

# Cassandra's Quandary:

*The Future of  
Long-Term Care  
in New Hampshire*

FEDERALISM IN ACTION

*and*

CENTER FOR LONG-TERM  
CARE REFORM



STEPHEN A. MOSES

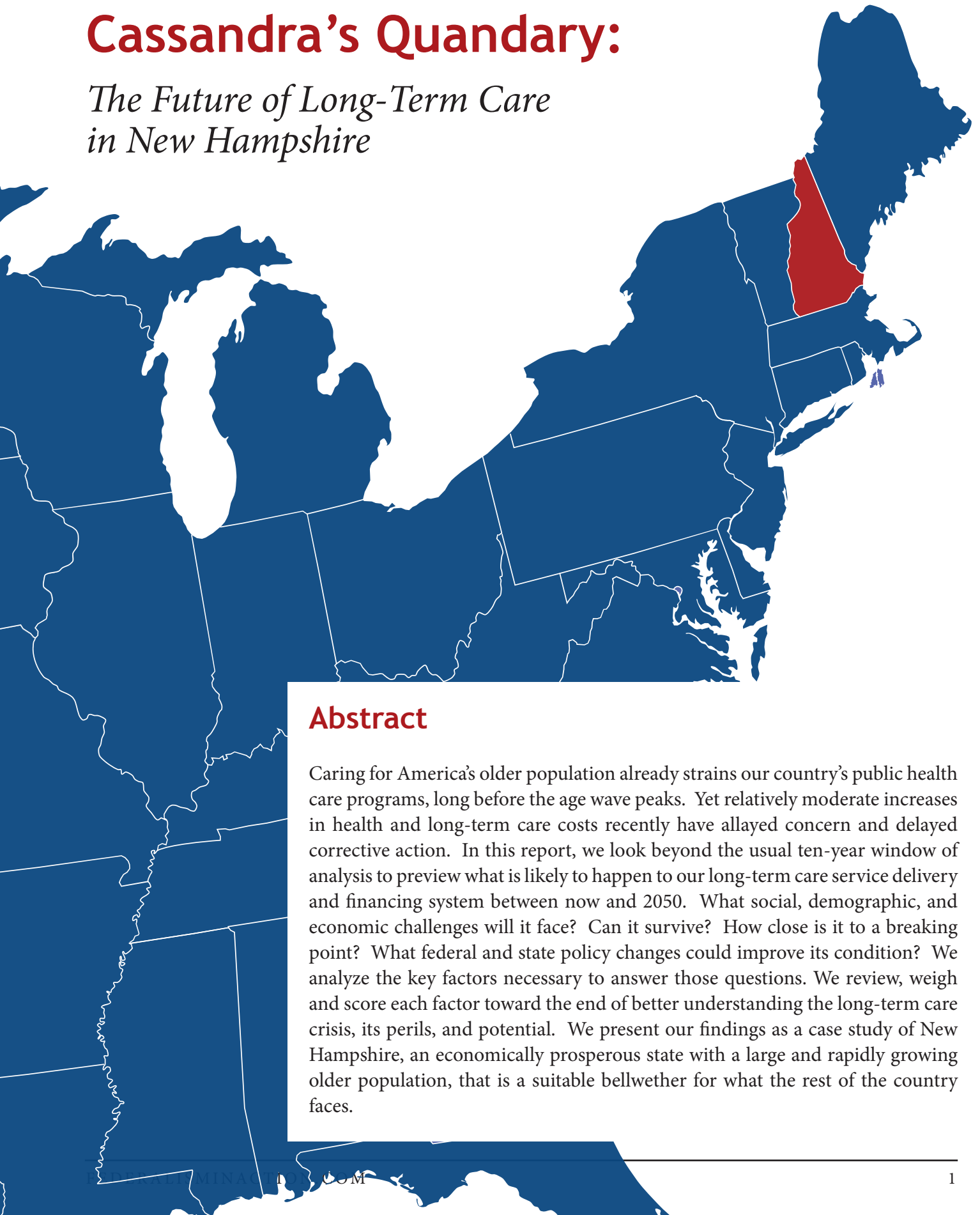
## Table of Contents

Abstract .....	1
Executive Summary .....	2
Introduction: Cassandra’s Quandary .....	4
National Overview.....	6
Long-Term Care Analysis .....	8
The Index of Long-Term Care Vulnerability.....	9
1. Aging Demographics .....	10
2. Morbidity .....	13
3. Public Funding (Medicaid) .....	15
3a. Expenditure Trends .....	15
3b. Other Medicaid Factors .....	19
3c. Special Medicaid Challenges .....	26
4. Economy, Federal .....	35
5. Economy, State .....	43
6. Private Financing Alternatives .....	50
7. Entitlement Mentality .....	57
Summary .....	63
Conclusion .....	65
Recommendations .....	66
Federal .....	66
State .....	67
Appendix 1: Long Term Care Complacency and a Wake-Up Call .....	68
Appendix 2: State of New Hampshire Expenditure History .....	74
Appendix 3: Table of Long-Term Care Vulnerability .....	75
Appendix 4: Interviewees .....	76

---

# Cassandra's Quandary:

## *The Future of Long-Term Care in New Hampshire*



### **Abstract**

Caring for America's older population already strains our country's public health care programs, long before the age wave peaks. Yet relatively moderate increases in health and long-term care costs recently have allayed concern and delayed corrective action. In this report, we look beyond the usual ten-year window of analysis to preview what is likely to happen to our long-term care service delivery and financing system between now and 2050. What social, demographic, and economic challenges will it face? Can it survive? How close is it to a breaking point? What federal and state policy changes could improve its condition? We analyze the key factors necessary to answer those questions. We review, weigh and score each factor toward the end of better understanding the long-term care crisis, its perils, and potential. We present our findings as a case study of New Hampshire, an economically prosperous state with a large and rapidly growing older population, that is a suitable bellwether for what the rest of the country faces.

## Executive Summary

It may already be too late to save America's long-term care safety net. But it is not too late to examine its problems and to propose policy changes to relieve or eliminate them. That is this report's objective.

Long-term care service delivery and financing face enormous challenges. Risk and cost are very high, yet few Americans plan early to save, invest or insure for long-term care (LTC). Consequently most people who need expensive LTC end up depending on Medicaid, an under-funded, means-tested, public welfare program.

Originally conceived as a last resort for people in dire need, Medicaid has become the dominant funder of long-term care for middle class and even affluent people, not only the poor. By trying to do too much for too many, Medicaid has hurt the poor. Decades of institutional bias and questionable access and quality resulted from dismally low reimbursement rates. Programs for the poor, as the adage goes, are poor programs.

Nor have more prosperous people truly benefited from easy access to Medicaid LTC benefits. Lenient and elastic eligibility rules mandated by the federal government enabled them to dodge high LTC costs, but only at the expense of losing their ability to choose their LTC providers, select their preferred level and venue of care, and demand high quality care as private payers who can change providers.

Today, on the cusp of an unprecedented increase in older Americans most likely to need long-term care, the United States faces exceptionally high debt and unfunded entitlement liabilities, a weak economy despite years of fiscal and monetary pump priming, and a populace more dependent on social insurance and welfare programs than ever before.

But health and long-term care expenditures have not yet exploded despite long and frequent warnings they would. Public program cost and utilization projections within the usual ten-year outlook window appear manageable. Deficit spending, enabled by artificially induced low interest rates, defers short-term worries. Complacency prevails.

**Lift your sights to 2050, only 35 years from now, and all confidence about the existing long-term care system should dissolve.**

Lift your sights to 2050, only 35 years from now, and all confidence about the existing long-term care system should dissolve. But we face a dilemma like the mythical Cassandra's. She was blessed with accurate prognostication but cursed to be disbelieved. The primary purpose of this report is to take the longer view, enumerate the coming challenges, estimate the current LTC system's survivability, awaken greater concern and propose corrective actions.

New Hampshire is an apt harbinger of the country's long-term care challenges. The state's age 85 plus population will nearly quadruple in the next three and a half decades. If its Medicaid long-term care expenditures for the elderly keep pace they'll increase from \$282 million per year to \$1,047 million, more than one billion dollars every year. Sustainability at that level is highly dubious.

What exactly are America and the Granite State up against? To answer that question, we offer an "Index of Long-Term Care Vulnerability" that lists the major challenges and provides a way to measure, analyze and score their impact. We break out aging demographics, future morbidity, Medicaid's viability, federal and state revenue sustainability, private financing potential, and entitlement mentality as the key subjects for review.

We conclude that America's and New Hampshire's long-term care service delivery and financing systems - as currently operating and as they are most likely to evolve - will not survive the coming demographic age wave and that radical changes in federal and state laws and regulations are needed to align consumer incentives with the need to finance future long-term care adequately.

We recommend (1) changing the system by which the federal government funds state long-term care systems; (2) empowering states to experiment with different approaches to long-term care financing; (3) reducing dependency on government funding of long-term care by re-targeting scarce public resources to the genuinely needy; and (4) incentivizing private long-term care financing to encourage early planning, saving, investing and insuring.

## Introduction: Cassandra's Quandary

In the ancient myth, Apollo granted Cassandra the ability to predict the future accurately, but when she declined his romantic advances, he doomed her to be disbelieved.

The evasion of reality and denial of risk surrounding long-term care public policy reminds one of Cassandra's quandary. No matter how much irrefutable evidence scholars adduce for the unsustainability of the current LTC financing system, the stubborn minions of complacency persist and prevail.

Our research on Medicaid and long-term care financing in New Hampshire produced some examples. A long-term care provider expressed optimism that science would cure Alzheimer's Disease and radically reduce future LTC costs. A wiser position: "Hope for the best, but plan for the worst."

A highly placed public official opined that LTC expenditures, which were predicted to explode two decades ago, haven't. A safer judgment: "Yet!"

He went on "Besides, we can always print more money." To which Margaret Thatcher would have responded: "Eventually you run out of other people's money."

Greek myth is a fitting lens through which to view predictions about the future of long-term care services and financing. Modern day Greece, and Puerto Rico closer to home, are canaries in the mineshaft warning us to heed today's LTC Cassandras.

Can we relax about LTC financing because institutional and home care costs have not exploded yet? Well, no, the first baby boomers won't reach 85, the age at which long-term care becomes much more likely and expensive, until the fourth decade of this century.

Can we rely on current fiscal (deficit spending) and monetary (credit expansion, money printing, and interest rate manipulation) indefinitely? Hardly. Sooner or later, economic gravity prevails, interest rates will rise making public debt un-serviceable.

But when?

A good guess, to employ some tired but evocative metaphors, is that it will happen when the "silver tsunami" becomes a "perfect storm" causing an "economic deep freeze."

## We have plenty of reasons to worry:

- The boomers start coming of heavy-LTC-usage age 85 in 2031.
- Social Security and Medicare run out of “trust funds” in the early 2030s, less than 20 years from now.
- Gallup pollsters report “51% of non-retirees doubt they will receive Social Security” and “[t]wo-thirds say Social Security is in crisis or has major problems.”<sup>1</sup>
- U.S. tax-generated general funds will have to make up the entitlements’ annual shortfalls as well as pay off the trust funds’ bonds (IOUs).
- Federal debt is \$18.9 trillion and rising rapidly.
- Heavy taxation impedes the economic activity necessary to generate needed tax revenue.
- The Federal Reserve domestically and central banks internationally are pushing the limits of their ability to expand credit in order to conceal economic malaise.
- Fiscal walls are closing on the U.S. and world economies.
- Promiscuous spending leads to impoverishment for individuals or families (sooner) and national economies (later, because of their ability to manipulate currency).
- These lessons are legion throughout history and around the world.<sup>2</sup>

But there are “none so blind as those who will not see,” so this report takes a wide-eyed look at an expansive range of indicators in order to identify and score the LTC system’s risk between now and 2050.

---

<sup>1</sup> Frank Newport, “Many Americans Doubt They Will Get Social Security Benefits,” August 13, 2015; <http://www.gallup.com/poll/184580/americans-doubt-social-security-benefits.aspx>.

<sup>2</sup> See Carmen M. Reinhart & Kenneth S. Rogoff, *This Time is Different: Eight Centuries of Financial Folly*, Princeton University Press, 2009.

## National Overview

Long-term care (LTC) is custodial or medical assistance needed for three months or more due to an inability to perform activities of daily living independently.<sup>3</sup> LTC is expensive<sup>4</sup> whether received in a nursing home, an assisted living facility or in one's own home. The risk of needing some form of long-term care after age 65 is 52.3 percent, one in two.<sup>5</sup> The catastrophic risk of needing five years or more is 13.9 percent, one in seven.<sup>6</sup> Nevertheless, people often ignore the probability and cost of long-term care. Few save, invest or insure privately to prepare for the possibility of large long-term care expenses in later life.

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

Many people, when asked, say they believe Medicare pays for long-term care.<sup>7</sup> It does not. But, its sister program Medicaid does pay for most expensive long-term care: 51 percent of the \$310 billion total in 2013.<sup>8</sup> Contrary to conventional wisdom, Medicaid long-term care benefits are relatively easy to qualify for financially.<sup>9</sup> Peer reviewed research indicates that the availability of Medicaid long-

---

3 This report uses the term "long-term care" (LTC) most of the time instead of the awkward neologism "long-term services and supports" (LTSS), which has entered common academic usage. LTSS implies a distinction without a difference. Long-term care, consisting of many kinds of medical and custodial services and supports, can be provided in institutional or home-based settings. The fact that Medicaid's monopsony financing induced decades of institutional bias in the LTC service delivery system does not make specifying the fact that LTC also consists of non-institutional services in every use of the clumsy term LTSS either necessary or desirable.

4 The national median daily rate for a private nursing home room is \$250 or \$91,250 per year; for a semi-private nursing home room, the daily rate is \$220 or \$80,300 per year. The national median monthly rate for assisted living is \$3,600 or \$43,200 per year. The national median daily rate for adult day health is \$69; for home health aide services, \$20 per hour; for homemaker services, \$20 per hour. Source: *Genworth 2015 Cost of Care Survey*, Genworth Financial, Inc., April 2015: [https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568\\_040115\\_gnw.pdf](https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_040115_gnw.pdf).

5 Melissa Favreault and Judith Dey, *Long-Term Services and Supports for Older Americans: Risks and Financing, Research Brief*, Office of the Assistant Secretary for Planning and Evaluation, Washington, DC, July 2015, TABLE 1. Projected Need for LTSS for Persons Turning 65 in 2015-2019, by Gender, Income Quintile and Self-Reported Health Status at Age 65," p. 4; <http://aspe.hhs.gov/daltcp/reports/2015/ElderLTCrb.cfm>.

6 Prior to the publication of *ibid.*, the LTC risk estimates most commonly quoted were 69 percent for any long-term care and 20 percent for five years or more sourced from 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/>. For an explanation of the difference between the two sets of estimates and a critique of the report presenting the new estimates, see Stephen A. Moses, "LTC Bullet: New Data on LTC Incidence, Duration, Cost and Financing Sources," Center for Long-Term Care Reform, Seattle, Washington, July 24, 2015; <http://www.centerltc.com/bullets/latest/1094.htm>.

