institutionalized spouse would be to require the use of reverse mortgages before Medicaid kicks in. Reverse mortgages allow homeowners age 62 or older to borrow against their home equity and receive the money in the form of a steady stream of income (annuity), a lump sum payment or a line of credit they can draw on. This income could then be used to pay for long-term care.

Phase out the public/private partnership, and replace it with a state income tax credit for the purchase of long-term care insurance. Public/private partnership program participation has been marginal at best, and more popular with higher-income households, who are least likely to qualify for long-term care through Medicaid to begin with. In order to provide a greater incentive for the purchase

of long-term care insurance across all income and wealth levels, offer a tax credit toward state income taxes that phases out with higher income levels.

Use home care in place of institutional care when possible. Through new programs under the Affordable Care Act, states can provide statewide home and community-based supports as an alternative to institutional care. The Community First Choice Option program allows states to receive an additional 6 percent in federal matching funds. Eligible recipients are those with incomes up to 150 percent of the federal poverty level or those with incomes over 150 percent of the poverty level who would otherwise be eligible for Medicaid services in their state.

Growing Needs. Wisconsin's aging population is expected to grow at a rate that is faster than the national average, meaning a growing need for long-term care. Wisconsin has not ignored this fact, and over the past few years, legislators have enacted some measures designed to reduce the cost of Medicaid long-term care. It is too early to tell whether these measures, such as expanding asset recovery, will have any effect. But provided they are effective, Wisconsin could be a model for other states to follow.

Wisconsin could further experiment with reducing long-term care costs by reforming programs that are only marginally effective (such as the public/private long-term care insurance partnership), including the home as a more countable asset toward the payment of long-term care, and expanding programs that provide more opportunities for home care.

About the Author

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Introduction

As the population ages and baby boomers enter their retirement years, state policymakers are concerned about meeting the increasing demand for and cost of long-term care. Over the next few years, the population of 85-year-olds in Wisconsin will grow more than 3 percent a year, faster than the U.S. average of around 2 percent. Wisconsin's population as a whole will grow only 0.31 percent every year (compared to the U.S. average of 0.80 percent). This means an increasing need for long-term care and future challenges in funding it. How can Wisconsin strengthen its long-term care resources?

About Medicaid Long-Term Care. Medicaid, the state/federal health care program for the poor, covers a variety of health services, including long-term care (either in a nursing home facility or through at-home visits) for those whose income and asset thresholds are low enough to qualify for Medicaid. Total Medicaid spending in Wisconsin for fiscal year 2014 is about \$7.5 billion (including federal funds). Wisconsin's share of Medicaid expenditures, approximately \$2.3 billion, is equivalent to nearly 16 percent of Wisconsin's general revenues for fiscal year 2014.¹ In fiscal year 2014, about 40 percent of state Medicaid expenditures in Wisconsin were spent on long-term care, even though only 7 percent of Medicaid enrollees were receiving long-term care services.²

Approximately 80,000 Wisconsinites are receiving some form of long-term care, and that number is expected to grow more than 2 percent annually. The federal government provides funds to states for their Medicaid

programs (including long-term care expenditures) through a matching formula known as the Federal Medicaid Assistance Percentage (FMAP). This formula is based on a state's personal income per capita compared to the U.S. average per capita income. The lower a state's per capita income, the higher the share of spending by the state will be matched by the federal government, with a minimum matching rate of 50 percent. Wisconsin's FMAP percentage is 58.27, meaning that for every dollar the state spends on Medicaid, the federal government will spend \$1.40. The FMAP formula is designed to give poorer states more federal aid; however, since higher-income states spend more, they tend to receive more in terms of dollars, even though their FMAP percentage may be lower.³

Eligibility Requirements for Medicaid Long-Term Care in Wisconsin

Medicare, the health care entitlement program for people ages 65 and over, provides limited coverage for individuals in a skilled nursing facility for up to 100 days. Home health care can be provided for up to 60 days or hospice care for up to 6 months. Beyond these time limits, the patient is responsible for additional costs. This is where private long-term care insurance, self-pay or Medicaid kicks in.

Medicaid will pay for long-term care for an unlimited time for residents who are financially unable to do so, but they must meet certain eligibility requirements.⁴

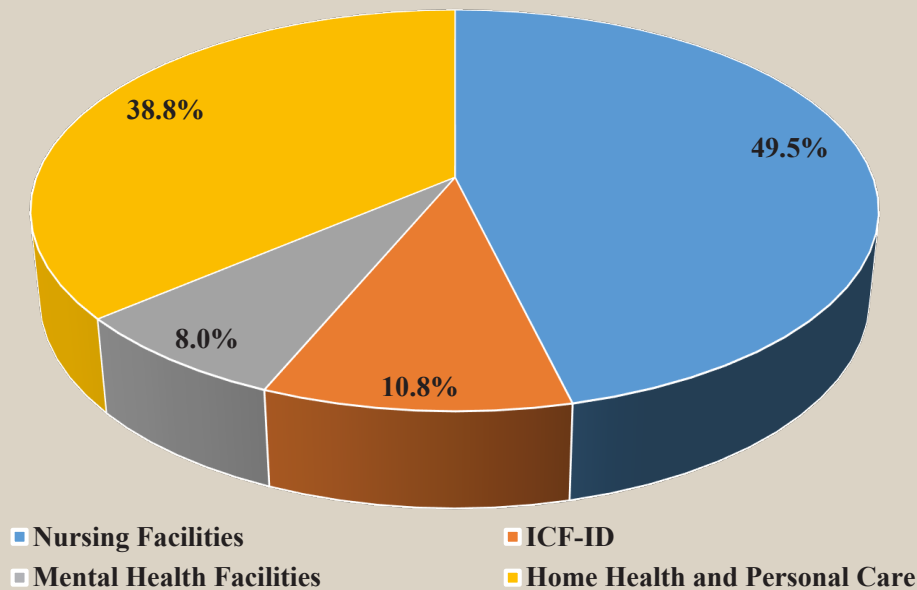
Single applicants. The cost of care must surpass the applicant's net

income (defined as modified adjusted gross income). Single applicants must have \$2,000 or less in countable assets. Assets that are exempt from countable assets include up to \$2,000 in cash, a reasonable value of personal property and furnishings, wedding rings, a car, life insurance with a death benefit of \$1,500 or less, property used in a trade or business and assets in a special needs trust. Additionally, a single applicant's home is exempt from the asset test up to a value of \$814,000.

