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The Long-Term Care Risk
A Developing and Accelerating Crisis for Seniors
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Read about the impoverishment rules and multi-generational impact related to Medicaid qualification and long-term care for seniors.

THE RISK CREATED BY the costs associated with long-term care (LTC) should be easily understood and easily transferable to a private and/or social insurance mechanism. However, the risk has thus far been unprotected and costs have been largely borne by the individual through private payment or handled under the public option of the Medicaid reimbursement system. A number of factors are converging to make this risk even more untenable in the United States.

First, the population continues to age rapidly with the maturity of the baby boomers. The 2010 U.S. Census revealed that more than 42 million Americans are age 65 or older, and this cohort is expected to double by 2050. As the population ages, the risk of disability and the need for long-term care also rises. Also, most individuals eligible for Social Security are taking reduced benefits at the earliest possible age of 62, leaving them with reduced purchasing power compared to starting benefits at normal retirement age. Of all the projections that would affect the economy and the ability of the public sector to absorb these costs, the demographic forecasts are the most predictable.

Recent Medicaid numbers indicate that nursing home costs vary from a high of $10,285 per month in New York City to a low of $4,000 in Louisiana.

Second, the size of the national debt and the impact of the slow-growing economy on the state budgets will increase the pressure to reduce both the number of claimants and the size of the reimbursement available through Medicaid. The primary weapon that the federal government has in its arsenal to reduce health care costs is to control the reimbursements provided by Medicare and Medicaid. This could further increase the costs of long-term care for private-pay individuals. The impact of the Affordable Care Act on Medicaid in this area has been considerable.
Third, the private option of long-term care insurance (LTCI) has not adequately addressed this problem. Although the Medicaid system has provided opportunity for an individual who purchases LTCI to preserve more assets through the states’ LTCI partnership programs, the benefit of such a program has not been clearly or persuasively marketed by either the states or private insurers. Perhaps even more ominously, three large insurers have terminated sales of new LTCI policies in the last two years.

Although there has been some growth in the private LTCI marketplace, only a small percentage of potentially affected Americans have any form of LTC coverage.

THE COST OF LTC IS STAGGERING
 Recent Medicaid numbers indicate that nursing home costs vary from a high of $10,285 per month in New York City to a low of $4,000 in Louisiana. The average cost nationally is more than $75,000 annually for a semi-private room in a nursing. The average monthly cost for assisted living facilities is $3,300 per month. In-home care will be costly and can exceed institutional care, depending on the amount of care the special needs person requires, but full-time nursing care would be an average of $432 daily. Recent data on inflation is even scarier. The inflation rate for nursing home costs far exceeds the inflation rate for other goods and services. This means that the inflation-adjusted real cost of nursing home care will double in 23 years.

MEDICAID’S PUBLIC OPTION REQUIRES IMPOVERISHMENT
 We need to start this discussion with a disclaimer. The rules for qualification for Medicaid are complex and involve an interaction of federal law and state administrative rules. Federal law provides guidelines and mandates implemented at the
The Department of Welfare at the state level often operates in a perceived gray area that may not mimic every aspect of the federal rules. On a case-by-case basis, it is critical to work with an attorney who specializes in elder care at the state level. However, the qualification for Medicaid does require impoverishment of the applicant, which ought to gain the attention of anyone in the population without unlimited assets and/or LTCI. Let’s examine the general guidelines for qualification for Medicaid and indicate where there may be significant state variance.

The state Medicaid programs must provide certain minimum benefits to qualifying persons including in-patient hospital services, nursing home care, and physicians’ services. States have discretion to provide additional services, such as home health care services, private duty nursing services, hospice care, dental services, physical therapy and related services, nurse-midwife services, community supported living arrangement services, as well as other services. The states must also pay the Medicare B premiums of Medicaid recipients who also qualify for Medicare.

There is a three-pronged eligibility test for applicants to qualify for Medicaid, including the categorical status of the Medicaid applicant, his or her income and assets. The eligible categories are financial need persons, individuals over age 65, blind, disabled and U.S. citizens.