7 "Misperceptions about the types of coverage Medicare provides for ongoing living assistance services have declined since 2014, but still exist. And more than 1 in 4 Americans age 40 and older are unsure whether Medicare pays for ongoing living assistance services like nursing homes and home health aides." Source: The Associated Press -NORC Center for Public Affairs Research, "Long-Term Care in America: Americans' Outlook and Planning for Future Care," July 2015; available [here](#) at a very long URL.

8 Erica L. Reaves and MaryBeth Musumeci, "Medicaid and Long-Term Services and Supports: A Primer," Kaiser Family Foundation, May 2015, "Figure 3: Medicaid is the Primary Payer for Long-Term Services and Supports (LTSS), 2013"; <http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>.

9 Income rarely interferes with Medicaid LTC eligibility because most states, including New Hampshire, 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, as of 2016, up to \$828,000 of home equity in some states and \$552,000 in other states, including New Hampshire. Also exempt under federal rules with no limit are one income producing business, one automobile, term life insurance, personal belongings, home furnishings, prepaid burial funds, and Individual Retirement Accounts (IRAs) if they generate regular outlays as all but Roth IRAs 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>.



term care benefits crowds out private financing and planning.<sup>10</sup> Other reliable research shows that, ironically, the rich gain as much or more from Medicaid's long-term care benefit as the poor.<sup>11</sup>

Even as Medicaid spending grows steadily, 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.<sup>12</sup> 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."<sup>13</sup> But managed care creates serious access and quality challenges, especially for these very vulnerable groups, as advocates for seniors and the disabled often warn.<sup>14</sup>

**A demographic "Age Wave" is coming soon that will strain Social Security and Medicare immediately and Medicaid, before very long.**

Medicaid already strains state and federal budgets. Many states are adding 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 very 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. We will explore all these issues in detail with respect to their bearing on long-term care services and financing in New Hampshire.

---

10 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](http://www.nber.org/~afinkels/papers/Brown_Finkelstein_Medicaid_Dec_04.pdf).

11 "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](http://www.chicagofed.org/webpages/publications/working_papers/2012/wp_13.cfm).

12 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](http://www.centerlrc.com/BriefingPapers/4.htm).

13 Dual eligibles are people who receive both Medicare and Medicaid benefits.

14 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.centerlrc.com/BriefingPapers/5.htm](http://www.centerlrc.com/BriefingPapers/5.htm).

## Long-Term Care Analysis

Much scholarly effort goes into studying problems related to the aging of America. Long-term care is a major target of such research. But LTC has many complicated components, such as risk, cost, care giving, service delivery and financing. These are impacted by many related issues, such as public awareness, the economy's health, government budgets, personal savings, and available financial products. Usually, these components and issues are examined one by one or in small groups, rarely all together. They are studied in silos rather than comprehensively.<sup>15</sup>

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 without first analyzing and explaining what caused the crisis. 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 answered that question and developed that theme in “The History of Long-Term Care Financing, or How We Got Into This Mess.”<sup>16</sup>

**How vulnerable is long-term care to the vicissitudes of aging demographics, limited financing sources, and consumers' denial of risk?**

This report takes a different approach and asks and answers different questions: 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? What specific directions might such a different approach take?

---

15 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>.

16 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>.

## The Index of Long-Term Care Vulnerability

To answer those questions, this report will look closely at the following variables individually and in combination based on national and state-level data for New Hampshire:

**Aging Demographics:**

*How many older people are coming in the next few decades?*

**Morbidity:**

*How sick will they be?*

**Public Funding:**

*How viable is Medicaid as the dominant long-term care payer?*

**Economy, Federal:**

*How reliable is federal revenue on which Medicaid mostly depends?*

**Economy, State:**

*How reliable is state revenue on which Medicaid secondarily depends?*

**Private Financing Alternatives:**

*How much private-pay revenue is available to relieve LTC financing pressure on Medicaid?*

**Entitlement Mentality:**

*How strong has cradle-to-grave dependency on public programs become?*

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

## 1. Aging Demographics:

*How many older people are coming in the next few decades?*

People 85 years of age and older are the most likely population 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 percent) 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.”<sup>17</sup>

New Hampshire is especially vulnerable to the demographic challenges of aging. Although not currently very old—only 21 states have fewer seniors proportionately—New Hampshire’s age 65 and over population will likely double in the next 20 years.<sup>18</sup> The state had a high median age of 41.1 years in 2010 because of its elevated concentration of baby boomers—only two states have more boomers proportionately.<sup>19</sup> Having so many citizens in their peak earnings years is a

### NEW HAMPSHIRE<sup>20</sup>

Population & Projections	Year	State Pop. (1,000s)	% of Total Population	Rank	U.S.	% Change from 2012	Rank	U.S.
All ages	2012	1,345		40	315,311			
	2032	1,581		42	376,660	+18%	30	+19%
	2050	1,765		42	434,447	+31%	36	+38%
Age 50-64	2012	301	22.4%	3	19.2%			
	2032	262	16.6%	13	16.4%	-13%	45	+2%
	2050	354	20.1%	1	16.6%	+18%	25	+19%
Age 65+	2012	197	14.6%	17	13.6%			
	2032	372	23.5%	2	19.8%	+89%	9	+74%
	2050	401	22.7%	2	20.4%	+104%	19	+107%
Age 65-74	2012	109	8.1%	9	7.4%			
	2032	194	12.3%	1	10.1%	+78%	8	+64%
	2050	166	9.4%	13	9.1%	+52%	38	+69%
Age 75-84	2012	59	4.4%	18	4.2%			
	2032	127	8.0%	5	6.8%	+114%	11	+94%
	2050	131	7.4%	2	6.6%	+120%	14	+116%
Age 85+	2012	28	2.1%	23	2.0%			
	2032	50	3.2%	8	2.9%	+77%	19	+69%
	2050	104	5.9%	1	4.8%	+267%	13	+224%

17 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>. In order to maintain consistency so that our findings are comparable between New Hampshire and other future study states, we are using the categories and data reported by AARP’s “Across the States—2012” publication for purposes of summary and scoring in all sections of this report. The next iteration of “Across the States” is due out in December 2015.

18 Kenneth M. Johnson, “New Hampshire Demographic Trends in the Twenty-First Century,” Carsey Institute, University of New Hampshire, Durham, New Hampshire, 2012, p. 3. Available online [here](#) at a very long URL.

19 *Ibid.*, p. 13.

20 Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, “Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012 New Hampshire,” AARP, Washington, DC, 2012, p. 3, available [here](#).

distinct economic advantage now, but it will become an economic burden later as they age and require health and long-term care. A Carsey Institute survey of New Hampshire's demographic trends summarized the situation this way: New Hampshire's population is "growing older as the large baby boom cohorts age in place, middle-aged and older adults move into the state, the young adult population grows only modestly, and the number of children diminishes."<sup>21</sup>

The New Hampshire Center for Public Policy Studies' (NHCPPS's) September 2011 "Silver Tsunami" report hammered home similar concerns, emphasizing the potential economic consequences of population aging. Health care spending in New Hampshire has already out-paced economic growth for decades. Older people require more health and long-term care services than younger people. A stunning consequence: "Currently, Medicaid allocates 25 percent of its total medical spending to those over 65. Assuming no significant changes to the services provided to that population, that percentage will increase to 52 percent by 2030. As the population ages, the share of Medicaid program expenditures associated with long term care will increase very quickly."<sup>22</sup> NHCPPS projected health care spending by major payers attributable solely to the aging of the state population and concluded Medicaid expenditures for people over the age of 85 could more than triple to \$350 million between 2010 and 2030.<sup>23</sup>

**“Considering only the expected growth in New Hampshire’s age 85-and-over population between now and 2050, LTC expenditures could nearly quadruple from \$282 million to \$1,047 million, more than one billion dollars every year.”**

Our analysis, looking beyond 2030 and focused exclusively on Medicaid's long-term care expenditures, reached even more alarming conclusions. Considering only the expected growth in New Hampshire's age 85-and-over population between now and 2050, LTC expenditures could nearly quadruple from \$282 million to \$1,047 million, more than one billion dollars every year. Looking beyond 2030 is critical because by that year, the front cusp of baby boomers is still only 84 years old. By 2050, all the boomers still living will be at least 85 years old and in their peak years of LTC need. That's when the fiscal impact on public programs, including Medicaid LTC expenditures, will be greatest. We will have more to say about this eventuality in the section on Medicaid's viability as a long-term care funding source and in Appendix 1 where we present the numbers and our methodology in detail.

---

21 *Ibid.*, p. 24.

22 Steve Norton, "New Hampshire's Silver Tsunami: Aging and the health care system," New Hampshire Center for Public Policy Studies, Concord, New Hampshire, September 2011, p. 1; available online [here](#) at a very long URL.

23 *Ibid.*, p. 24.

## Summary and Scoring for Aging Demographics:

*How many older people are coming in the next few decades?*

People age 85+	United States <sup>24</sup>	New Hampshire <sup>25</sup>
Number in 2012	6,426,000 (2.0%)	28,000 (2.1%)
2012 to 2032 increase	69%	77%
2012 to 2050 increase	224%	267%

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

New Hampshire’s expected age 85 population growth is much higher than the national average. In fact, between 2012 and 2050, New Hampshire’s proportion of population 85 years of age or older is expected to move from 23<sup>rd</sup> highest in the country to number 1.<sup>26</sup>

We calculate based on New Hampshire’s expected increase in age 85 plus population that Medicaid long-term care expenditures for the elderly could nearly quadruple to over \$1 billion per year by 2050.

Assign a weight and score in the Table of Long-Term Care Vulnerability. (The Table of Long-Term Care Vulnerability is a worksheet in “Appendix 3” designed to help the reader translate objective data provided in this report into a subjective estimate (best guess) of the future prospects for long-term care service delivery and financing nationwide and in New Hampshire. Whenever you see the instruction “assign a weight and score,” we invite you to open the Table of LTC Vulnerability and indicate your best sense of the factor’s significance.” The author’s filled out Table of LTC Vulnerability is provided for comparison.)

<sup>24</sup> 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>, p. 36.

<sup>25</sup> *Ibid.*, p. 216.

<sup>26</sup> *Ibid.*

## 2. Morbidity

*How sick will they be?*

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.

America's elderly are depressingly prone to chronic illness. "Two-thirds of traditional Medicare beneficiaries older than 65 have multiple chronic conditions... More than 4 million — about 15% — have at least six long-term ailments. Those sickest seniors account for more than 41% of the \$324 billion spent on traditional Medicare."<sup>27</sup> Among the traditional fee-for-service Medicare population, the incidence of high blood pressure increased from 50.6 percent in 2007 to 54.4 percent in 2013. In the same period, the percentage afflicted by arthritis jumped from 17.8 percent to 29.2 percent and high cholesterol increased from 32.9 to 44.9 percent. Heart disease dipped significantly from 38.2 percent to 27.7 percent, but diabetes surged from 20.4 percent to 26.9 percent.

Our country's obesity epidemic exacerbates these problems and magnifies their cost. "Obesity is one of the biggest drivers of preventable chronic diseases and healthcare costs in the United States. Currently, estimates for these costs range from \$147 billion to nearly \$210 billion per year."<sup>28</sup> Obesity rates among the elderly have increased from 23.4 percent to 27.4 percent in the past five years.<sup>29</sup> Among New Hampshire's adult population, 61.8 percent are overweight, only slightly below the overall U.S. rate of 63.8 percent.<sup>30</sup>

Of course, as one of our project's interviewees observed, medical science may come to the rescue. Many studies published in the last two decades of the twentieth century identified "compression of morbidity" as a promising trend. It seemed people were living longer and healthier until dying quicker with less long-term care required at the end. But more recent studies cast doubt on that optimism. "Length of life with disease and mobility functioning loss has increased between 1998 and 2008. . . . Empirical findings do not support recent compression of morbidity when morbidity is defined as major disease and mobility functioning loss."<sup>31</sup> Perhaps a cure for Alzheimer's Disease will be found

---

27 Meghan Hoyer, "Nation's sickest seniors reshape health care: 10,000 seniors cost Medicare \$1 billion; containing costs a challenge as nation ages," *USA Today*, June 10, 2015; <http://www.usatoday.com/story/news/2015/06/05/medicare-costs-seniors-sick-chronic-conditions/27390925/>.

28 "Cost Containment and Obesity Prevention," *The State of Obesity*, A project of the Trust for America's Health and the Robert Wood Johnson, extracted August 7, 2015; <http://stateofobesity.org/cost-containment/>.

29 Rachael Rettner, "US Obesity Rates Have Risen Most in Older Adults," *LiveScience*, January 27, 2015; <http://www.livescience.com/49587-obesity-rates-older-adults.html>.

30 "Percent of Adults Who are Overweight or Obese," *StateHealthFacts*, Kaiser Family Foundation, extracted August 7, 2015; <http://kff.org/other/state-indicator/adult-overweightobesity-rate/>.

31 Eileen M. Crimmins and Hiram Beltran-Sanchez, "Mortality and Morbidity Trends: Is There Compression of Morbidity?," *Journal of Gerontology: Social Sciences*, Vol. 66B(1), 75-86, December 6, 2010, p. 75; <http://psychogerontology.oxfordjournals.org/content/66B/1/75.full.pdf+html>.

as New Mexico researchers believe<sup>32</sup> saving the country the \$1.1 trillion in 2050 that the Alzheimer’s Association predicts it will otherwise cost.<sup>33</sup> But we’ve heard frequently about promising research to treat and/or cure dementia with few actual breakthroughs occurring. For the time being, it is best to hope for the best, but plan for the worst.

### Summary and Scoring for Morbidity:

*How sick will they be?*

People age 65+ with disabilities, 2010	United States <sup>35</sup>	New Hampshire <sup>34</sup>	
		Percent	Rank
a. Self-care difficulty	8.8%	5.9%	47
b. Cognitive difficulty	9.5%	6.1%	51
c. Any disability	37%	32%	48
<b>Nursing facility residents w/ dementia, 2010</b>	46% <sup>36</sup>	55%	1 <sup>37</sup>

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

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

Assign a weight and score for this factor in the Table of Long-Term Care Vulnerability.<sup>38</sup>

32 Donna Olmstead, “Alzheimer’s: UNM researchers may be closing in on a cure,” *Albuquerque Journal*, August 9, 2015; <http://www.abqjournal.com/625597/news/unm-researchers-may-be-closing-in-on-a-cure.html>.

33 Alzheimers Association, “2015 Alzheimer’s Disease Facts and Figures,” extracted August 10, 2015; <http://www.alz.org/facts/>. “Unless something is done, in 2050, Alzheimer’s is projected to cost over \$1.1 trillion (in 2015 dollars).” Extracted August 10, 2015.

34 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>, p. 217.

35 *Ibid.*, p. 37.

36 *Ibid.*, p. 40.

37 *Ibid.*, p. 220.

38 The Table of Long-Term Care Vulnerability is a worksheet in “Appendix 3” designed to help the reader translate objective data provided in this report into a subjective estimate (best guess) of the future prospects for long-term care service delivery and financing nationwide and in New Hampshire. Whenever you see the instruction “assign a weight and score,” we invite you to open the Table of LTC Vulnerability and indicate your best sense of the factor’s significance.” The author’s filled out Table of LTC Vulnerability is provided for comparison.