Married applicants and their spouses. Eligibility for married applicants is somewhat different. The assets of both spouses are countable, regardless of which spouse is the named owner. The institutionalized spouse must have \$2,000 or less in countable assets. The community (at-home) spouse is permitted to keep half of the couple's assets, known as a Community Spouse Resource Allowance (CRSA), of no less than \$50,000 and up to a maximum of \$117,240 in assets. Additionally, the community spouse is allowed a monthly maintenance needs allowance (MMNA) of at least \$2,585, up to a maximum of \$2,931. If the community spouse does not have enough of his or her own income (that is, Social Security benefits, pension, and so on) to meet the \$2,585 monthly income minimum, the institutionalized spouse can transfer enough of his/her income to the community spouse to meet the monthly minimum. Only after this point is the eligibility of the institutionalized spouse determined. This is known as the "income first" rule, which is used by Wisconsin and the majority of states.⁵ If both spouses enter a nursing home, the income and asset limits for single

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**Figure I
Distribution of Wisconsin Medicaid Spending
FY2012**



Source: "Distribution of Medicaid Spending on Long Term Care, FY2012" Kaiser Family Foundation. Available at <http://kff.org/medicaid/state-indicator/spending-on-long-term-care/#>.

individuals would apply.

For married couples, the home is exempt from the asset test as long as the spouse lives there. The equity interest of the home for the institutionalized spouse is half of the equity value of the home. If a married couple lives in the home, and has a home equity value of, say, \$1,000,000, each spouse's equity interest is only \$500,000, so the home will still fall under the \$814,000 equity exemption. This rule also applies to unmarried couples living in the home.

Eligibility Differences for Home Care. The federal government allows states to use federal Medicaid funds for home care. These Home and Community Based Service (HCBS) waivers mean that states are permitted to "waive" certain requirements that

apply to other Medicaid services; namely, that the service must be available in all counties and that it must be available to all Medicaid enrollees. Wisconsin has several types of assistance available through the use of HCBS waivers for seniors who are able to receive at-home care:⁶

Community Options Program Waivers (COP-W) and Community Integration Program Waivers (CIP-II) provide financial assistance for home care, as well as assistance for adult day care and home modifications, respite care for caregivers and services such as home-delivered meals and transportation. Applicants must demonstrate they have difficulty in performing daily tasks, such as bathing and dressing, but that home care would not be more expensive than a nursing home.⁷

The financial limits for eligibility are generally the same as the financial limits for a single person applying for financial assistance in a nursing home: Countable assets cannot exceed \$2,000, monthly income cannot exceed \$2,163, and the home is generally exempt.⁸

These programs must be approved through the CMS by obtaining a 1915(c) waiver. About 35,000 people in the state who are aged and disabled are receiving home care through a 1915(c) waiver program.⁹ Furthermore, the programs are not available in all counties and funds are limited. These programs are referred to as "sum certain" programs, meaning that once allocated funds are spent for the fiscal year, individuals may be put on waiting lists.¹⁰

Wisconsin Family Care and IRIS are home care programs based on "cash and counseling," where family members or home care agency workers receive payments for caregiving services. The Family Care program is a managed care benefit, where the recipient becomes part of a Managed Care Organization (MCO) and receives long-term care and health care services tailored to his or her needs.

The IRIS program is completely self-directed in that the recipient purchases services within a budget amount. In this arrangement, the patient "employs" caregivers, who may be family members, friends or an employee of a home care agency.

Until recently, Family Care and IRIS were available in only 57 of 72 counties, but were expanded to seven additional counties in April 2014. Eligibility requirements are the same as they are under the COP-W and CIP-II programs.¹¹

Spending Down to Attain Eligibility. Analyzing data from Medicare and the 1996 to 2008 Health and Retirement Study, authors at the Research Triangle Institute (RTI) found that, nationally, about 10 percent of the non-Medicaid population age 50 and over spent down their assets to become eligible for Medicaid:¹²

- However, about 46 percent of those who spent down did not use any long-term care services or supports.
- Of the remaining, 7 percent used personal home care, 33 percent used only nursing home care and over 13 percent used a combination of both.

It is often assumed that middle-class earners are most likely to spend down in order to become eligible for Medicaid, but RTI researchers found:

- Those with total wealth (excluding Individual Retirement Accounts) in the bottom quarter of the population at the beginning of the study period were most likely to spend down to become eligible for Medicaid services, in both the under- and over-65 age cohorts.
- Some 65 percent of individuals under age 65 who spent down to become eligible were in the bottom quarter (with total wealth of less than \$38,900 minus IRAs) while 49 percent of those age 65 and over were in the bottom quarter.
- Only 24 percent of spend-down individuals under the age of 65 were in the second-lowest quarter (with total wealth ranging from \$38,900 to \$111,999), while nearly 32

percent of those age 65 and over were in the second quarter.