The income limitations depend on whether the state is an income-cap or a spend-down state. The income-cap states restrict Medicaid eligibility to those below the supplemental security income (SSI) limitation (actually three times the SSI monthly benefit amount). In these states, if the Medicaid applicant’s countable income exceeds the limit ($2,094 in 2012) by even one dollar, the applicant is ineligible for Medicaid. However, this is a maximum limit. A limit of $5,000 of annual income would cause ineligibility in at least one state. The worst scenario is the pure cap state, where any excess prevents coverage, or states that exclude nursing home care in their medically needy program. This could leave many individuals in a bind, unable to afford long-term care, but unable to qualify for Medicaid reimbursement.

Other states have an income spend-down approach to cover individuals once their medical expenses reduce their income below the limit. Spend-down states would begin eligibility once the Medicaid applicant has spent income on health care to reduce income to the eligibility threshold.

The income test is based on amounts deemed available to the Medicaid applicant. In general, “anything received in cash or kind that can be used to meet needs for food, clothing and shelter” is available income. The state may consider the income and resources of the applicant and his or her spouse to determine whether he or she can qualify for Medicaid. States cannot require your other relatives to contribute, but any contributions other relatives make in cash or to provide and shelter are considered income. This rule may require rethinking the strategy of making gifts up to the annual exclusion for financially struggling older parents.

Only a portion of countable income is required to be expended for the applicant’s LTC. A number of deductions are subtracted from countable income for Medicaid purposes. The balance of income must then be used for the costs of care. These deductions include:

- A personal needs allowance of $30 per month for an individual or $60 per month for an eligible institutionalized couple.
- An additional amount for the maintenance needs of a needy spouse or needy family living at home.
- Incurred medical expenses not paid by a third party, including Medicare or other health insurance premiums, deductibles or coinsurance charges, and care not covered by Medicaid.
- At the state’s discretion, an amount for maintenance of a residence for up to six months if a physician certifies that the applicant is likely to return home after that period.

There is also an asset or resource limitation that would cause an individual to consume all assets on health or LTC expenses before Medicaid is available. Individuals whose resources and deemed resources exceed $2,000 (down to a low of $1,000 in one state), if single, or $3,000 ($2,000 in the lowest state), if married, may be ineligible for Medicaid benefits (until resources go below the applicable limit). The resources that must be counted for this purpose vary from state to state; however, the following rules generally apply.

Non-excluded resources (resources that must be counted to determine your eligibility) are cash, financial instruments convertible to cash, and real and personal property, which may be liquidated. The community spouse (the spouse not currently receiving LTC) also can retain a certain amount in non-excluded resources without affecting the institutionalized spouse’s Medicaid eligibility. The community spouse is al-
Excluded resources (not countable for eligibility purposes whether the institutionalized or the community spouse own such assets) vary by state, but the following are typically not counted as resources:

- The house, trailer or mobile home used as a home;
- Household furnishings;
- Clothing;
- Personal effects;
- One family automobile;
- Burial space for the Medicaid applicant and certain enumerated family members;
- Life insurance coverage not exceeding $1500 face amount for the spouse and each dependent;
- Income-producing real property if the value and income produced are reasonably related;
- Irrevocable burial reserves;
- The community spouse's pension funds; and
- A qualifying annuity.

Note that the individual practice with the state’s Department of Welfare may provide some limits on excluded assets, such as the value of the automobile. Also, even excluded assets will probably be subject to estate recovery to reimburse the state for Medicaid benefits provided to the decedent while he or she was alive.

These impoverishment rules should certainly frighten anyone in the family of someone needing to qualify for Medicaid. There had been planning techniques that could help a family preserve more assets, but such planning was significantly curtailed by the Deficit Reduction Act of 2005. Like most plan-
Estate planning, it is clearly advantageous to begin as soon as possible with qualified advisors. The planning should begin well before any Medicaid application will be made. There is a five-year look back for any transfers made by the Medicaid applicant. Any currently available planning techniques will potentially be on the chopping block for future government cost-containment legislation.