### 3. Public Funding

*How viable is Medicaid as the dominant long-term care payer?*

#### 3a. Expenditure Trends

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 whether or not the long-term care system now in place can survive. Medicaid's LTC viability breaks down into several sub-factors.

What follows is the latest information we learned during our current research about Medicaid financing of long-term care in New Hampshire. This analysis is based on expenditure data provided by the New Hampshire Office of Legislative Budget Assistant, a copy of which is displayed in Appendix 2.

New Hampshire's broad budget categories and 2014 expenditures were:

**Category 1** - General Government (\$425,806,000)

**Category 2** - Administration of Justice and Public Protection  
(\$480,720,000)

**Category 3** - Resource Protection and Development (\$140,316,000)

**Category 4** - Transportation (\$541,316,000)

**Category 5** - Health and Social Services (\$2,153,341,000)

**Category 6** - Education (\$1,335,566,000)

**While [New Hampshire's] Health and Social Services spending increased in absolute terms, it actually declined as a proportion of the state budget from 2005 (\$1,785,525,000) to 2014 (\$2,153,341,000) from 43.0 percent to 42.4 percent.**

Medicaid long-term care for the elderly represents approximately 20 percent of the expenditures in Category 5 - Health and Social Services. We initially anticipated that increases in the cost of long-term care for the elderly over the past decade would have put pressure on other expenditure categories. That turned out not to be the case. While Health and Social Services spending increased in absolute terms, it actually declined as a proportion of the state budget from 2005 (\$1,785,525,000) to 2014 (\$2,153,341,000) from 43.0 percent to 42.4 percent.

Relatively slow inflation in the cost of long-term care for the elderly contributed to the decline in Health and Social Services' share of spending. For example:

- **Nursing Homes** only increased from \$174,491,000 to \$192,854,000 or **10.5%**.
- **Home Nursing Services** (Choices for Independence Waiver) increased more rapidly from \$26,086,000 to \$43,512,000 or **66.8%**, but these services help recipients stay out of a nursing home and in their own homes at less cost, so they're presumed to explain the low inflation in nursing home expenditures.

- Likewise **Mid-Level Care** (Choices for Independence Waiver, AKA residential care or assisted living) grew from \$1,497,000 to \$9,327,000 or **523.0%**, but again this increase is considered to be in lieu of higher institutional costs.
- **Medical Services** to support home care declined from \$50,536,000 to \$36,052,000, a **28.7% decrease**, but they have leveled out around \$36,000.
- **Total Medicaid LTC expenditures for the elderly** increased from \$252,610,000 in 2005 to \$281,745,000 in 2014, an increase of only **11.5%** over a ten-year period!

We concluded that Medicaid long-term care spending is not crowding out other budget priorities in New Hampshire . . . yet. We infer that this low Medicaid LTC expenditure inflation over the past decade has desensitized public officials in New Hampshire to potential cost inflation in the future. In our interviews, they were less concerned about rising Medicaid LTC costs than we expected them to be. But the real risk of high and rapidly increasing LTC expenditures is still to come due primarily to predictable increases in the state's over-85 aged population. That danger is explained in the section above on aging demographics and elaborated upon below in "Appendix 1: Long Term Care Complacency and a Wake-Up Call."

Also noteworthy is that the LTC spending categories that were prone to significant cost increases over the past decade—Home Nursing Services, up 66.8 percent and Mid-Level Care, up 523.0 percent, both Choices for Independence waiver services—may be vulnerable later to even greater expenditure growth for reasons discussed below under "rebalancing vulnerability."

In order to maintain consistency so that our findings are comparable between New Hampshire and other future study states, we are using the categories and data reported by AARP's "Across the States—2012" publication<sup>39</sup> for purposes of summary and scoring in all sections of this report. Use the preceding analysis to inform, modify and enhance the data cited below from the AARP report."

Note that the data above supplied by the State of New Hampshire are for aged Medicaid recipients only whereas the data from "Across the States" and from Truven Health Analytics cited below are for the aged and adults with physical disabilities. For purposes of analyzing New Hampshire's vulnerability to aging demographics, the aged-only data is most relevant.

---

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. 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>

**Summary and Scoring for Public Funding (Medicaid) Expenditure Trends**

Expenditure trends	United States	New Hampshire	
		Percent	Rank
Percent of budget for Medicaid <sup>40</sup>	17.8%	40.4%	1
Medicaid LTSS spending change for older people and adults with physical disabilities 2004 to 2009	+28% <sup>41</sup>	+31%	15 <sup>42</sup>
Medicaid nursing facility spending change 2004 to 2009	+12% <sup>43</sup>	+23%	10 <sup>44</sup>
Medicaid HCBS spending change for older people and adults with physical disabilities 2004 to 2009	+70% <sup>45</sup>	+80%	18 <sup>46</sup>
Medicaid HCBS change as a % of LTSS spending for older people and adults with physical disabilities 2004-2009	+9% <sup>47</sup>	+5%	29 <sup>48</sup>
Federal Medical Assistance Percentage (FMAP)	50% (minimum) <sup>49</sup>	50%	NA

40 *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/>, extracted July 28, 2015. We use this source for consistency between states, but data provided by New Hampshire’s Office of Legislative Budget Assistant gave a somewhat different breakout of spending by budget category.

41 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>.

42 *Ibid.*, p. 221.

43 *Ibid.*

44 *Ibid.*

45 *Ibid.*

46 *Ibid.*

47 *Ibid.*

48 *Ibid.*

49 *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/>, extracted July 28, 2015.

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.<sup>50</sup>

New Hampshire has the lowest possible Federal Medical Assistance Percentage, 50 percent, which means the state has to raise one dollar in state funds to get one dollar in federal Medicaid funds. New Hampshire has the highest percentage of its state general fund expenditures going to Medicaid, 40.4 percent. New Hampshire ranked above average in most of the key measures of long-term care spending increases in the five year period between 2004 and 2009. Nursing facility spending nearly doubled the national rate of increase (23 percent compared to 12 percent, rank 10) and HCBS spending increased faster than the national rate (80 percent compared to 70 percent, rank 18), but because of New Hampshire's disproportionately high increase in nursing facility spending, its HCBS spending as a percentage of total LTC spending increased at only slightly more than half of the national rate (5 percent compared to 9 percent), rank 29.

More recent data, however, indicate a major change in New Hampshire's LTC spending patterns. The state spent less on nursing facilities in Fiscal Year (FY) 2013 (\$300.2 million) than it did in FY 2009 (\$303.2 million) and its "rebalanced" spending on Home and Community-Based Services (HCBS) accelerated significantly between those years from \$251.0 million in FY 2009 to \$385.1 million in FY 2013.<sup>51</sup> Combining nursing facility and HCBS expenditures, New Hampshire spent \$683.3 million on long-term care in FY 2013 compared to \$554.2 million in FY 2009, an increase of \$129.1 or 23.3 percent. Thus, total LTC expenditures continue to rise despite the decline in spending for nursing homes because of the rapid increase in HCBS spending.

After reviewing all three sub-sections of Section 3 (Public Funding--Medicaid), assign a weight to the section and scores to each of the sub-sections in the Table of LTC Vulnerability.<sup>52</sup>

---

50 For further explanation, 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](http://www.centerlrc.com/BriefingPapers/4.htm).

51 We used the older data cited for 2004-2009 from AARP's "Across the States" report for consistency between all states and spending categories. The newer data comes from Steve Eiken, Kate Sredl, Brian Burwell, and Paul Saucier, "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending," Truven Health Analytics, June 30, 2015, Table 30; available [here](#) at a very long URL.

52 The Table of Long-Term Care Vulnerability is a worksheet in "Appendix 3" designed to help the reader translate objective data provided in this report into a subjective estimate (best guess) of the future prospects for long-term care service delivery and financing nationwide and in New Hampshire. Whenever you see the instruction "assign a weight and score," we invite you to open the Table of LTC Vulnerability and indicate your best sense of the factor's significance." The author's filled out Table of LTC Vulnerability is provided for comparison.

## Public Funding (Medicaid) Continued

### 3b. Other Medicaid Factors

**The Affordable Care Act, AKA ObamaCare:** New Hampshire implemented Medicaid expansion under the Patient Protection and Affordable Care Act of 2010 (PPACA '10), but with an escape hatch. The authorizing legislation is sunsetted to expire on December 31, 2016 unless reauthorized. The state's objective was to take advantage of PPACA '10's 100 percent federal funding during the first year of implementation, after which future participation could be reassessed. Based on our interviews with state legislators, it remains uncertain whether New Hampshire will continue to participate in the "ObamaCare" program after 2016. The Kaiser Family Foundation has published details on New Hampshire's program.<sup>53</sup> Whatever its merits or deficiencies, Medicaid expansion under PPACA '10 would entail substantial increases in caseload and cost for New Hampshire's program over the long run.

### *Medicaid LTC Financial Eligibility and Medicaid Planning*

#### *Income Eligibility*

**Because the average Medicaid nursing home reimbursement rate in New Hampshire is \$157 per day or \$57,305 per year [within the U.S. middle income quintile], any medically qualified elderly person with net income at or below that level is eligible based on income.**

Eligibility for Medicaid long-term care benefits is not as difficult to attain in the United States as commonly reported. New Hampshire is no exception. The State Department of Health and Human Services' (DHHS) website explains that applicants "Must have net monthly income less than the rate Medicaid pays to the facility."<sup>54</sup> Net monthly income is determined by subtracting eligible health care and other expenditures paid out of pocket by the Medicaid applicant from the applicant's total income. Such deductions can be substantial. Because the average Medicaid nursing home reimbursement rate in New Hampshire is \$157 per day or \$57,305 per year, any medically qualified elderly person with net income at or below that level is eligible based on income. Although media and even academic studies on Medicaid long-term care financing invariably say the program is only available to low-income people, the truth is that people with income of \$57,305 per year fall in the middle income quintile for all Americans according to the U.S. Census Bureau, as of 2013.<sup>55</sup> Hardly low income.

#### *Asset Eligibility*

Medicaid long-term care applicants must also qualify based on their level of financial resources. The DHHS website cited earlier says the "Resource limit cannot exceed \$2,500." That's what most articles and reports also say, but the statement is misleading because it does not take into account exempt resources.

---

<sup>53</sup> "Medicaid Expansion in New Hampshire," Kaiser Family Foundation, March 27, 2015; <http://kff.org/medicaid/factsheet/medicaid-expansion-in-new-hampshire/>. Extracted August 10, 2015.

<sup>54</sup> "Nursing Home Care," New Hampshire Department of Health and Human Services; <http://www.dhhs.state.nh.us/dcbcs/beas/nursinghome.htm>. Extracted August 10, 2015.

<sup>55</sup> U.S. Census Bureau; <http://www.census.gov/hhes/www/income/data/historical/families/2013/f01AR.xls>. Extracted August 10, 2015.

**Since homes with less than \$552,000 in equity are not countable assets, most homeowners may qualify for Medicaid.**

To pinpoint those uncounted assets, it is helpful to consult the lawyers who advise clients on how to become eligible for Medicaid LTC benefits. According to the Elder Law, Estate Planning, and Probate Section of the New Hampshire Bar Association and New Hampshire Legal Assistance in their “Medicaid Income and Asset Rules for Nursing Home Residents and Guide for New Hampshire Residents Seeking Medicaid Coverage For Nursing Home Care,”<sup>56</sup> “A person’s home as long as the equity value is less than \$552,000, motor vehicle, furniture, clothing and other personal effects are not countable” which means “Since homes with less than \$552,000 in equity are not countable assets, most homeowners may qualify for Medicaid.”

Other exempt assets, none of which have a dollar limit, include one business, Individual Retirement Accounts (IRAs), prepaid burial plans, and term life insurance. For a full list of exempt assets including footnoted links to the authorizing federal regulations, see the Pacific Research Institute’s “Medi-Cal Long-Term Care: Safety Net or Hammock.”<sup>57</sup> People can and do convert countable assets into noncountable assets by purchasing more expensive homes, new cars and other exempt resources with or without legal advice.<sup>58</sup>

### *Spousal Impoverishment Protections*

Recipients with spouses encounter far more generous income and asset eligibility rules, including a maximum spousal maintenance allowance of \$2,981 per month and a spousal resource allowance equal to half the couple’s joint assets up to a maximum of \$119,220 with a minimum of no less than \$23,844 as of 2015.<sup>59</sup> These allowances increase annually with inflation. Balances in excess of those limits are supposed to be “spent down,” but the Bar Association guide explains “It is important to note that the money which must be spent down can be used for any purpose that would benefit either spouse, such as home repairs, vehicles, life insurance, prepaid funerals, furniture, travel, etc.”<sup>60</sup> These “spousal impoverishment protections,” originally intended to protect only spouses of institutionalized Medicaid recipients, were recently expanded to cover husbands or wives of Home and Community-Based Services (HCBS) recipients as well.<sup>61</sup>

56 Elder Law, Estate Planning, and Probate Section of the New Hampshire Bar Association and New Hampshire Legal Assistance, “Medicaid Income and Asset Rules for Nursing Home Residents and Guide for New Hampshire Residents Seeking Medicaid Coverage For Nursing Home Care,” January 1, 2015, available [here](#) at a very long URL. Cited as of August 10, 2015.

57 Stephen A. Moses, “Medi-Cal Long-Term Care: Safety Net or Hammock,” Pacific Research Institute, San Francisco, California, pps. 19-21; [http://www.centerltc.com/pubs/Medi-Cal\\_LTC--Safety\\_Net\\_or\\_Hammock.pdf](http://www.centerltc.com/pubs/Medi-Cal_LTC--Safety_Net_or_Hammock.pdf).

58 For details and examples, see Stephen A. Moses, “Briefing Paper #2: Medicaid Long-Term Care Eligibility,” [www.centerltc.com/BriefingPapers/2.htm](http://www.centerltc.com/BriefingPapers/2.htm) and Briefing Paper #3: Medicaid Planning for Long-Term Care, [www.centerltc.com/BriefingPapers/3.htm](http://www.centerltc.com/BriefingPapers/3.htm), which are parts of “How to Fix Long-Term Care,” Center for Long-Term Care Reform, Seattle, Washington, 2012; <http://www.centerltc.com/BriefingPapers/Overview.htm>.

59 Elder Law, Estate Planning, and Probate Section of the New Hampshire Bar Association and New Hampshire Legal Assistance, “Medicaid Income and Asset Rules for Nursing Home Residents and Guide for New Hampshire Residents Seeking Medicaid Coverage For Nursing Home Care,” January 1, 2015, available [here](#) at a very long URL, pps.6-7. Cited as of August 10, 2015.

60 *Ibid.*, p. 7.

61 CMS State Medicaid Director Letter, “Affordable Care Act’s Amendments to the Spousal Impoverishment Statute,” SMD# 15-001, ACA# 32, May 7, 2015; <http://salsa4.salsalabs.com/dia/track.jsp?v=2&c=DFLBSkzLKEZjgzA8Bnop-w%2FmgdUfyUIo9>.