In general, over the 10-year period studied, almost 10 percent of the non-Medicaid population age 50 and over spent down to Medicaid eligibility. But only 54 percent went on to use Medicaid long-term care. Of those who utilized some form of long-term care through Medicaid, one-fifth of them used personal at-home care at some point during their eligibility.¹³

Wisconsin’s Long-Term Care Expenditures: Past, Present and Future Growth

An analysis of spending by the Kaiser Family Foundation found that in 2012, out of \$7 billion in state and federal Medicaid spending in Wisconsin, \$1.8 billion went to long-term care [see Figures I and II]:¹⁴

- Nearly half (49.5 percent) was spent on nonpsychiatric institutionalized care, a higher share than the national average of 41 percent.
- Another 39 percent was spent on home health care, compared to the national average of 45 percent.
- The remainder (nearly 19 percent) was spent on mental health institutions and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-ID), also known as “group homes.” This is a much larger share than the national average of 13 percent.

Wisconsin’s distribution of Medicaid long-term care is weighted more toward institutionalized care than group home or individualized home care. In fact, 15.4 percent of

Wisconsin residents age 65 and over are in a nursing home, compared to the national average of 13 percent.¹⁵ This may result in a more costly system than need be. Regardless of whether patients choose a nursing home or home care, Wisconsin is facing some challenges that will result in future growth in Medicaid long-term care expenditures.

Changing demographics.

According to Census data, from 2015 to 2030 Wisconsin’s population of 85-year-olds is projected to grow at less than 1 percent a year compared to the U.S. average of 1.31 percent.¹⁶ However, their population of 85-year-olds is to grow at more than 3 percent a year, faster than the U.S. average of 2 percent. The state’s population as a whole will grow only 0.31 percent every year compared to the U.S. average of 0.80 percent. Thus a larger share of Wisconsin’s population will be uber-elderly, crowding out younger residents who are best able to care for them. [See Figure III.]

Growing Use of Facilities.

According to the Centers for Medicare and Medicaid Services:¹⁷

- 3.2 percent of Wisconsin residents age 65 and over are in a nursing home.
- 12.2 percent of residents age 85 and over are in a nursing home.

Based on Wisconsin’s projected population growth, mortality rate for 85+ year-olds and the share of Wisconsinites currently in a nursing home, an additional 5,000 residents could be in need of long-term institutional care by 2030.¹⁸

Cost of Institutional Care versus Home Care. A handful of studies have found that home care is less expensive than institutional care. While this may seem obvious, there has long been

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concern regarding a “woodwork” effect — that those who rely on volunteers to help with care would be encouraged to sign up for paid home care services. But the few studies comparing the costs of home care to institutional care have found this is not the case. A 2002 study from the University of California-Berkeley found that the use of HCBS waivers for the aged in a home care setting produced a cost savings of more than \$15,000 per participant for that year, compared to a nursing facility.¹⁹

A study from the University of California – San Francisco analyzed state spending on Medicaid institutional and noninstitutional care from 1995 to 2005. They found:²⁰

- States with very limited home and community-based services that expanded their programs from 1995 to 2005 experienced a 3.4 increase in institutionalized care expenses, but their total long-term care expenses increased nearly 9 percent.
- However, states with well-established home and community-based services that expanded their programs from 1995 to 2005 experienced a 16.3 percent reduction in institutionalized care expenses and a 7.9 percent reduction in total long-term care expenses.

In Wisconsin, individual home care is also generally less expensive than institutional care.²¹

- Among Wisconsin nursing homes, the median annual cost of a semi-private room is \$87,363; for a private room, the cost is \$97,465.
- In contrast, the median cost of a one-bedroom unit in an assisted living facility is \$46,200,

although assisted living facilities provide fewer services than nursing homes.

- The median annual cost of a home health aide in Wisconsin is \$50,336; the median annual cost of homemaking services (a person who comes to the home and cooks, cleans and runs errands) is \$46,904.²²

The home care and home health aide estimates are based on 44-hours per week, but often home care recipients need only part-time assistance, thus this cost estimate is closer to an upper limit.

The estimates above represent the state as a whole. When comparing costs by geographic area in Wisconsin, they vary widely:²³

- The median hourly rate for a home health aide ranges from \$19 in Sheboygan to \$27 in Madison; the U.S. median is \$20.
- For homemakers, the median hourly rate ranges from \$16 in Green Bay to \$27 in Madison; the U.S. median is \$19.
- The median daily rate in a private room in a nursing home ranges from \$233 in Eau Claire (\$84,863 annually) to \$305 in Milwaukee (\$111,325 annually); the U.S. median is \$240 a day (\$87,600 annually).

According to the Bureau of Labor Statistics, private nursing home and residential (group home) facilities in Wisconsin pay employees an average weekly wage of \$453, below the U.S. average of \$546.²⁴ This average is general, since it includes both skilled nursing (registered nurses, licensed vocational nurses) and workers who do not fall into that category (such as certified nursing assistants, cooks,

custodians, and so forth). Some may argue that the wage is too low, but the state’s cost of living is slightly lower than the U.S. average.²⁵

Those employed by Wisconsin’s state and local governments earn far more — weekly averages of \$815 and \$584, respectively [see Figure IV]. For skilled nursing alone, average weekly wages are \$80 higher in the local government sector than the private sector.²⁶ But there are fewer nurses directly employed by the state or local governments, since such institutions are primarily correctional facilities and mental health institutions.

Potential Labor Cost Increases.