FILIAL RESPONSIBILITY LAWS—A TERRIFYING NEW DEVELOPMENT

States provide that parents have a legal obligation to support minor children. Most states have requirements that provide for spousal support. However, 30 states also have filial responsibility laws. Pennsylvania recently moved its filial responsibility law into its Domestic Relations Code. It provides that the following individuals (with some exceptions) will have responsibility for the financial needs of an indigent person:

- Spouse of the indigent person;
- Child of the indigent person; and
- Parent of the indigent person

Note there is no limitation that the child be a minor to potentially obligate the parent for the indigent-child’s expenses.

Thus far, it does not appear that states will use the filial responsibility statutes to deny the eligibility of an indigent person to Medicaid. However, nursing homes or health care facilities have begun to initiate suits under the statute. A very troubling result was reached recently in a Pennsylvania decision (HCR v. Pittas, 2012 PA Super 96 (May 7, 2012)). The court held a child financially responsible to the tune of $92,943 for the nursing home expenses of his parent. Interestingly, the nursing home resident had a pending appeal for qualification under Medicaid. And the parent had not made any asset transfers to the child held responsible for these expenses. Nothing in the filial responsibility statute required the court to take into consideration that public resources would soon be available to provide for the parent’s LTC. Also, the law allows the health care provider to institute a lawsuit against any of the children for the indigent parent’s support without any consideration of the impact this might have on the relationship between siblings. Do we have your attention yet?

WHY AREN’T AMERICANS DEALING WITH THE LTC RISK?

Although there has been some growth in the private LTCI marketplace, only a small percentage of potentially affected
Americans have any form of LTC coverage. Surveys indicate a surprising lack of understanding of the LTC risk. For example, 75 percent of individuals under age 55 reported that they had no idea of the cost of institutionalized LTC. These individuals would certainly be affected if a parent became impoverished by the costs of LTC. Presumably, there will be less ignorance among the senior population. Data is certainly available. MetLife and Genworth have annual cost-of-care reports available to the public. Maybe the cost of LTC is too staggering and creates deniability for those at risk and their family members.

There also appears to be a general state of denial among individuals most likely to face the risk of LTC in the immediate future. A recent survey by the National Council on Aging indicates some surprising opinions of seniors concerning their future state of health. For example, survey respondents age 70+ indicated that 66 percent felt their health would be the same, somewhat better or much better in the next five to 10 years. Only 31 percent expected their health to be worse.

**MULTI-GENERATIONAL SOLUTIONS— THERE MAY BE NO OTHER PLACE BUT HOME**

The cost of LTC and the impoverishment rules of Medicaid will have an impact on both the individual who needs LTC and his or her heirs. A recent study by three college professors (Poterba, Venti and Wise) found that 46.1 percent of Americans die with assets less than $10,000. The costs of LTC certainly have added to that depressing statistic. Even if the Pittas case previously discussed is an aberration, the high cost of care in the impoverishment rules of Medicaid will reduce or eliminate the inheritances of many family members of individuals who have the need for significant LTC.

Given the current financial stresses on federal, state and local governments, the expansion of any public program to assist with the costs of long-term care expenses is unlikely. All the traditional public options are stressed and will be so for the foreseeable future.

So where does a senior citizen turn for help? A recent MetLife Mature Market Survey “Multi-Generational Views on Family Financial Obligations,” suggests parents would do well to rely upon their adult children who often have a strong sense of obligation or responsibility. But even that sense comes with a limit. According to the study, many adult children are willing to allow a parent to live with them if the parent is not healthy enough to live alone without caregiving, or if a parent is having difficulty making ends meet.

While planning for an increasingly uncertain future with LTCI policies may seem an inadequate response, it well may be the only viable one assuming parents do enough advance planning to make the cost of LTCI manageable. Perhaps the cost sharing of premiums by family members interested in preserving Mom and Dad’s estate could be a viable strategy.

If elderly parents are anticipating assistance from adult children, they need to raise the possibility of that need sooner rather than later. Adult children need to be on the alert early for signs that support of their parents may be required. Proactive communication between the generations leading to timely planning likely will help the elderly dealing with some of the severest financial and economic challenges in recent memory.