The “ElderLawAnswers website”<sup>62</sup> speaks to some additional nuances. For example, if applicants are not happy with their community spouse resource allowance, “a fair hearing can be obtained.” The “Average monthly cost of nursing home care according to [the] state[is] : \$8,889.94 (\$292.24/day).” That means Medicaid applicants are penalized only one month of eligibility for each nearly \$9,000 they give away for the purpose of qualifying for Medicaid. Finally: “Actuarially sound annuities are permitted, with certain restrictions.” More follows below on the enormous costs to Medicaid such annuities can entail.

### *Medicaid Planning*

It is clear from the foregoing, that Medicaid applicants with substantial income and wealth can qualify for Medicaid long-term care benefits with little or no asset spend down required. But the long-term care eligibility rules are complicated and elastic. Applicants, and their families, with even much greater income and assets than allowed under the basic rules summarized above often consult lawyers who specialize in the artificial impoverishment of clients to qualify them for Medicaid. Such “Medicaid Planning” specialists are easy to find. When asked, interviewees for this project spoke of how Medicaid planners advertise frequently on the radio and in newspapers throughout New Hampshire. Elder law experts are also easy to find online by means of an internet search for “Medicaid planning in New Hampshire.” For example:

We assist clients with asset preservation and asset protection for themselves and their families in anticipation of applying for long-term care through the Medicaid program. . . . Our attorneys have significant experience in asset protection strategies, such as Medicaid-Qualifying Irrevocable Trusts; Special Needs Trusts; conversion of assets into income through the use of Medicaid-Qualifying Annuities; Personal Care and Service Agreements; as well as other spend-down techniques that allow for transfers of assets to family members without violating Medicaid gifting rules. We frequently work with clients when preparing and filing New Hampshire and Massachusetts Medicaid applications, meeting with caseworkers for applicant resource assessments, as well as successfully litigating denials of Medicaid benefits.<sup>63</sup>

### *Medicaid-Compliant Annuities*

One of the more egregious eligibility “loopholes” that Medicaid planning attorneys and their clients take advantage of is the “Medicaid-compliant or Medicaid-qualifying annuity.” Such annuities can be used to shelter large sums of money immediately before an individual applies for Medicaid long-term care benefits, as much as a million dollars or more in some states. We sought but

---

62 “Key Medicaid Information for New Hampshire for 2015,” *ElderLawAnswers*; <http://www.elderlawanswers.com/key-medicaid-information-for-new-hampshire-for-2015-12209>. Extracted August 10, 2015.

63 McLane, Graf, Raulerson & Middleton Professional Association: <http://www.mclane.com/services/practice-groups/trust-and-estates/medicaid-planning.aspx>. “McLane services clients from its four offices, with three located in New Hampshire – Concord, Manchester and Portsmouth. Our newest office is in Woburn, MA.” Extracted August 10, 2015.

were not able to arrange interviews with New Hampshire's Medicaid long-term care eligibility policy specialist to learn specifically how such annuities are reviewed and treated by DHHS. For details on the Medicaid-compliant annuity problem nationally, see "LTC Bullet: Medicaid Annuity Abuse: A Case Study."<sup>64</sup> Annuity cases involving hundreds of thousands of dollars are commonplace and well-documented. So far state Medicaid programs have been unsuccessful in several attempts to reverse the use of Medicaid-compliant annuities in state and federal courts.

### *209-B Status*

**The bottom line, however, on Medicaid long-term care eligibility in New Hampshire, as elsewhere, is that people who seek state funding for long-term care and are willing to accept the conditions that apply, can, with or without the legal assistance of a Medicaid planner, qualify for assistance much more easily than is commonly understood.**

It is true that eligibility in New Hampshire is slightly more restrictive, and could be made even more so, because it is one of ten "209-B" states. This means New Hampshire was grandfathered in with more restrictive eligibility requirements than were allowed after the Supplemental Security Income Program (SSI) replaced state welfare programs for the aged, blind and disabled in 1974. For example, 209-B states "do not automatically grant Medicaid to persons with disabilities who qualify for SSI because they use their own criteria for determining whether someone is eligible for Medicaid. These states may have income limits that are higher or lower than SSI's, different asset limits, or different requirements for what makes someone disabled."<sup>65</sup> New Hampshire's 209-B status enables the state to require institutionalized recipients to sell their homes within six months if they have no exempt relatives occupying their home and no reasonable medical expectation that they will be able to return home.<sup>66</sup> Non-209-B states do not have this flexibility.

The bottom line, however, on Medicaid long-term care eligibility in New Hampshire, as elsewhere, is that people who seek state funding for long-term care and are willing to accept the conditions that apply, can, with or without the legal assistance of a Medicaid planner, qualify for assistance much more easily than is commonly understood.

### ***Low Reimbursement and Cost Shifting***

#### *Nursing Facility Providers*

In our interviews with long-term care providers and their trade association representatives, to the person each complained that New Hampshire Medicaid's reimbursement rates are inadequate and threaten the viability of publicly funded long-term care services. When asked "What are the biggest challenges facing the nursing home profession in New Hampshire today?" respondents concurred

---

64 Stephen A. Moses, "LTC Bullet: Medicaid Annuity Abuse: A Case Study," Center for Long-Term Care Reform, Seattle, Washington, June 5, 2015; <http://www.centerlrc.com/bullets/archives2015/1088.htm>.

65 "Does Medicare or Medicaid Come With Social Security or SSI Disability Benefits?," *Nolo Law for All*; <http://www.nolo.com/legal-encyclopedia/does-medicare-medicaid-come-with-social-security-ssi-disability-benefits.html>. Extracted August 10, 2015.

66 Elder Law, Estate Planning, and Probate Section of the New Hampshire Bar Association and New Hampshire Legal Assistance, "Medicaid Income and Asset Rules for Nursing Home Residents and Guide for New Hampshire Residents Seeking Medicaid Coverage For Nursing Home Care," January 1, 2015, p. 3; available [here](#) at a very long URL. Cited as of August 19, 2015.



**With 64 percent of their caseload on Medicaid, New Hampshire nursing homes are losing money on nearly two thirds of their residents.**

unequivocally “It has to be inadequate Medicaid reimbursement. We suffer an actual cash loss per patient day. This is the difference between allowable costs and what we actually get paid.”<sup>67</sup>

Research sponsored and reported by the American Health Care Association confirms this assessment. New Hampshire Medicaid’s 2012 nursing home reimbursement rate was \$179.66 which only partially covered average costs of \$237.05 leaving a shortfall of \$57.38 per bed day,<sup>68</sup> the highest shortfall in the United States for that year. Currently, interviewees estimated that the reimbursement rate is only \$157 per day which is 29.8 percent less than allowable costs of \$224 representing a shortfall of \$67 per bed day. Because their private-pay rate is just over \$300, New Hampshire’s nursing homes are receiving only slightly more than half from Medicaid what private patients must pay, which amounts to a serious problem of cost shifting.

With 64 percent of their caseload on Medicaid, New Hampshire nursing homes are losing money on nearly two thirds of their residents. How do they survive? “Cut backs, wage freezes, eliminating positions, curtailing services that don’t affect quality, and by attracting private payers and Medicare patients at higher rates.” Unfortunately, private payers are harder and harder to find and Medicare’s more generous reimbursement rates are being steadily reduced.

#### *Home and Community-Based Providers*

Gina Balkus of the Home Care Association of New Hampshire and Eldon Munson of the New Hampshire Association of Residential Care Homes (NH-ARCH), who represent most of the providers of home and community-based care under New Hampshire’s Choices for Independence waiver, had similar things to say. Ms. Balkus observed that “It can take months to get Medicaid approval” which means providers have to carry the Medicaid applicants in the meantime and may lose out entirely if Medicaid coverage is eventually denied. Because “by statute residential care can’t cost more than 60 percent in aggregate or 80 percent per person nor home care more than 50 percent of nursing home cost,” reimbursement under the Choices for Independence waiver is “woefully inadequate” and “some agencies are saying they can’t afford to do CFI [Choices for Independence waiver] anymore.”<sup>69</sup>

Munson of NH-ARCH also emphasized payment issues under the Choices for Independence waiver for which the per diem rate of \$49 only covers care. Providers need to seek private or other public funding for room and board costs. Mr. Munson stated:

---

67 Interview on June 15, 2015 with representatives of the New Hampshire Health Care Association, LeadingAge Maine & New Hampshire, Catholic Charities New Hampshire, and the Webster at Rye nursing facility.

68 “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](http://www.ahcancal.org/research_data/funding/Documents/FINAL%20Medicaid%20Underfunding%20for%20Nursing%20Home%20Care%20Report.pdf).

69 Interview with Gina Balkus, CEO, Home Care Association of New Hampshire, on June 29, 2015.

All told the typical fee is in the \$2,300 range, which is half the going rate for private-pay assisted living in New Hampshire. The only way these small providers survive on 100 percent Medicaid is by doing the work themselves and keeping expenses very tight. Rate levels today are poised to drive all the Medicaid providers out of the business. They're not making any profit; just paying themselves a salary.

Billing Medicaid is also a major problem. "Providers have to have a full time billing person just for Medicaid." What nursing home and home care providers projected as serious financial problems caused by low Medicaid reimbursement rates took on a tone of near desperation on behalf of small, 100 percent Medicaid "assisted living" providers.<sup>70</sup>

The net effect of low Medicaid long-term care reimbursement rates at all levels of care is that costs are either shifted to other sources of private or public funding or providers go out of business. The more cost shifting that occurs, the higher private pay rates become and the greater incentive private payers have to qualify for Medicaid. But as private payers disappear, the burden of funding Medicaid becomes greater and greater. It is a downward cycle that becomes catastrophically more dangerous in times of economic recession.

---

<sup>70</sup> Interview with Eldon Munson, Board President for the New Hampshire Association of Residential Care Homes, on July 7, 2015.

### Summary and Scoring for Public Funding (Other Medicaid Factors)

Other Medicaid factors	United States	New Hampshire
Medicaid expansion under ACA?	31 yes; 19 no; 1 undecided as of August 12, 2015 <sup>71</sup>	Yes, expanding
Medicaid LTC eligibility and Medicaid planning (Rank on range from less easy to more easy)	Easy <sup>72</sup>	Less easy <sup>73</sup>
Low reimbursement vulnerability (shortfall per SNF bed day)	\$21.20 <sup>74</sup>	\$57.38 <sup>75</sup>
Cost shifting: Medicaid nursing home rate as percentage of private pay rate	92.2% <sup>76</sup>	74.1% <sup>77</sup>

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, and (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.<sup>78</sup>

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

71 *State Health Facts*, The Henry J. Kaiser Family Foundation, “Status of State Action on the Medicaid Expansion Decision,” as of August 12, 2015, <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medic-aid-under-the-affordable-care-act/>.

72 See footnotes #9 and #11 for why Medicaid LTC financial eligibility is relatively “easy.”

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

74 “A Report on Shortfalls in Medicaid Funding for Nursing Center Care,” ELJAY, LLC for the American Health Care Association, March 2015, p. 1, [http://www.ahcancal.org/research\\_data/funding/Documents/2014%20Medicaid%20Underfunding%20for%20Nursing%20Center%20Care%20FINAL.pdf](http://www.ahcancal.org/research_data/funding/Documents/2014%20Medicaid%20Underfunding%20for%20Nursing%20Center%20Care%20FINAL.pdf).

75 New Hampshire is not included in the “shortfalls” report published in March 2015, because the New Hampshire Health Care Association was unable to get the necessary data from the Medicaid state agency. New Hampshire’s shortfall in the previous report (published December 2012) was \$57.38 per bed day, the highest in the country according to “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](http://www.ahcancal.org/research_data/funding/Documents/FINAL%20Medicaid%20Underfunding%20for%20Nursing%20Home%20Care%20Report.pdf).

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. 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.

77 *Ibid.*, p. 219.

78 For details, see footnotes #9 and #11 and Stephen A. Moses, “Briefing Paper #2: Medicaid Long-Term Care Eligibility,” Center for Long-Term Care Reform, Seattle, Washington, <http://www.centerltc.com/BriefingPapers/2.htm>.

ity workers to show definitely whether New Hampshire has a more strict or less strict LTC eligibility system.

After reviewing all three sub-sections of Section 3 (Public Funding--Medicaid), assign a weight to the section and scores to each of the sub-sections in the Table of LTC Vulnerability.<sup>79</sup>

## Public Funding (Medicaid) Continued

### 3c. Special Medicaid Challenges: Dual Eligibles, Rebalancing and Managed Care

#### *Dual Eligibles*

Nationally, older and disabled Medicaid recipients consume a disproportionate share of total program expenditures. For example, the aged, blind and disabled are 1/4 of Medicaid recipients (24 percent)<sup>80</sup> but account for nearly 2/3 of program costs (63 percent),<sup>81</sup> whereas poor women and children are 3/4 of the recipients (75 percent)<sup>82</sup> but account for only slightly more than 1/3 of the cost (36 percent).<sup>83</sup> This disproportionality of Medicaid spending is slightly less pronounced in New Hampshire where 29 percent<sup>84</sup> of Medicaid recipients are aged, blind and disabled but account for 67 percent of program costs,<sup>85</sup> whereas poor women and children are 72 percent of New Hampshire's recipients,<sup>86</sup> but account for 33 percent of the cost.<sup>87</sup>

Another group that consumes a disproportionate share of Medicaid expenditures consists of people eligible for both Medicaid and Medicare, known as "dual eligibles." Although they're only 14 percent of all Medicaid recipients, the 9.6 million

---

79 The Table of Long-Term Care Vulnerability is a worksheet in "Appendix 3" designed to help the reader translate objective data provided in this report into a subjective estimate (best guess) of the future prospects for long-term care service delivery and financing nationwide and in New Hampshire. Whenever you see the instruction "assign a weight and score," we invite you to open the Table of LTC Vulnerability and indicate your best sense of the factor's significance." The author's filled out Table of LTC Vulnerability is provided for comparison.

80 Kaiser Family Foundation, [StateHealthFacts.org](http://kff.org/medicaid/state-indicator/distribution-of-medicare-enrollees-by-enrollment-group/), "Distribution of Medicare Enrollees by Enrollment Group," extracted August 12, 2015;

<http://kff.org/medicaid/state-indicator/distribution-of-medicare-enrollees-by-enrollment-group/>.

81 Kaiser Family Foundation, [StateHealthFacts.org](http://kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/), "Medicaid Spending by Enrollment Group," extracted August 12, 2015; <http://kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/>.

82 Kaiser Family Foundation, [StateHealthFacts.org](http://kff.org/medicaid/state-indicator/distribution-of-medicare-enrollees-by-enrollment-group/), "Distribution of Medicare Enrollees by Enrollment Group," extracted August 12, 2015;

<http://kff.org/medicaid/state-indicator/distribution-of-medicare-enrollees-by-enrollment-group/>.

83 Kaiser Family Foundation, [StateHealthFacts.org](http://kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/), "Medicaid Spending by Enrollment Group," extracted August 12, 2015; <http://kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/>.

84 Kaiser Family Foundation, [StateHealthFacts.org](http://kff.org/medicaid/state-indicator/distribution-of-medicare-enrollees-by-enrollment-group/), "Distribution of Medicare Enrollees by Enrollment Group," extracted August 12, 2015;

<http://kff.org/medicaid/state-indicator/distribution-of-medicare-enrollees-by-enrollment-group/>.