Until this year, federal regulations exempted home health care workers from minimum wage and overtime pay, but the U.S. Department of Labor issued new rules, taking effect in January 2015, requiring home care workers to be paid the federal minimum wage of \$7.25 an hour plus time-and-a-half in overtime pay for anyone working more than 40 hours per week.²⁷ Wisconsin and 20 other states already require minimum wage and overtime pay for home care workers employed by an agency. But prior to the changes made by the Department of Labor, those employed directly by a private household were exempt from overtime pay and those working less than 15 hours a week in a private household were exempt from minimum wage requirements.²⁸

In 2009, Wisconsin Governor Jim Doyle (D) included a provision in the biennial budget which would require home care workers funded through Medicaid to be represented by a union, essentially treating them as “public employees” since they received public funding.²⁹ As a result,

5,200 home care workers paid dues and had their salaries negotiated by the Service Employees International Union. This could explain the exceptionally high cost for home care services and the above-average pay for state and local home care workers.

However, in 2011 current Governor Scott Walker (R) signed into law Act 10, which limited collective bargaining for public employees to base wages only. Furthermore, unions would be required to take annual votes in order to maintain their certification, and employees could not be forced to pay union dues. While the Act was subject to legal challenges, the Wisconsin Supreme Court found it to be constitutional.³⁰

In a similar case, the United States Supreme Court ruled in *Harris vs. Quinn* that home care employees in Illinois who were funded by Medicaid but working for individual patients in their homes could not be forced to join a union or pay union dues.³¹

Public/Private Partnership Programs

Currently, 33 states have a public/private partnership program that encourages individuals to purchase private long-term care insurance in exchange for asset protection before qualifying for Medicaid. There are different types of long-term care partnership programs. Wisconsin’s program is the dollar-for-dollar model; for every dollar of long-term care coverage an individual purchases, that amount of assets is protected from spend down requirements in the event the individual exhausts the coverage

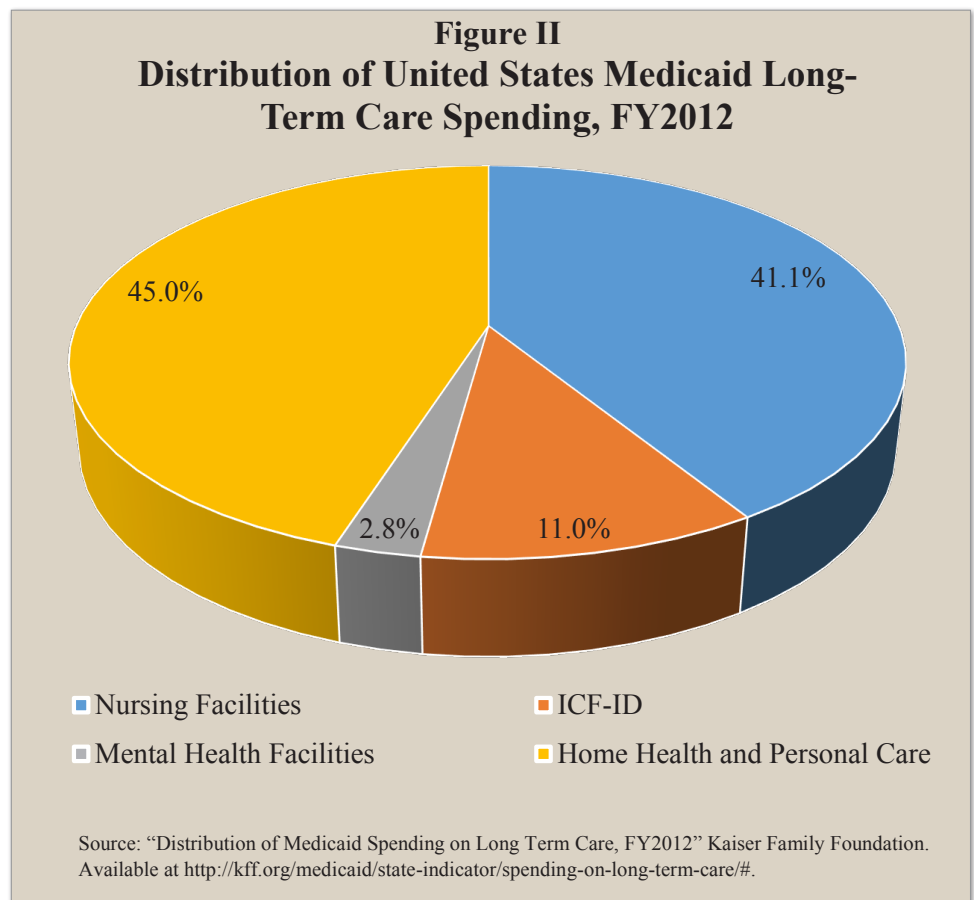
on his/her private long-term care policy.³² The amount of asset protection is also the amount that the insurer pays out in long-term care benefits. After the private benefits are exhausted, Medicaid begins paying for long-term care, provided the policyholder pays any of his/her income toward the cost of care under the state’s Medicaid income eligibility rules.³³ Furthermore, policies that qualify for Wisconsin’s partnership program must provide inflation coverage for those under age 76.³⁴

Types of Long-term Care Insurance Policies. Long-term care insurance provides a specified dollar amount of coverage per day spent in a nursing home, ranging from \$50 to \$250 per day, depending on how much coverage an individual purchases. Long-term care insurance

can cover home care or assisted living, but it is important not to assume that it does. Many policies purchased before 1980 do not cover assisted living facilities because they were not prevalent at the time.³⁵

Long-term care policies vary widely on what they offer, such as inflation protection, a waiting period before coverage begins, a length of time that coverage is provided and daily and monthly cover limits. Of course, the greater coverage for a greater length of time, the more expensive the premiums. However, in some cases, premiums are tax-deductible as part of an individual’s health care costs.

- Premiums on policies purchased prior to 1997 are tax-deductible, up to a certain amount (based on age).



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- Premiums on policies purchased after 1979 are tax-deductible only if the purchaser's out-of-pocket medical expenses exceed 10 percent of his or her income (7.5 percent for people age 65 and older).