85 Kaiser Family Foundation, [StateHealthFacts.org](http://kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/), "Medicaid Spending by Enrollment Group," extracted August 12, 2015; <http://kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/>.

86 Kaiser Family Foundation, [StateHealthFacts.org](http://kff.org/medicaid/state-indicator/distribution-of-medicare-enrollees-by-enrollment-group/), "Distribution of Medicare Enrollees by Enrollment Group," extracted August 12, 2015;

<http://kff.org/medicaid/state-indicator/distribution-of-medicare-enrollees-by-enrollment-group/>.

87 Kaiser Family Foundation, [StateHealthFacts.org](http://kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/), "Medicaid Spending by Enrollment Group," extracted August 12, 2015; <http://kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/>.

duals in the U.S. account for 36 percent of all Medicaid expenditures.<sup>88</sup> This disproportionality of spending on duals holds true in New Hampshire where 19 percent of recipients who are duals accounted for 49 percent of spending.<sup>89</sup> What's more, on average 65 percent of Medicaid spending on duals nationally was for long-term care.<sup>90</sup> New Hampshire is one of only four states where long-term care spending on duals was 80 percent or more of total Medicaid spending on duals.<sup>91</sup>

The heaviest users of Medicaid's most expensive benefit (LTC)—dual eligibles and the aged, blind and disabled (ABD)—consume a disproportionate share of Medicaid's total resources. Therefore, every actual or potential dual eligible, ABD or LTC recipient diverted from Medicaid dependency will result in a disproportionate savings to the Medicaid program. Conclusion: prevent future Medicaid dependency for even a small number of these heavy LTC users and the savings will be extraordinarily high. We will emphasize and operationalize this potential in the "Recommendations" section of this report.

### ***Rebalancing***

The federal Medicaid LTC program began in 1965. To win industry support, the new program originally paid exclusively and generously for nursing home care. But exploding costs and declining quality led in time to calls for Medicaid to "deinstitutionalize" or "rebalance" LTC benefits. The Omnibus Budget Reconciliation Act of 1981 authorized home and community-based services (HCBS) waivers which allowed state Medicaid programs to fund home care with restrictions. For example, states could not spend more for HCBS than they would have spent for nursing home care.

The Supreme Court's 1999 "Olmstead" decision held that people with disabilities have the right to live at home or in the community if they are able and do not prefer nursing home care. Olmstead encouraged states to provide more HCBS within reasonable budget limitations. Major initiatives during the George W. Bush administration expanded opportunities for state Medicaid programs to cover HCBS. The Deficit Reduction Act of 2005 and the Affordable Care Act of 2010 (health care reform) also added options and funding to encourage rebalancing to HCBS.

The argument in favor of rebalancing, made strenuously by many academic and policy experts, is that taking care of frail or chronically ill elders in their homes is much cheaper than in a nursing home. Therefore, rebalancing from skilled nursing facility (SNF) services to HCBS should save the state and federal Medicaid programs money while giving people more of what they want (home care)

---

88 Katherine Young, *et al.*, "Medicaid's Role for Dual Eligible Beneficiaries," The Kaiser Commission on Medicaid and the Uninsured, August 2013, p. 1; available [here](#) at a very long URL.

89 *Ibid.*, "Table 4a: Medicaid Expenditures for Dual Eligible Beneficiaries by State, 2010," p. 8.

90 Katherine Young, *et al.*, "Medicaid's Role for Dual Eligible Beneficiaries," The Kaiser Commission on Medicaid and the Uninsured, August 2013, p. 2; available [here](#) at a very long URL.

91 *Ibid.*, p. 7.

and less of what they would rather avoid (nursing home care). But is that true? Decades of empirical research have sown doubt. For example:

- When compared to an elderly population for whom traditionally available care is offered, recipients of expanded community-based services do not use significantly fewer days of nursing home care.<sup>92</sup>
- The Channeling demonstration... found that, while community-care models were often welcome by recipients and their caregivers, they led to overall increases in public spending for long-term care.<sup>93</sup>
- The primary argument for the cost savings potential of home care rests on a comparison of the average per person Medicaid expenditures for people in the community and in nursing homes... This comparison, however, is incomplete because it does not address differences in disability levels, use of acute care services, and the exclusion of housing and room and board costs from home care expenditures. Thus, it is not strictly an 'apples to apples' comparison.<sup>94</sup>
- The research evidence that changing [*i.e.*, rebalancing] the delivery system will produce substantial Medicaid savings is not strong, but it is a premise strongly held by many state officials and consumer advocates.<sup>95</sup>

**The research evidence that changing [*i.e.*, rebalancing] the delivery system will produce substantial Medicaid savings is not strong, but it is a premise strongly held by many state officials and consumer advocates.**

Nevertheless, as we saw in our examination of New Hampshire's Medicaid long-term care expenditures for elderly recipients over the past decade, cost increases have been moderate (11.5 percent) during a period of gradual and increasing rebalancing of benefits from institutional to home and community-based services. Setting aside for now concerns already discussed related to the aging of the population, should policy makers assume savings from rebalancing will moderate LTC expenditure growth in the future? Probably not for reasons that go beyond the empirical findings referenced above. For example:

- Most people prefer to receive long-term care in their homes rather than in a nursing home. Providing home and community-based services makes Medicaid more desirable than it would otherwise be and thus reduces consumers' sense of urgency about planning to pay privately for long-term care. The more attractive Medicaid financing becomes, the more people will seek ways to take advantage of it and such ways are readily available as explained in the sections on LTC financial eligibility and Medicaid planning.

---

92 General Accounting Office, "The Elderly Should Benefit From Expanded Home Health Care But Increasing Those Services Will Not Insure Cost Reductions" (Dec. 7, 1982), p. 43, <http://archive.gao.gov/f0102/120074.pdf>

93 Francis Caro, "Long-Term Care: Informed by Research," AcademyHealth, Washington, D.C., 2003, p. 2; <http://www.academyhealth.org/files/publications/lcresearch.pdf>.

94 Joshua M. Wiener and Wayne L. Anderson, "Follow the Money: Financing Home and Community-Based Services," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2009, p. 10, footnote omitted; available [here](#) at a very long URL.

95 *Ibid.*, p. 22.

- Medicaid-financed home and community-based care runs the risk of replacing so-called “free” care provided by friends, family, and loved ones.<sup>96</sup> AARP estimates the economic value of such care at \$470 billion per year.<sup>97</sup> Obviously, given the enormous financial and emotional strain it places on caregivers, such care is hardly free. But it does help to offset formal care that would otherwise be paid by Medicaid.
- Other tough questions arise: Would people who receive HCBS have otherwise entered skilled nursing facilities (SNFs)? Does home care reduce costs or merely add recipients? Isn't losing the institutional economy of scale very expensive? How can providing home care services people want instead of nursing home care they dread save money? Won't it be much harder and more expensive to monitor care quality in small, home-like settings compared to sending teams of reviewers into nursing facilities?

That people prefer home care to care in a nursing home is well established and irrefutable. Ensuring that long-term care is provided in the most appropriate setting and that care is available along a wide continuum from the patient's home, through supervised residential care, to highly skilled, 24-hours-a-day nursing facility care is a worthy goal that should be pursued. The point here is that rebalancing Medicaid from principally institutional to mainly home and community-based care may not be the money saver many have expected. It may rather be necessary to find alternative and additional public or private sources of LTC financing in order to achieve the objective of expanding the continuum of care nationwide.

### ***Managed Care***

When I served as the federal HCFA<sup>98</sup> state representative for Oregon in 1982, Medicaid was purely cost plus and fee-for-service. Any Medicaid recipients anywhere in the state could see any Medicaid provider who would schedule an appointment with them. We frequently saw examples of elderly recipients scheduling numerous health care appointments for no apparent reason other than to have something to do and someone with whom to speak and visit. That was a very expensive way to manage Medicaid.

So over the years the rules have changed. Nowadays, most Medicaid acute care is provided through managed care organizations (MCOs). State Medicaid agencies farm out the responsibility to provide health care for recipients to MCOs,

---

<sup>96</sup> How much more would the following finding apply to free Medicaid-financed HCBS than for expensive private long-term care insurance? “LTCI coverage induces less informal caregiving, suggesting the presence of intra-family moral hazard. We also find that children are less likely to co-reside or live nearby parents with LTCI and more likely to work full-time, suggesting that significant economic gains from private LTCI could accrue to the younger generation.” Source: Norma B. Coe, Gopi Shah Goda, Courtney Harold Van Houtven, “Family Spillovers of Long-Term Care Insurance,” National Bureau of Economic Research (NBER) Working Paper 21483, p. 2; <http://www.nber.org/papers/w21483>.

<sup>97</sup> Susan C. Reinhard, *et al.*, “Valuing the Invaluable: 2015 Update, Undeniable Progress, but Big Gaps Remain,” AARP Public Policy Institute, July 2015, p. 1; <http://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-undeniable-progress.pdf>.

<sup>98</sup> The Health Care Financing Administration was the predecessor organization to the Centers for Medicare and Medicaid Services.

usually large private insurance companies. The Medicaid agencies set a maximum reimbursement level below what they would otherwise expect to spend for a certain population over a prescribed period of time and they invite the MCOs to bid for contracts to deliver specified health care services to that group.

On the acute care side of Medicaid, managed care has been a panacea. It allows state Medicaid programs to get out from under the responsibility of managing recipients' care while, simultaneously, saving money automatically by setting global reimbursement maximums. In 2014, Avalere Health predicted that more than three-fourths of Medicaid recipients would be enrolled in a managed care plan by 2016.<sup>99</sup>

Medicaid managed care is now sweeping into the long-term care side of the program as well. Data tracking has not yet caught up with managed care's rapid expansion. Truven Health Analytics reports that:

Expenditures for LTSS provided through managed care organizations grew 44 percent in FY 2013, from \$10.0 billion to \$14.4 billion. Managed care accounted for 9.9 percent of [overall] LTSS spending in FY 2013. Because of ongoing challenges with collecting managed care data, not all managed care spending is included. As a result, the \$14.4 billion figure is a conservative estimate.<sup>100</sup>

Furthermore, "For programs targeting older adults and people with physical disabilities, MLTSS was 12.8 percent of all Medicaid LTSS spending."<sup>101</sup> Clearly, Medicaid managed long-term care expansion is accelerating at a rapid pace and with a steep level of ascent.

### ***Managed Care for Dual Eligibles***

The latest development is the expansion of Medicaid managed long-term care in some states, including New Hampshire, to cover dual eligibles, the frailest and most chronically ill of all Medicaid recipients. Senior advocates have expressed concern about this move. They urge caution until the new approach has been put to the test of ongoing demonstration projects.

Given the extensive and diverse health care needs of the dual-eligible population and the lack of proven approaches to successfully coordinate care across Medicare and Medicaid on a large scale, federal policymakers should await the results of these demonstrations rather than act precipitously to take risky steps such

---

<sup>99</sup> "In total, managed care enrollment will increase from 67 percent of total Medicaid and CHIP enrollees in 2013 to 76 percent in 2016." Source: Caroline F. Pearson, "Avalere Analysis: Medicaid Managed Care Enrollment Set to Grow by 13.5 Million," October 23, 2014; <http://avalere.com/expertise/managed-care/insights/avalere-analysis-medicaid-managed-care-enrollment-set-to-grow-by-13.5-milli>.

<sup>100</sup> Steve Eiken, Kate Sredl, Brian Burwell, and Paul Saucier, "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending," Truven Health Analytics, June 30, 2015, p. 4; available [here](#) at a very long URL.

<sup>101</sup> *Ibid.*, p. 17.



as moving large numbers of dual eligibles into managed care on a mandatory basis and capping federal funding for their health care services.<sup>102</sup>

In “Mandatory Managed Care for Dual Eligibles Could Harm Patients and Stifle Innovation,” the Center for Medicare Advocacy, Inc.; Families USA; the Medicare Rights Center; the National Committee to Preserve Social Security & Medicare; the National Council on Aging; and the National Senior Citizens Law Center worry that such programs are “one-size-fits-all” and that “Most Medicaid managed care plans have never before been tasked with providing long term services and supports, a key issue for the dually eligible population.”<sup>103</sup>

It also appears that potential dual eligible participants in Medicaid managed long-term care are not very eager to take part. According to *Modern Healthcare*:

There are growing worries about the future of an ambitious federal demonstration aimed at improving coordination of care for millions of low-income and disabled Americans who are dually eligible for Medicaid and Medicare. . . . The main reason why states are struggling to achieve their cost-savings goals is that beneficiaries’ participation is optional and many are deciding to opt out, the plans say.<sup>104</sup>

The Centers for Medicare and Medicaid Services (CMS) has proposed 653 pages of new rules to shore up Medicaid managed care. For example, they propose a minimum medical loss ratio for such plans. Participating MCOs would have to spend at least 85 percent of the premiums they collect on medical care, not administration or profits. The new rules, if implemented will also place numerous regulatory constraints on everyone involved in managed care. A long article in *Health Affairs* summarizes provisions of the proposed rules.<sup>105</sup>

The expansion of Medicaid managed care into serving long-term care recipients, especially dual eligibles, has New Hampshire’s long-term care providers very concerned. Nursing home representatives worry about a two percent “handlers’ fee” they say the Affordable Care Act mandated. They puzzle over how putting another third party, the MCO, in between Medicaid and nursing homes is going to save money. With only two MCOs bidding in New Hampshire, they point out competition is very limited. They also observe that everyone involved in the

---

102 Judith Solomon “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, D.C., October 10, 2012, pps. 1-2; <http://www.cbpp.org/files/10-10-12health.pdf>.

103 Center for Medicare Advocacy, Inc., Families USA, Medicare Rights Center, National Committee to Preserve Social Security & Medicare, National Council on Aging, and the National Senior Citizens Law Center, “Mandatory Managed Care for Dual Eligibles Could Harm Patients and Stifle Innovation,” undated; <http://www.medicarerights.org/pdf/Dual-Eligibles-and-Mandatory-Managed-Care.pdf>.

104 Virgil Dickson, “Future of dual-eligible demonstrations questioned due to low enrollment,” *Modern Healthcare*, April 21, 2015; <http://www.modernhealthcare.com/article/20150421/NEWS/150429978/future-of-dual-eligible-demonstrations-questioned-due-to-low>.

105 Sara Rosenbaum, “Game Changer: CMS’ Proposed Medicaid Managed Care Regulation,” *Health Affairs Blog*, June 10, 2015; <http://healthaffairs.org/blog/2015/06/10/game-changer-cms-proposed-medicaid-managed-care-regulation/>.

process, including DHHS, the MCOs and the LTC providers, needs answers that have not yet been forthcoming. Consequently implementation delays are likely to continue. Representatives of the home health and assisted living provider categories also expressed serious concerns about the implementation of Medicaid managed long-term care.

**Summary and Scoring for Special Medicaid Challenges: *Dual Eligibles, Rebalancing and Managed Care***

Dual eligibles vulnerability <sup>106</sup>	United States	New Hampshire
Dual eligibles as share of all Medicaid enrollees	15% <sup>107</sup>	19% <sup>108</sup>
Duals as share of all aged and disabled enrollees	60% <sup>109</sup>	73% <sup>110</sup>
Dual eligibles spending as % of total Medicaid	39% <sup>111</sup>	49% <sup>112</sup>

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

New Hampshire’s dual eligibles vulnerability is exceptionally high. Only two states, Connecticut and Wisconsin, spend a higher percentage of Medicaid on duals.<sup>113</sup> New Hampshire is also substantially higher than the national average in duals as a share of all Medicaid enrollees and as a share of aged and disabled enrollees.

106 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, [https://www.cbo.gov/sites/default/files/44308\\_DualEligibles2.pdf](https://www.cbo.gov/sites/default/files/44308_DualEligibles2.pdf)

107 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>

108 *Ibid.*

109 *Ibid.*

110 *Ibid.*

111 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>

112 *Ibid.*

113 *Ibid.*

Rebalancing vulnerability	New Hampshire		
	United States	Number	Rank
Family Caregivers #/1000	137 <sup>114</sup>	138 <sup>115</sup>	24 <sup>116</sup>
Value in \$Million/1000	\$1,460 <sup>117</sup>	\$1,680 <sup>118</sup>	6 <sup>119</sup>
Ratio	3.8 <sup>120</sup>	3.9 <sup>121</sup>	29 <sup>122</sup>

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.<sup>123</sup>

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

Rebalancing also tends to increase overall Medicaid expenditures for long-term care, but these cost factors were captured above under “expenditure trends.”<sup>124</sup>

Managed care vulnerability	United States	New Hampshire
Managed care for aged, blind and disabled recipients?	Expanding <sup>125</sup>	Expanding <sup>126</sup>
Managed care for “dual eligibles”?	Expanding <sup>127</sup>	Expanding <sup>128</sup>

114 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>.

115 *Ibid.*, p. 217.

116 *Ibid.*

117 *Ibid.*

118 *Ibid.*

119 *Ibid.*

120 *Ibid.*

121 *Ibid.*

122 *Ibid.*

123 “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](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).

124 For details, 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](http://www.centerltc.com/BriefingPapers/4.htm).

125 “Approximately 70% of Medicaid enrollees are served through managed care delivery systems.” “Managed Care,” “Managed Care State Profiles,” Medicaid.gov, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>.

126 “New Hampshire has recently expanded managed care for all adults through an Alternative Benefit Plan (ABP). New Hampshire’s expansion went into effect on July 1, 2014, with coverage becoming effective August 15, 2014.” *Ibid.*, Managed Care State Profiles, “Managed Care in New Hampshire;” <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/new-hampshire-mcp.pdf>.

127 *Ibid.*

128 *Ibid.*

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."<sup>129</sup>

According to cited sources, New Hampshire has begun to move all adult Medicaid recipients into managed care.

Assign a weight and score for New Hampshire Medicaid's viability as a LTC payer in the Table of Long-Term Care Vulnerability.<sup>130</sup>

---

129 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.centerlrc.com/BriefingPapers/5.htm](http://www.centerlrc.com/BriefingPapers/5.htm).

130 The Table of Long-Term Care Vulnerability is a worksheet in "Appendix 3" designed to help the reader translate objective data provided in this report into a subjective estimate (best guess) of the future prospects for long-term care service delivery and financing nationwide and in New Hampshire. Whenever you see the instruction "assign a weight and score," we invite you to open the Table of LTC Vulnerability and indicate your best sense of the factor's significance." The author's filled out Table of LTC Vulnerability is provided for comparison.

## 4. Economy, Federal

*How reliable is federal revenue on which Medicaid mostly depends?*

States partially fund and administer Medicaid, paying on average 43 percent of the program's cost. The federal government partially funds and oversees Medicaid, contributing 57 percent of its cost. The share provided by the federal government is based on a formula that reflects a state economy's strength or weakness, with needier states getting a higher "federal match."

The FMAP [Federal Medical Assistance Percentage] system was originally intended to balance the economic scales by moving disproportionately more federal funds to poorer states, but Robert Helms of the American Enterprise Institute argues that it has had the opposite effect inducing wealthier states to leverage up the federal matching funds they receive by funding as many state priorities as possible through Medicaid.<sup>131</sup> New Hampshire, which currently has a relatively strong economy, receives the minimum federal match rate of 50 percent, but if there were no minimum match, New Hampshire's rate would be only 46.8 percent. The FMAP system encourages higher Medicaid expenditures by rewarding excess state expenditures with more federal funds, an effect that is even greater under the Patient Protection and Affordable Care Act's much higher federal match rates that start at 100 percent and only decline over time to 90 percent.

The reliability of federal funding, which is based on the full faith and credit of the United States government, is rarely challenged. In fact, when the U.S. economy retrenches, federal financial support for Medicaid often increases to help states weather the storm. This occurred most recently in response to the "Great Recession" of 2007 to 2009. But (1) with a uniquely severe aging demographic challenge approaching, (2) with the U.S. economy already lagging most post-recession recoveries, (3) with loose monetary and fiscal policies presaging another economic bubble potentially bursting and (4) with historically high debt and unfunded entitlement liabilities, we are certainly justified to ask "What if?" What if the federal government reneged on its full share of Medicaid funding either by reducing the federal match rate or by defaulting through inflation or some other means?

Federal Fiscal Year 2014 spending on Medicaid was \$476 billion, 29.3 percent higher than in 2009. New Hampshire's Medicaid expenditures were \$1.3 billion in 2014, virtually unchanged since 2009. Gradually, by controlling expenditure growth, the state is moving toward less dependency on federal funds for its Medicaid program. But what about overall dependency on federal money? The State Budget Solutions public policy organization reports that "Money from the federal government still generates over 30% of the general revenue in the majority of states . . .," but only 27.1 percent in New Hampshire which ranks 38<sup>th</sup> nationally

---

<sup>131</sup> We draw this argument about the spending incentive effect of the FMAP system from a presentation by Robert B. Helms, Resident Scholar at the American Enterprise Institute, delivered July 15, 2015 at the AEI-Heritage Joint Program "Medicare and Medicaid: The Next 50 Years."

**But (1) with a uniquely severe aging demographic challenge approaching, (2) with the U.S. economy already lagging most post-recession recoveries, (3) with loose monetary and fiscal policies presaging another economic bubble potentially bursting and (4) with historically high debt and unfunded entitlement liabilities, we are certainly justified to ask "What if?"**

in federal financial dependency.<sup>132</sup> In terms of overall dependency on federal funds, New Hampshire is relatively better off than most states.

### *Provider Taxes*

One way states are vulnerable to possible federal funding cutbacks is through their provider tax programs. All states except Alaska have levied special taxes on their long-term care providers for the purpose of generating extra funds that can then be used to leverage up federal funding. Provider taxes are especially lucrative for states with higher federal match rates. Mississippi, for example, with a match rate of 74 percent needs to raise only one dollar to receive almost three dollars back from the federal government. At New Hampshire's match rate of 50/50, the state can get an extra dollar from the federal government for every dollar it obtains from taxing providers. That extra dollar can then be refunded to the providers in whole or in part with the state retaining the remainder. The procedure is similar to Medicaid planning whereby affluent individuals use "loopholes" in the eligibility rules to facilitate their financial eligibility, only on a much larger scale and in order to maximize federal matching funds to the state. For more on provider taxes as federal revenue maximization, see "LTC Bullet: Medicaid Planning Writ Large."<sup>133</sup>

**New Hampshire imposes a 5.5 percent "bed tax" on both Medicaid and private long-term care patient revenue. In state fiscal year 2015, the bed tax raised \$37.5 million, which, matched with federal funds, returned \$75 million to the state.**

New Hampshire imposes a 5.5 percent "bed tax" on both Medicaid and private long-term care patient revenue. In state fiscal year 2015, the bed tax raised \$37.5 million, which, matched with federal funds, returned \$75 million to the state.<sup>134</sup> Naturally, the U.S. government is leery of this widely used technique to increase federal expenditures. During the last recession it considered reducing the current provider tax cap of six percent to 3.5 percent, which would have had the effect of cutting New Hampshire's 5.5 percent bed tax, and the revenues it generates, substantially. In relatively good economic times and under the current administration, such a reduction may be unlikely. But in a worse economy or with a different political ideology in power, that could quickly change.

### *Debt and Entitlement Liabilities*

Much greater potential danger to federal funding of state programs in general and Medicaid in particular resides in the coming pressure of aging demographics (discussed above) on federal debt and entitlement liabilities. The U.S. Debt Clock currently shows our national debt at \$18.9 trillion growing with a budget deficit of nearly half a trillion (\$446.6 billion) per year and representing a debt of \$200,256 per citizen and \$792,004 per family.<sup>135</sup>

---

132 State Budget Solutions, "Federal Aid to States Dips Slightly, But Remains High," by Joe Luppino-Esposito, February 17, 2015, <http://www.statebudgetsolutions.org/publications/detail/federal-aid-to-states-dips-slightly-but-remains-high#ixzz3XEEL4Z5T>.

133 Stephen A. Moses, "LTC Bullet: Medicaid Planning Writ Large," Center for Long-Term Care Reform, Seattle, Washington, April 10, 2015, <http://www.centerltc.com/bullets/archives2015/1081.htm>.

134 Telephone interview with Michael W. Hoffman of the New Hampshire Office of Legislative Budget Assistant on July 8, 2015.

135 U.S. National Debt Clock as of January 20, 2016, <http://www.usdebtclock.org/>.

But that formal debt figure is less worrisome compared to the unfunded entitlement liabilities representing promises made to current and future beneficiaries of Social Security (nearly \$26 trillion) and Medicare (nearly \$48 trillion). Of course, both of these major programs have substantial “trust funds” that are not expected to run out for nearly two decades. The problem is that their trust funds do not contain spendable revenue. They have only IOUs or promises from the federal government to repay money it already borrowed from the trust funds to support past and current spending on other priorities. So while the trust funds won't ‘run out’ for a good while, Social Security and Medicare will constitute a drain on general revenue in the meantime, because the federal government will have to make up shortfalls in payroll tax receipts while simultaneously paying off the trust funds’ IOUs with interest.

### ***Fiscal and Monetary Policy Risks***

But here's the bigger risk and how it could impact federal funding for Medicaid. U.S. fiscal, *i.e.* spending, policy has created large public debt that already consumes substantial sums for interest and other carrying costs. Federal reserve monetary policy has inflated the money supply and pushed interest rates to near zero for six years. Excess money supply and unnaturally low interest rates facilitate the federal government's ability to spend more than it receives in tax revenue by borrowing. If, or more likely when, interest rates return to a more normal level, carrying costs on federal debt will climb steeply making it much harder for the federal government to meet all of its financial obligations.

But that is not the only, or even the biggest problem. Artificially low interest rates have also discouraged savings by individuals and families, encouraged private borrowing and spending, diverted capital into stocks and real estate, and starved the economy for investment capital to grow businesses and create jobs. That is exactly what happened before 2008 and led directly to the Great Recession. The affluent prosper under these policies as their investments in the stock market and real property go up, but the poor and middle class struggle as jobs and salaries recede. If these policies are leading again to another major economic downturn, it is anyone's guess when debt and deficits remain so high whether the federal government will be able to help states snap back as in the past. How can the Federal Reserve help the federal government sustain its spending and borrowing when interest rates have nowhere lower to go. A *Wall Street Journal* op-ed concluded on August 17, 2015 that the “U.S. Lacks Ammo for Next Economic Crisis.”<sup>136</sup>

---

136 Jon Hilsenrath and Nick Timiraos, “U.S. Lacks Ammo for Next Economic Crisis,” *Wall Street Journal*, August 17, 2015; <http://www.wsj.com/articles/u-s-lacks-ammo-for-next-economic-crisis-1439865442>.

### ***How Federal Revenue Reductions Could Impact State Medicaid LTC Programs***

So, what if the federal government had to reduce Medicaid match rates or otherwise lower support for state Medicaid programs? State Medicaid budgets for long-term care would be impacted in three major ways, only one of which is obvious. The direct impact of reduced federal revenue would put immediate pressure on states' ability to attract and retain high quality LTC providers. Reimbursement rates are already very low, as explained above, with very little room, if any, to decline further. States would have to find other sources of revenue to make up the difference or watch their long-term care systems decline in access and/or quality.

The other two, less evident ways, that federal revenue declines could negatively impact state Medicaid long-term care programs would occur if the reductions come in the form of lower Social Security benefits or Medicare provider reimbursement cuts. But neither Social Security nor Medicare pays for long-term care, so why would cuts in those programs impact Medicaid's ability to pay for LTC?

### ***How Social Security Pays for Long-Term Care***

Although Social Security does not fund long-term care directly, it does play a major indirect role in LTC financing. Medicaid is the dominant funder of long-term care. People on Medicaid are required to contribute most of their income to offset the cost of their care to Medicaid--all but a small personal needs allowance of \$65 per month in New Hampshire. Most people who rely on Medicaid for their long-term care also receive income from Social Security. So Social Security income of people already on Medicaid represents a substantial contribution to long-term care funding. It covers as much as 13 percent of total long-term care expenditures and represents roughly half of all "out of pocket" spending for long-term care.<sup>137</sup> If Social Security reduced payments to beneficiaries by 21 percent as it has warned it would have to do when trust fund revenues run out, Medicaid residents in nursing homes would not be significantly affected. They already have to contribute nearly all of their Social Security checks to Medicaid. The impact would rather hit the state Medicaid program and long-term care providers massively and immediately as recipients' contributions toward the cost of their care would decline precipitously.

---

<sup>137</sup> Although Social Security is not usually considered to be a financing source for nursing home care, the fact is that it contributes very significantly albeit indirectly as "spend-through." Social security spend-through refers to income most seniors collect in the form of Social Security benefits which must be contributed toward their cost of care when they receive nursing-home services paid for by Medicaid. According to HCFA: "An estimated 41 percent...of out-of-pocket spending for nursing home care was received as income by patients or their representatives from monthly social security benefits." (Helen C. Lazenby and Suzanne W. Letsch, "National Health Expenditures, 1989," *Health Care Financing Review*, Vol. 12, No. 2, Winter 1990, p. 8.) Later research confirmed that Social Security spend-through is almost half of nursing home out-of-pocket costs. (Nelda McCall, "Long Term Care: Definition, Demand, Cost, and Financing," in Nelda McCall, editor, *Who Will Pay for Long-Term Care*, Health Administration Press, Chicago, Illinois, 2001, p. 19.)



### ***How Medicare Supports Medicaid LTC Funding***

Although Medicare does not pay directly for long-term care, it too plays a major role in long-term care financing. Medicare pays only for short-term skilled care such as rehabilitation in a nursing home or in beneficiaries' homes after hospitalization. What makes Medicare so important to Medicaid's ability to fund long-term care is that historically Medicare reimbursement to nursing homes and home health agencies has been much more generous than Medicaid's meager reimbursement rates.