How Effective are Public/Private Partnerships? Public/private partnerships for long-term care were designed to reduce costs for Medicaid by sharing the risk with private insurers. In the limited time that such arrangements have been available, however, there has been little evidence that these partnerships have reduced beneficiaries' dependency on Medicaid and lowered costs.

One of the issues is the structure of Medicaid as the secondary payer of long-term care. If an individual

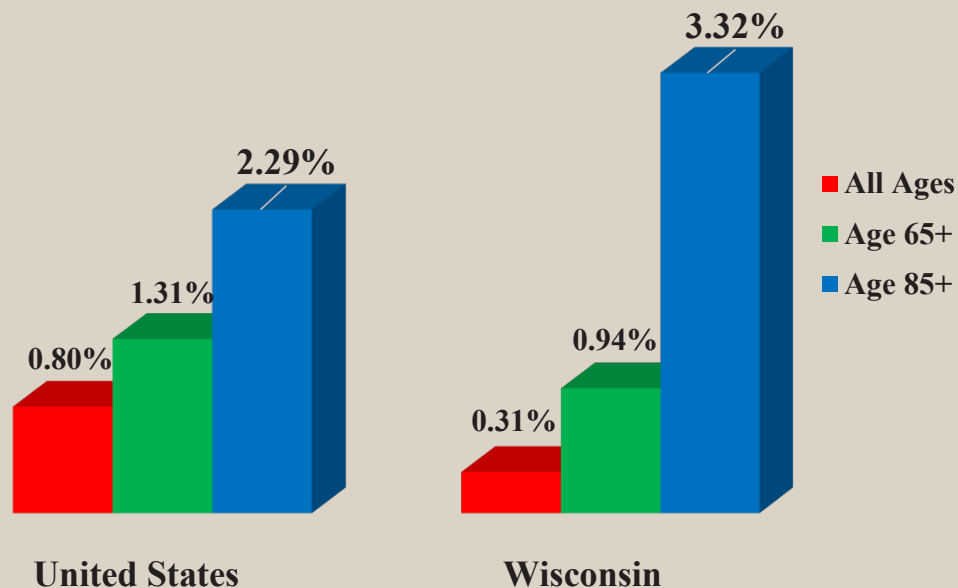
purchases a long-term care policy, benefits paid by that policy are, for the most part, redundant to what Medicaid would pay without a long-term care policy. For most people, the private policy is simply not worth the cost when they know they will probably qualify for Medicaid, an effect known as crowd-out. In fact, health policy researchers Jeffrey Brown and Amy Finkelstein measured the crowd-out effect in a 2004 study by determining the "implicit tax" for individuals of different income levels purchasing long-term care insurance.³⁶ The implicit tax was defined as the "percentage of expected present discounted value (EPDV) benefits that are redundant of benefits that Medicaid would otherwise have paid."³⁷ They found:

- For the bottom 10 percent of income earners, the implicit tax of a private insurance policy is nearly 100 percent for both men and women, meaning that those individuals would receive nothing from a private policy in terms of net benefits.
- For median income earners at the 50th percentile, the implicit tax is about 60 percent for men and 77 percent for women. (It is higher for women because they will be more likely to need long-term care and end up on Medicaid, with or without private insurance.)
- For the top 10 percent of income earners, the implicit tax on a private policy is 3.6 percent for men and 5.4 percent for women, since people of this income level will unlikely ever qualify for Medicaid.

Participation. Despite the fact that an estimated 70 percent of Americans aged 65 and over will need long-term care at some point, only about 10 percent of Americans have private LTC insurance. Haizhen Lin and Jeffrey Prince of Indiana University measured the overall impact of the program on the purchase of private LTC insurance and the likely impact of the program on Medicaid spending in the four states examined (California, Connecticut, Indiana and New York). They found:³⁸

- The PLTC program had a rather modest impact (less than a 1 percent increase) on the purchase of private LTC insurance overall.
- However, individuals in the top 20 percent were most

Figure III
Average Annual
Population Growth, 2015-2030



Source: Author's calculations based on U.S. Census, "Interim Projections of the Total Population for the United States and States: April 1, 2000 to July, 2030."

likely to purchase long-term care insurance in the presence of a partnership program, by 3 percentage points.

- The program’s target demographic, the middle class (those in the 50th to 80th percentile in assets), did not purchase more private LTC insurance, suggesting the effect of Medicaid crowd-out.

Researchers also discovered a subset within the top 20 percent: Those who worked in finance or those who used the Internet as their primary source of information were most likely to purchase LTC insurance, indicating that these individuals perhaps were more aware of insurance products and the existence of the partnership program in their state.³⁹

All in all, the study found that the PLTC programs had little effect on those who would most need to purchase LTC insurance to avoid going on Medicaid.

Costs. Do PLTC partnerships reduce Medicaid expenditures? Lin and Prince analyzed three scenarios: those without private long-term care insurance, those with long-term care insurance in the absence of a partnership plan and those who have PLTC-qualified insurance policies. They found:

- For individuals who are in the lower 40th percentile in terms of assets, there was no significant increase in Medicaid’s share of expenditures between a LTC plan they purchased on their own and a PLTC plan. This is because these individuals have so few assets that they would be eligible for Medicaid after

a low level of long-term care expenses, regardless of whether they had protected assets or not.

- However, for those in the 60th percentile and above, the share of Medicaid’s expenditures increased if they went from a LTC plan to a PLTC plan, due to the increased asset exemption provided by the partnership plan.