Long-term care providers actually make profits from their residents and patients whose bills are paid by Medicare. Margins of 10 to 15 percent are common.<sup>138</sup> Compare that to the losses providers incur on every one of their Medicaid payees as explained earlier in this report. In the past, relatively generous reimbursements from Medicare for a minority of patients have made it possible for long-term care providers to support a majority of their patients with Medicaid reimbursement rates less than the cost of providing the care.

There is real reason to believe that this system will not continue much longer. The Medicare Payment Advisory Commission (MedPAC) advises Congress year after year to reduce Medicare reimbursement levels to nursing homes. Thus far Congress has demurred. But a serious economic setback impacting federal tax revenue and limiting the government's ability to borrow might tip the balance against the traditionally high compensatory Medicare reimbursement rates. The impact on state Medicaid programs and their long-term care providers could be catastrophic and immediate.

---

<sup>138</sup> "Nursing facilities made an average profit margin of about 13% in 2013 on their Medicare business, compared with about a 2% margin overall [including Medicaid and private pay] for such facilities, the agency found in a separate report." Source: "How Medicare Rewards Copious Nursing-Home Therapy," by Christopher Weaver, Anna Wilde Mathews Tom McGinty, *Wall Street Journal*; <http://www.wsj.com/articles/how-medicare-rewards-copious-nursing-home-therapy-1439778701>.

## Summary and Scoring for Economy, Federal:

*How reliable is federal revenue on which Medicaid mostly depends?*

	United States	New Hampshire	
		Number	Rank
Total Medicaid spending (2009)	\$368,330,000,000 <sup>139</sup>	\$1,328,000,000 <sup>140</sup>	43 <sup>141</sup>
Five year % increase (2004-2009)	29% <sup>142</sup>	16% <sup>143</sup>	46 <sup>144</sup>
FY2012: Fed./State shares of Medicaid <sup>145</sup>	57% federal; 43% state	50% /50% <sup>146</sup>	
Dependency on federal funds	30.0% <sup>147</sup>	27.1% <sup>148</sup>	38 <sup>149</sup>
Dependency on “provider taxes” <sup>150</sup>	Every state but Alaska <sup>151</sup>	2, at least 1 > 3.5% <sup>152</sup>	

*(continued on the next page)*

139 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>.

140 *Ibid.*, p. 218.

141 *Ibid.*

142 *Ibid.*, p. 41.

143 *Ibid.*, p. 221.

144 *Ibid.*

145 *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/>.

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

147 State Budget Solutions, “Federal Aid to States Dips Slightly, But Remains High,” by Joe Luppino-Esposito, February 17, 2015, <http://www.statebudgetsolutions.org/publications/detail/federal-aid-to-states-dips-slightly-but-remains-high#ixzz3XEEL4Z5T>.

148 *Ibid.*

149 *Ibid.*

150 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/>.

151 *Ibid.*

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

Social Security role in sustaining Medicaid (2015 infinite-horizon unfunded liability) <sup>153</sup> (2015 infinite-horizon unfunded liability) <sup>156</sup>	\$25.8 trillion <sup>154</sup>	Vulnerable <sup>155</sup>
Medicare role in sustaining Medicaid (2013 infinite-horizon unfunded liability) <sup>159</sup>	\$47.6 trillion <sup>157</sup>	Vulnerable <sup>158</sup>
Federal debt (as of January 20, 2015)	\$18.9 trillion <sup>160</sup>	Less Vulnerable <sup>161</sup>

On average, 57 percent 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.

153 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 when Social Security needs to cut back benefit payments by 21% as it has warned, the extra cost will fall directly on state Medicaid programs and LTC providers. This is the warning from the 2015 trustees report: “At the time of depletion of these theoretical combined reserves, continuing income to the combined trust funds would be sufficient to pay 79 percent of scheduled benefits. By 2089, continuing income equals about 73 percent of program cost.” Source: “The 2015 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds,” p. 24, <http://www.ssa.gov/oact/tr/2015/tr2015.pdf>.

154 “Table VI.F1 shows that the OASDI open group unfunded obligation over the infinite horizon is \$25.8 trillion in present value, which is \$15.1 trillion larger than for the 75-year period.” Source: “The 2015 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds,” p. 196, <http://www.ssa.gov/oact/tr/2015/tr2015.pdf>.

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

156 Social Security may be in a much worse fiscal condition than reported by the Social Security Trustees. According to Konstantin Kashin, Gary King, and Samir Soneji, “Systematic Bias and Nontransparency in US Social Security Administration Forecasts,” *Journal of Economic Perspectives*, Vol. 29, No. 2, Spring 2015, pps. 239-258: “In recent years, especially after about 2000, the Social Security Administration began issuing systematically biased forecasts with overconfident assessments of uncertainty. Reliance on such forecasts led policymakers and other users of the forecasts to conclude that the Social Security Trust Funds were on firmer financial ground than actually turned out to be the case.” (p. 255)

157 Michael D. Tanner, *Going For Broke: Deficits, Debt and the Entitlement Crisis*, Cato Institute, Washington, D.C., 2015, p. 95. Tanner explains that although the ACA made a number of changes to the Medicare program designed to reduce its cost, both the Congressional Budget Office and the Centers for Medicare and Medicaid Services have expressed doubt that those reductions will actually be realized.

158 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.

159 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.

160 U.S. National Debt Clock as of January 20, 2016, <http://www.usdebtclock.org/>.

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

New Hampshire's Medicaid expenditures grew much more slowly than the national average in the 2004-2009 review period. The state is less dependent on provider taxes than some other states, but at least one of its two taxes exceeds the 3.5% threshold deemed vulnerable to future cuts in federal matching funds. New Hampshire depends less on federal revenue, 27.1% of its budget compared to the average state, 30.0%. Social Security benefit reductions or decreases in Medicare LTC provider reimbursement levels would severely impact New Hampshire's ability to fund its long-term care safety net, as would any deficit-related federal revenue retrenchment. The state is marginally less vulnerable to cutbacks in federal funding because of its relatively low FMAP (50%).

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

## 5. Economy, State

*How reliable is state revenue on which Medicaid secondarily depends?*

Overview: “State budgets continue to grow at a moderate pace after several years of slow recovery in the national economy following the Great Recession. According to executive budget proposals, general fund spending is projected to grow 3.1 percent in fiscal 2016.”<sup>162</sup>

Medicaid is a counter-cyclical program. Because it is means tested, Medicaid's caseloads and expenditures rise during downturns in the economy. People lose jobs; unemployment increases; more individuals and families need help meeting their medical needs, including long-term care. Historically, during poor economies, the federal government finds various ways to supplement Medicaid funds for the states to help them sustain their programs until their economies improve. As we explained in the previous section, however, whatever the federal will in this regard, the ways and means to help states may become harder or impossible to find and employ in the future.

State economies must generate sufficient revenue to support the non-federal side of LTC financing. States may be less able than in the past to rely on financial support from the federal government. So what are the prospects that state economies in general and New Hampshire's economy in particular will be able to generate the financial resources to support current and likely future long-term care systems?

### *Rich States, Poor States*

Fortunately, this is a question for which abundant data sources are available to help us answer. For example, the American Legislative Exchange Council (ALEC) annually publishes *Rich States, Poor States*, currently in its eighth edition, which includes an “Economic Outlook Ranking [that] is a forecast based on a state's current standing in 15 state policy variables”<sup>163</sup> and an “Economic Performance Ranking [that] is a backward-looking measure based on a state's performance on three important variables: State Gross Domestic Product, Absolute Domestic Migration, and Non-Farm Payroll Employment—all of which are highly influenced by state policy.”<sup>164</sup>

New Hampshire ranks well below average on both measures. On Economic Performance, it is 36<sup>th</sup>, two-thirds of the way down from #1, Texas, toward #50, Michigan. On Economic Outlook, New Hampshire fares a little better at 29, a little below halfway between #1, Utah, and #50, New York. New Hampshire's

---

162 Fiscal Survey of States, Spring 2015, National Association of State Budget Officers, Spring 2015, <http://www.nasbo.org/publications-data/fiscal-survey-states/fiscal-survey-states-spring-2015>.

163 Arthur B. Laffer, Stephen Moore, and Jonathan Williams, *Rich States, Poor States: ALEC-Laffer State Economic Competitiveness Index*, 8<sup>th</sup> edition, Table 1: ALEC-Laffer State Economic Outlook Rankings, 2015 and Table 2: ALEC-Laffer State Economic Performance Rankings, 2003-2013, American Legislative Exchange Council, 2015, <http://www.alec.org/publications/rich-states-poor-states/>, pages are unnumbered.

164 *Ibid.*

Economic Outlook highlights include its positive “Top Marginal Personal Income Tax Rate” of zero (Rank #1), its “Sales Tax Burden” of zero (Rank #1) and its negative “Property Tax Burden ([extract\_itex]53.07] per[/extract\_itex]1,000 of personal income)” (Rank #49, second highest property taxes in the country).

### ***Fiscal Report Cards***

The Cato Institute issues states a “Fiscal Policy Report Card,”<sup>165</sup> and New Hampshire’s is not one any kid would want to bring home to Mom. Scores range from 78, an “A,” for Republican Governor Pat McCrory of North Carolina to 19, an “F” for Democratic Governor Jerry Brown of California with Democrat Maggie Hassan, Governor of New Hampshire, coming in below the mid-point at 42, a “D.” Cato summarizes “Governor Hassan’s tenure as New Hampshire governor is moving the state in the wrong fiscal direction. In 2013 she proposed a cigarette tax increase of 30 cents a pack, and the legislature agreed to a 10 cent hike. In 2014 she approved a gasoline tax increase of 4.2 cents per gallon. State general fund spending increased an estimated 5.6 percent in 2014, and Hassan support- ed Medicaid expansion under the ACA.”<sup>166</sup>

*Forbes* magazine ranks the “Best States for Business and Careers” and concludes New Hampshire is not one of them.<sup>167</sup> It ranks in the fourth quintile at 35th overall with sub-category ranks at 43rd in Business Costs; 19th in Labor Supply; 46th in Regulatory Environment; 33rd in Economic Climate; and 24th in Growth Prospects; balanced on the upside by a rank of 6th in Quality of Life. *Forbes* concludes “Like the rest of the northeast, New Hampshire suffers from high labor and energy costs.”

New Hampshire fares better on the Mercatus Center’s “Fiscal Condition Index”<sup>168</sup> showing in the top half at #20. Mercatus explains

Based on the fiscal year 2013 Comprehensive Annual Financial Reports of the 50 states, this study ranks states’ fiscal solvency using 14 metrics that assess whether the states can meet their short-term bills and long-term obligations. State finances are analyzed according to five dimensions of solvency: cash, budget, long-run, service-level, and trust fund. These five dimensions are combined to produce an overall ranking of state fiscal solvency.<sup>169</sup>

---

165 Nicole Kaeding and Chris Edwards, “Fiscal Policy Report Card on America’s Governors, 2014,” Cato Institute, Washington, DC, Table 1: Overall Grades for the Governors, pps. 2-3, October 2, 2014, <http://www.cato.org/publications/white-paper/fiscal-policy-report-card-americas-governors-2014>

166 *Ibid.*, p. 23.

167 “The Best States for Business and Careers,” *Forbes*, November 12, 2014, <http://www.forbes.com/best-states-for-business/>.

168 Eileen Norcross, “Ranking the States by Fiscal Condition,” Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, July 2015; <http://mercatus.org/sites/default/files/Norcross-StateFiscal-Condition.pdf>.

169 *Ibid.*, p. 2

**New Hampshire was one of only eight states with unemployment rates below 4.0 percent (3.8 percent)**

Unfortunately, New Hampshire is one of only “Fourteen states [that] have cash ratios of less than one, meaning they have less cash on hand than short-term liabilities.” But for overall fiscal condition, New Hampshire scores -.13 placing it 20<sup>th</sup> after #1 Alaska at 8.26 and far above bottom-ranking Illinois at -1.86.<sup>170</sup>

The Pew Charitable Trust’s *Stateline* publication ranked states based on their job growth since the last recession.<sup>171</sup> It found that New Hampshire is one of ten states that “have seen total employment grow 5 percent or less compared to their lowest points . . .” At 5.08 percent, New Hampshire far exceeded West Virginia’s cellar performance of 2.16 percent but lagged North Dakota’s stellar 28.86 percent by a long shot.

The Urban Institute’s “State Economic Monitor”<sup>172</sup> rates states based on unemployment, weekly wages, housing price growth, and taxes. New Hampshire was one of only eight states with unemployment rates below 4.0 percent (3.8 percent). Average weekly wages of \$831 came in just below the national average of \$861. Home prices increased 3.4 percent in New Hampshire compared to 5.0 percent nationally. Total tax revenue increased 6.5 percent, almost double the 3.3 percent increase for the country as a whole. In a nutshell, more people are working in New Hampshire but at lower wages than in other states; their home values are increasing slower than elsewhere, but their tax burden is increasing faster.

### ***Economic Freedom Indicators***

**New Hampshire ranks fourth on overall freedom, a highly promising position for its future economic prospects. Still, it slipped from number one in 2007, a less encouraging sign.**

From Adam Smith’s 1776 treatise, *An Inquiry into the Nature and Causes of the Wealth of Nations*, through the Heritage Foundation’s “2015 Index of Economic Freedom,”<sup>173</sup> the connection between economic freedom and economic prosperity is well and irrefutably established. So it is fitting and relevant that the Mercatus Center publishes an index ranking states based on personal and economic freedom.

This book scores all 50 states on their overall respect for individual freedom, and also on their respect for three dimensions of freedom considered separately: fiscal policy, regulatory policy, and personal freedom.<sup>174</sup>

New Hampshire ranks fourth on overall freedom, a highly promising position for its future economic prospects. Still, it slipped from number one in 2007, a less encouraging sign.

170 *Ibid.*, “Table 9. Ranking of States by Fiscal Condition (FY 2013),” p. 28.

171 Jake Grovum, “Which States Have the Most Job Growth Since the Recession?” *Stateline*, May 13, 2015; <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/5/13/which-states-have-the-most-job-growth-since-the-recession>.

172 “State Economic Monitor,” Urban Institute; <http://datatools.urban.org/features/state-economic-monitor/index.html>; data extracted August 1, 2015.

173 “2015 Index of Economic Freedom,” Heritage Foundation, Washington, DC; <http://www.heritage.org/index/book/chapter-2>.

174 William P. Ruger and Jason Sorens, “Freedom in the 50 States: An Index of Personal and Economic Freedom, 2013 Edition,” Mercatus Center, Washington, D.C., p. 3; <http://freedominthe50states.org/print>.

### ***Taxes and Medicaid LTC Financing***

Taxes weigh like an anchor on a state's potential economic prosperity. The Tax Foundation ranks states' tax burdens annually.<sup>175</sup> Their latest data and rankings are for 2011. The "lag is due to data availability."<sup>176</sup> The average state-local tax burden nationally is 9.8 percent ranging from #1 New York at 12.6 percent to #50 Wyoming at 6.9 percent with New Hampshire in a favorable position at #44 with an 8.0 percent tax burden. New Hampshire achieves that good overall tax burden rating in spite of very high property taxes: 2.15 percent ranking the state third nationally between #1 New Jersey, 2.38 percent and #50 Hawaii, .28 percent. The Tax Foundation explains "Some states with high property taxes, like New Hampshire and Texas, rely heavily on property taxes in lieu of other major tax categories . . ."<sup>177</sup> New Hampshire's high property taxes go largely to support the state's Medicaid long-term care financing. That state of affairs leaves New Hampshire uniquely vulnerable to any reduction in real estate values and property tax revenue.