Using estimates from the work of Brown and Finkelstein, Lin and Prince found that for a male under the median level (50th percentile) of assets, there is no increase in Medicaid expenditures between those with an LTC plan and those with a PLTC plan.⁴⁰ For those at and above the 50th percentile, however, the net costs (the difference between the LTC and PLTC plans) increased by a range of about \$8 to \$49 for males. For females in the same percentile, the net cost was much greater, ranging from about \$41 to nearly \$300 per person.

Brown and Finkelstein concluded that in order for Medicaid to save money, households in the 50th percentile and below would need to increase their enrollment in long-term care insurance policies by about 1 percent to 2 percent.⁴¹

Medicaid Estate Recovery

Federal law requires that “states must recover, at a minimum, all property and assets that pass from a deceased person to his or her heirs under state probate law,” except in the event it is not cost effective for the state to do so.⁴² As with many states, Wisconsin has had a poor track record of doing so, recovering less than 1 percent of its long-term care expenditures.⁴³

In June 2013, the Wisconsin budget committee proposed legislation to expand the property Medicaid could recover to pay long-term care costs. While there was some concern about the new law’s impact on the elderly, the general premise in expanding the asset recovery program was that taxpayers should not be required to pay long-term care costs simply because beneficiaries wish to pass their estate on to their heirs. The new rules were eventually scaled back over concerns about leaving surviving spouses impoverished. However, as of August 1, 2014, some of the expansions remain and now include:

- Joint tenancy property — previously, property held in joint tenancy could not be recovered for Medicaid payments, since it passes outside of probate. However, repayments can be made from property owned jointly by the beneficiary and others, such as the surviving spouse.
- Life insurance policies — repayment can also be made through Medicaid recipients’ life insurance policies created on or after August 1, 2014, regardless of who is the beneficiary.
- Revocable trusts (which, unlike irrevocable trusts, can be changed at any time and are considered assets for creditor purposes) created on or after August 1, 2014, are now subject to Medicaid estate recovery after the beneficiary has passed away. A lien can be filed on homes placed in a revocable trust regardless of when the trust was created.
- Marital property — repayment can be made from 50 percent

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of the property acquired during a beneficiary's marriage. Transferring all property to the name of the surviving spouse does not exempt it from estate recovery.

It is too soon to tell what effect these new estate recovery rules will have on the repayment rate of Medicaid expenditures to the state, but it will largely depend on the priority placed on asset recovery by state Medicaid administrators and the cost of doing so.

Considerations for Reducing Future Long-term Care Costs

The primary reason that the Medicaid public/private partnership is not as effective as it could be is that the focus is on preserving assets, not income. This is not an indictment of the insurance product itself; however, households that the program is targeting are more concerned with preserving income, not assets. Thus, solutions that would help middle-income households preserve monthly income could be more promising. Following are some recommendations to do so.

At the federal level, allow states to establish their own home equity limits, or none at all, for Medicaid eligibility. The current minimum and maximum home equity exemptions of \$543,000 and \$814,000 are large enough that almost anybody who is asset rich and cash poor can qualify for Medicaid. While such an exemption may be necessary for high-cost states such as California, this is probably not much so for Wisconsin, where the median home value is \$157,000. Instead state legislatures

should be allowed to establish their own, lower home equity limits, based on the median home price in the state and the distribution of assets among the residents' income quintiles.

Allow Medicaid to require and support reverse mortgages as an alternative to asset recovery. Because of asset recovery laws, the full value of the home is not protected once the Medicaid beneficiary, the spouse and any dependents or adult disabled children who live in the home die. Since asset recovery can begin while the surviving spouse is still in the home, the program often conjures up scare stories of the elderly being kicked out of their homes due to Medicaid placing liens on them. This is not allowed by law and certainly far from the truth, but it makes for good political theater because people perceive it to be so.

A better option for asset recovery could begin before a patient even begins to receive Medicaid benefits for long-term care, through the process of reverse mortgages. Reverse mortgages allow homeowners age 62 or older to borrow against their home equity and receive the money in the form of a steady stream of income (annuity), a lump sum payment or a line of credit they can draw on. This income could then be used to pay for long-term care.

Currently, seniors rarely use reverse mortgages for long-term care. Why should they? Home equity is generally an exempt asset when qualifying for Medicaid long-term care, and the income from a reverse mortgage is usually exempt provided it is spent in the month it is received. It is only when the reverse mortgage is received in a lump-sum payment

(which is considered an asset) that it could disqualify an individual for eligibility.

But there are ways to make reverse mortgages a more affordable option for long-term care by providing incentives for their use. Eligible Medicaid recipients who do not wish to spend down to the monthly maintenance needs allowance of \$2,585 could be given the option of paying for long-term care with a reverse mortgage supported by Medicaid.

Reverse mortgages differ from home equity loans in that repayment of the loan is not due until the loan recipients die or move out of the home. As long as the borrowers continue to live in the home, they can receive payments until death. Once the borrowers die, however, the loan must be paid back either through the sale of the home or with other funds from the borrower's estate. If the loan amount exceeds the value of the home when the loan comes due, the house becomes the property of the lender.

What would be the role of Medicaid? First, federal law should allow monthly income from reverse mortgages to be considered as countable income. In exchange for an individual using the reverse mortgage to pay for long-term care, Medicaid would pay the origination fee (although the interest, property taxes, hazard insurance and PMI would be the responsibility of the borrower). The Federal Housing Authority requires origination fees to be capped at \$6,000, so Medicaid would have a clear picture of the cost of this process per beneficiary.

How Much Money Can a Reverse

Mortgage Provide? The amount that a borrower can obtain through a reverse mortgage is based on two main criteria: the amount of equity in the borrower's home and the borrowers' age. Thus:

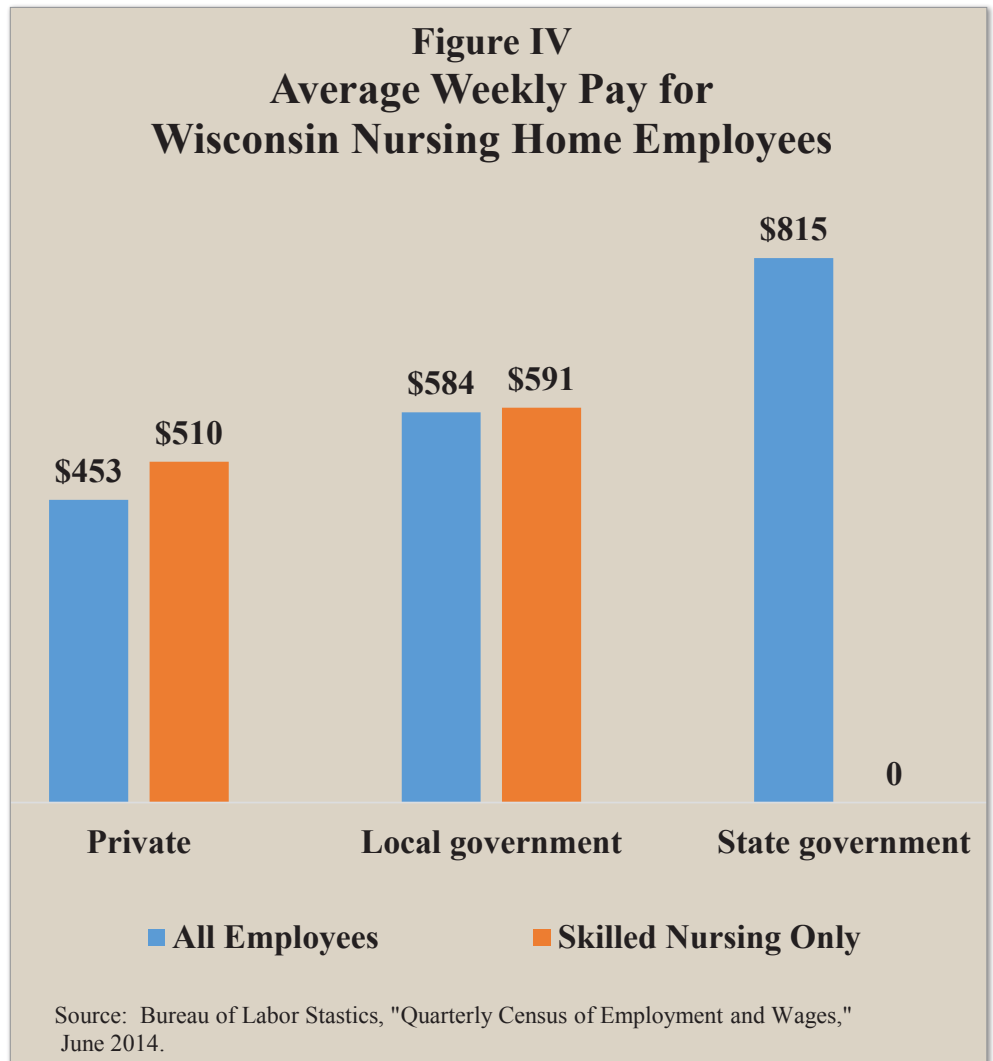
- A single individual must be at least 62 years old in order to apply for a reverse mortgage; for a married couple, both spouses must be 62 years of age.
- The older the borrower, the more home equity he can access. For instance, a 62-year old borrower may only receive about 40 percent of his home's equity, whereas a 72-year old borrower could access about 60 percent of home equity.

As of August 2014, the median price of a Wisconsin home was \$157,000.⁴⁴ Assuming the home is free and clear, the homeowner could tap 60 percent of the equity, or \$94,200,⁴⁵ which would likely cover at least a year in a full-service nursing home minus interest and fees from the reverse mortgage. Only when the reverse mortgage payments end would Medicaid resume payments. Payments from the reverse mortgage would be large enough to cover the monthly billing charge from the long-term care institution of choice.

Eligibility. A reverse mortgage program would apply only to individuals who otherwise meet asset tests for eligibility, either single or married, as discussed previously under "Eligibility Requirements for Medicaid." Thus, such a program would not allow Medicaid to fund reverse mortgages for those would not be asset-eligible in the first place.

If the cost of Medicaid financing a reverse mortgage is less than the costs

Figure IV
Average Weekly Pay for Wisconsin Nursing Home Employees



involved in asset recovery for the home after the beneficiary has passed away, a reverse mortgage program could save money in paying for care for those who are middle-income and would be politically more palatable than asset recovery after death.

Of course, the above recommendations would require application to and approval from Centers for Medicare and Medicaid Services through a waiver. States can apply for three different types of waivers that allow them flexibility in trying different approaches, for five years, to improve quality and reduce costs in the Medicaid program. In

fact, the Family Care and Community Options programs in Wisconsin were made possible by 1915 waivers.⁴⁶

Phase out the public/private partnership, and replace it with a state income tax credit for the purchase of long-term care insurance. The public/private partnership program participation has been marginal at best, and more popular with higher-income households, who are least likely to qualify for long-term care through Medicaid to begin with. In order to provide a greater incentive for the purchase of long-term care insurance across all income and wealth levels,

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offer a tax credit toward state income taxes that phases out with higher income levels. The credit could be refundable to a certain extent for those who do not have a state income tax liability.

Use home care in place of institutional care when possible.

Through new programs under the Affordable Care Act, states can provide statewide home and community-based supports as an alternative to institutional care. The Community First Choice Option program allows states to receive an additional 6 percent FMAP. Eligible recipients are those with incomes up

to 150 percent of the federal poverty level or those with incomes over 150 percent of the poverty level who qualify under their own state's Medicaid eligibility standards for long-term care.⁴⁷

Conclusion

Wisconsin's aging population is expected to grow at a rate that is faster than the national average, meaning a growing need for long-term care. Wisconsin has not ignored this fact, and over the past few years, legislators have enacted some measures designed to reduce the cost of Medicaid long-term care. It is too

early to tell whether these measures, such as expanding asset recovery, will have any effect. But provided they are effective, Wisconsin could be a model for other states to follow.

Wisconsin could further experiment with reducing long-term care costs by reforming programs that are only marginally effective (the public/private long-term care insurance partnership), including the home as a more countable asset towards the payment of long-term care and expanding programs that provide more opportunities for home care.

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The NCPA is a nonprofit, nonpartisan organization established in 1983. Its aim is to examine public policies in areas that have a significant impact on the lives of all Americans — retirement, health care, education, taxes, the economy, the environment — and to propose innovative, market-driven solutions. The NCPA seeks to unleash the power of ideas for positive change by identifying, encouraging and aggressively marketing the best scholarly research.

Health Care Policy.

The NCPA is probably best known for developing the concept of Health Savings Accounts (HSAs), previously known as Medical Savings Accounts (MSAs). NCPA research, public education and briefings for members of Congress and the White House staff helped lead Congress to approve a pilot MSA program for small businesses and the self-employed in 1996 and to vote in 1997 to allow Medicare beneficiaries to have MSAs. In 2003, as part of Medicare reform, Congress and the President made HSAs available to all nonseniors, potentially revolutionizing the entire health care industry. HSAs now are potentially available to 250 million nonelderly Americans.

The NCPA outlined the concept of using federal tax credits to encourage private health insurance and helped formulate bipartisan proposals in both the Senate and the House. The NCPA and BlueCross BlueShield of Texas developed a plan to use money that federal, state and local governments now spend on indigent health care to help the poor purchase health insurance. The SPN Medicaid Exchange, an initiative of the NCPA for the State Policy Network, is identifying and sharing the best ideas for health care reform with researchers and policymakers in every state.

The NCPA developed the concepts of Health Savings Accounts and Roth IRAs.

Taxes & Economic Growth.

The NCPA helped shape the pro-growth approach to tax policy during the 1990s. A package of tax cuts designed by the NCPA and the U.S. Chamber of Commerce in 1991 became the core of the Contract with America in 1994. Three of the five proposals (capital gains tax cut, Roth IRA and eliminating the Social Security earnings penalty) became law. A fourth proposal — rolling back the tax on Social Security benefits — passed the House of Representatives in summer 2002. The NCPA’s proposal for an across-the-board tax cut became the centerpiece of President Bush’s tax cut proposals.

NCPA research demonstrates the benefits of shifting the tax burden on work and productive investment to consumption. An NCPA study by Boston University economist Laurence Kotlikoff analyzed three versions of a consumption tax: a flat tax, a value-added tax and a national sales tax.

A major NCPA study, “Wealth, Inheritance and the Estate Tax,”

completely undermines the claim by proponents of the estate tax that it prevents the concentration of wealth in the hands of financial dynasties. Senate Majority Leader Bill Frist (R-Tenn.) and Senator Jon Kyl (R-Ariz.) distributed a letter to their colleagues about the study. The NCPA recently won the Templeton Freedom Award for its study and project on free market solutions to the problems of the poor. The report outlines an approach called Enterprise Programs that creates job opportunities for those who face the greatest challenges to employment.

Retirement Reform.

With a grant from the NCPA, economists at Texas A&M University developed a model to evaluate the future of Social Security and Medicare, working under the direction of Thomas R. Saving, who for years was one of two private-sector trustees of Social Security and Medicare.

The NCPA study, “Ten Steps to Baby Boomer Retirement,” shows that as 77 million baby boomers begin to retire, the nation’s institutions are totally unprepared. Promises made under Social Security, Medicare and Medicaid are inadequately funded. State and local institutions are not doing better — millions of government workers are discovering that their pensions are under-funded and local governments are retrenching on post-retirement health care promises.

Pension Reform.

Pension reforms signed into law include ideas to improve 401(k)s developed and proposed by the NCPA and the Brookings Institution. Among the NCPA/Brookings 401(k) reforms are automatic enrollment of

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employees into companies' 401(k) plans, automatic contribution rate increases so that workers' contributions grow with their wages, and better default investment options for workers who do not make an investment choice.

Environment & Energy.

The NCPA's E-Team is one of the largest collections of energy and environmental policy experts and scientists who believe that sound science, economic prosperity and protecting the environment are compatible. The team seeks to correct misinformation and promote sensible solutions to energy and environment problems. A pathbreaking 2001 NCPA study showed that the costs of the Kyoto agreement to reduce carbon emissions in developed countries would far exceed any benefits.

Educating the Next Generation.

The NCPA's Debate Central is the most comprehensive online site for free information for 400,000 U.S. high school debaters. In 2006, the site drew more than one million hits per month. Debate Central received the prestigious Templeton Freedom Prize for Student Outreach.

Promoting Ideas.

NCPA studies, ideas and experts are quoted frequently in news stories nationwide. Columns written by NCPA scholars appear regularly in national publications such as the Wall Street Journal, the Washington Times, USA Today and many other major-market daily newspapers, as well as on radio talk shows, on television public affairs programs, and in public policy newsletters. According to media figures from BurrellesLuce, more than 900,000 people daily read or hear about NCPA ideas and activities somewhere in the United States.

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Newt Gingrich, former Speaker of the U.S. House of Representatives



"We know what works. It's what the NCPA talks about: limited government, economic freedom; things like Health Savings Accounts. These things work, allowing people choices. We've seen how this created America."

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