### ***New Hampshire's Unique Reliance on County Property Taxes to Fund Medicaid LTC***

New Hampshire's high property taxes are the flip side of its nonexistent income and sales taxes. Revenue to fund state government has to come from somewhere. But property taxes are especially and uniquely relevant to funding Medicaid long-term care in New Hampshire. No other state relies as heavily on them. In state fiscal year 2015, county property taxes contributed \$107.5 million toward New Hampshire's share of Medicaid long-term care expenditures for the elderly. State revenues made up the \$20 million dollar difference needed to match \$128 million in federal funds.<sup>178</sup> This peculiar arrangement resulted from a 2008 deal whereby the state took full responsibility for funding the relatively slow-growing acute care side of Medicaid and the counties became responsible for the relatively more costly and fast-growing long-term care side. In compensation, the counties' share was capped which is why the state still contributes when the county cap is exceeded.

Relying so heavily on county property taxes to fund Medicaid LTC in New Hampshire has not been without problems. Interviewees representing the nursing home business observed that the counties sued to prevent implementation of the plan, but lost in court. They said:

The state keeps increasing the cap to limit general fund exposure.  
The problem is they set rates for all levels of care, but they have

---

175 Elizabeth Malm and Gerald Prante, "Annual State-Local Tax Burden Rankings FY 2011," Tax Foundation, April 2014; [http://taxfoundation.org/sites/taxfoundation.org/files/docs/Burdens\\_2014\\_Final.pdf](http://taxfoundation.org/sites/taxfoundation.org/files/docs/Burdens_2014_Final.pdf).

176 "State-Local Tax Burdens Report," Tax Foundation, extracted August 17, 2015; <http://taxfoundation.org/tax-topics/state-taxes>.

177 Jared Walczak, "How High Are Property Taxes in Your State?," Tax Foundation, August 13, 2015; <http://taxfoundation.org/blog/how-high-are-property-taxes-your-state>.

178 Telephone interview with Michael W. Hoffman of the New Hampshire Office of Legislative Budget Assistant on July 8, 2015.



no skin in the game because all the money comes from feds and counties. They want to restrain expenditures up to the cap, which they keep increasing, but no higher.<sup>179</sup>

Lori Shibinette, Administrator of Merrimack County Nursing Home Administrator, who is familiar with the history and current status of county LTC funding in New Hampshire observed:

We are unique. We're both payer and provider. The counties pay most of the cost, but the state sets policy on Medicaid eligibility and reimbursement rates. The county has nothing to do with that. We just get a bill and pay it. We think we should have some say in eligibility and case management because we have the financial incentive to lower the expenditures for Medicaid.<sup>180</sup>

A June 6, 2015 article in the *Washington Times* cited George Maglaras, a Strafford County commissioner and vice president of the New Hampshire Association of Counties. "Between 50 to 60 percent of all county taxes go toward long-term care, Maglaras said. Taxpayers in a county with a higher need for long-term care services or a smaller tax base get hit hardest."<sup>181</sup> The article continues "But causing more concern is the state's planned move next year to a managed care system, where an outside company will manage the entire continuum of an individual's care, from doctor's visits to prescription drug purchases. . . . Counties worry the shift will further reduce their influence over how the system operates and that money currently spent on care will go toward fees for the managed care companies."<sup>182</sup>

**A more severe recession causing a steeper decline in property values could imperil New Hampshire's unusual Medicaid long-term care financing system.**

Some other states, including California and New York, have relied partially on county funding for their Medicaid programs. But no other state has relied as heavily on county property taxes as New Hampshire. A significant decline in real property values could diminish the state's ability to generate Medicaid matching funds. It has happened before. New Hampshire's median property value decreased by \$18,500 or seven percent from \$257,600 in 2007-2009 to \$239,100 in 2010-2012.<sup>183</sup> A more severe recession causing a steeper decline in property values could imperil New Hampshire's unusual Medicaid long-term care financing system.

---

179 Interview on June 15, 2015 with representatives of the New Hampshire Health Care Association, Leading Age Maine & New Hampshire, Catholic Charities New Hampshire, and the Webster at Rye nursing facility.

180 Interview on June 29, 2015 with Lori Shibinette, Administrator, Merrimack County Nursing Home Administrator.

181 Kathleen Ronayne, "State, counties grapple with long-term care as state ages," Associated Press, June 6, 2015; <http://www.washingtontimes.com/news/2015/jun/6/state-counties-grapple-with-long-term-care-as-stat/?page=all>.

182 *Ibid.*

183 Christine Flanagan and Ellen Wilson, "Home Value and Homeownership Rates: Recession and Post-Recession Comparisons from 2007-2009 to 2010-2012," American Community Survey Briefs, United States Census Bureau, November 2013, "Table 1. Homeownership Rate and Median Property Value by State: 2007-2009 and 2010-2012," p. 4; available [here](#) at a very long URL.

## Summary and Scoring for Economy, State:

*How reliable is state revenue on which Medicaid secondarily depends?*

*Rich States, Poor States* “Economic Competitiveness Index”<sup>184</sup>

		<u>New Hampshire Rank</u>
Economic Performance Rank	From Texas #1 to Michigan #50	36
Economic Outlook Rank	From Utah #1 to New York #50	29
“Fiscal Policy Report Card,” <sup>185</sup>		
Grades state Governors from A to F on their fiscal policies	From Pat McCrory (R), North Carolina, 78, A To Jerry Brown (D), Calif., 19, F	Maggie Hassan (D), 42, D
<i>Forbes</i> Best States for Business and Careers <sup>186</sup>		
	From Utah #1 to Mississippi #50	35
Mercatus Fiscal Condition Index (FY 2013) <sup>187</sup>		
	From Alaska, 8.26, #1 to Illinois, -1.86, #50	-.13, #20
Job Growth Since the Great Recession <sup>188</sup>		
	From North Dakota, 28.86% to West Virginia, 2.16%	5.08%, one of ten lowest states
State Economic Monitor Urban Institute <sup>189</sup>		
Employment <sup>190</sup>	From 7.4% West Virginia to 2.6% Nebraska; U.S. 5.3%	3.8%
Wages <sup>191</sup>	From \$1,365 D.C to \$663 Arkansas; U.S. \$861	\$831

184 Arthur B. Laffer, Stephen Moore, and Jonathan Williams, *Rich States, Poor States: ALEC-Laffer State Economic Competitiveness Index*, 8<sup>th</sup> edition, Table 1: ALEC-Laffer State Economic Outlook Rankings, 2015 and Table 2: ALEC-Laffer State Economic Performance Rankings, 2003-2013, American Legislative Exchange Council, 2015, <http://www.alec.org/publications/rich-states-poor-states/>.

185 Nicole Kaeding and Chris Edwards, “Fiscal Policy Report Card on America’s Governors, 2014,” Cato Institute, Washington, DC, Table 1: Overall Grades for the Governors, pps. 2-3, October 2, 2014, <http://www.cato.org/publications/white-paper/fiscal-policy-report-card-americas-governors-2014>. “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. The same methodology was used on Cato’s 2012, 2010, and 2008 fiscal report cards.” (p. 2)

186 “The Best States for Business and Careers,” *Forbes*, November 12, 2014, <http://www.forbes.com/best-states-for-business/>.

187 Eileen Norcross, “Ranking the States by Fiscal Condition,” Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, July 2015, Table 9: Ranking of States by Fiscal Condition (FY 2013), p. 28; <http://mercatus.org/sites/default/files/Norcross-StateFiscal-Condition.pdf>.

188 “On average, employment has increased 8 percent among all 50 states and the District of Columbia since each one’s individual nadir.” Source: Jake Grovum, “Which States Have the Most Job Growth Since the Recession?,” *Stateline*, May 13, 2015; <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/5/13/which-states-have-the-most-job-growth-since-the-recession>.

189 “The State & Local Finance Initiative’s State Economic Monitor tracks and analyzes economic and fiscal trends at the state level. Its interactive graphics highlight particular differences across all 50 states and the District of Columbia in employment, wages, housing, and taxes.” Source: “State Economic Monitor,” Urban Institute; <http://datatools.urban.org/features/state-economic-monitor/index.html>; data extracted August 1, 2015.

190 *Ibid.* Unemployment Rate

191 *Ibid.* “National real weekly earnings (i.e., earnings adjusted for inflation) for all US private employees averaged \$861 in June 2015.”

Housing <sup>192</sup>	From 11.2% Colorado to -3.9% West Virginia; U.S. 5.0%	3.4%
Taxes <sup>193</sup>	From 14.9% Michigan to -47.8% Alaska; U.S. 3.3%	6.5%
Mercatus 2013 “Freedom Index” <sup>194</sup>		
Overall fiscal, regulatory and personal rank; change from 2009	From #1, North Dakota; +4 To #50, New York; 0 change	#4, -2
Tax Foundation <sup>195</sup> State-Local Tax Burden	U.S. Average: 9.8%; Range: #1, NY, 12.6% to #50, WY, 6.9%	44, 8.0%
Tax Foundation Property Taxes <sup>196</sup>	U.S. Average: None shown; Range: #1, NJ, 2.38% to #50, HI, .28%	3, 2.15%

Budget Challenges: “As of July 27, [2015] 45 states have enacted budgets for fiscal 2016, while an additional 2 states have enacted temporary spending bills for fiscal 2016 (New Hampshire and North Carolina).”<sup>197</sup>

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

New Hampshire ranks below average on ALEC’s “economic competitive index” and *Forbes*’ “Best States for Business and Careers.” It ranked 20<sup>th</sup> on the Mercatus Fiscal Condition Index with a small minus score. New Hampshire’s job growth since the Great Recession is among the ten worst. The state’s governor received a poor grade (D) on Cato’s “Fiscal Policy Report Card.” On the Urban Institute’s State Economic Monitor’s four measures, New Hampshire was below the national average on unemployment, near the average on weekly wages, well below the average on housing inflation, and almost double the average on tax increases. New Hampshire ranked very high on the Mercatus Freedom Index (#4) and showed a relatively low tax burden on the Tax Foundation’s State-Local Tax Burden listing. But the state’s heavy dependency on county property taxes to fund its Medicaid LTC system is highly worrisome. New Hampshire’s budget was in limbo as it began Fiscal Year 2016 operating on a continuing resolution.

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

192 *Ibid.* “Assessing quarterly state house prices data compared with one year earlier and the national peak (first quarter of 2007).”

193 *Ibid.* “Examining total, sales, individual income, and corporate income tax revenue data for all 50 states and DC during the most recent four quarters compared with the previous four quarters.”

194 William P. Ruger and Jason Sorens, “Freedom in the 50 States: An Index of Personal and Economic Freedom, 2013 Edition,” Mercatus Center, Washington, D.C., p. 166; <http://freedominthe50states.org/print>.

195 Elizabeth Malm and Gerald Prante, “Annual State-Local Tax Burden Rankings FY 2011,” Tax Foundation, April 2014; [http://taxfoundation.org/sites/taxfoundation.org/files/docs/Burdens\\_2014\\_Final.pdf](http://taxfoundation.org/sites/taxfoundation.org/files/docs/Burdens_2014_Final.pdf).

196 Jared Walczak, “How High Are Property Taxes in Your State?,” Tax Foundation, August 13, 2015; <http://taxfoundation.org/blog/how-high-are-property-taxes-your-state>.

197 “States’ Proposed & Enacted Budgets,” National Association of State Budget Officers, extracted July 29, 2015; <http://www.nasbo.org/resources/states-proposed-enacted-budgets>.

## 6. Private Financing Alternatives

*How much private-pay revenue is available to relieve LTC financing pressure on Medicaid?*

There are four ways in which the pressure on Medicaid to finance long-term care could be relieved by additional private financing in New Hampshire.

**First: Asset spend down:** As explained above in the section on Medicaid long-term care financial eligibility and Medicaid planning, 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 in New Hampshire without significant expenditure of private funds. The home equity exemption of \$552,000 in New Hampshire (up to \$828,000 in 13 other states) is a major factor, but the many other exempt assets, not to mention Medicaid planning techniques of artificial self-impoverishment, also contribute substantially. By comparison the total amount of exempt assets, including home equity, that participants may retain while qualifying for the United Kingdom's long-term care public assistance program is only £23,500<sup>198</sup> or \$33,370 at today's exchange rate.<sup>199</sup>

On the one hand, middle class and affluent people believe they should not be excluded from public long-term care benefits simply because they were responsible citizens who accumulated adequate retirement income and savings. But, on the other hand, how does anyone benefit if public programs prove inadequate to fund access to quality care in appropriate venues of care for everyone, poor and affluent alike? Therein lies the political sensitivity of the issue which makes targeting Medicaid's scarce resources to the most needy very difficult to accomplish.

How much private revenue could be released to help fund long-term care if Medicaid financial eligibility rules were less generous? Little research has been done to answer that question and more should begin as soon as possible. But given the ease with which middle class and affluent people qualify for Medicaid's ostensibly means-tested long-term care benefits, it is highly likely that savings from re-targeting Medicaid exclusively to the genuinely needy would be substantial.

**Second: Estate recovery:** Arguably, if Medicaid allows people to retain substantial wealth while receiving publicly financed long-term care benefits, those recipients ought to reimburse Medicaid for the cost of their care out of their estates. Otherwise, Medicaid operates as free inheritance insurance for recipients' heirs. Making Medicaid into a government-sponsored LTC financing advance on recipients' estates was the principle embodied in the Omnibus Budget Reconcil-

---

<sup>198</sup> "Housing assets are taken into account in the current system. If you have more than £23,250 in assets (figures differ slightly in Scotland and Wales) you will be responsible for your own care costs." Source: Adrian Walker, "Logical step? Using equity release to pay for long-term care," *Professional Adviser*, August 18, 2015; <http://www.professionaladviser.com/professional-adviser/opinion/2422519/logical-step-using-equity-release-to-pay-for-long-term-care>.

<sup>199</sup> One British Pound equals \$1.42 as of January 20, 2016.

iation Act of 1993, which made Medicaid estate recovery mandatory as a condition of receiving any federal matching funds for the program. Unfortunately, actual results have disappointed. States did not implement estate recoveries aggressively. The federal government did not enforce mandatory estate recoveries. The media did not widely report this new condition for receipt of Medicaid LTC benefits. Consequently, consumer behavior with regard to long-term care planning changed little.

We have two sources of data on state-by-state Medicaid estate recoveries. Both indicate mediocre returns. The first is a 2005 report, based on 2004 data, by the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE).<sup>200</sup> ASPE found that state Medicaid programs collected a total of \$361.8 million from recipients' estates, a mere .8 percent of the program's expenditures in that year on skilled nursing facilities. New Hampshire recouped \$4.4 million, recovering at double the national rate (1.6 percent) but only a little more than one-fourth the rate of the most effective estate recovery state, Oregon, 5.8 percent. If New Hampshire had matched Oregon's recovery rate, it would have brought in substantially more non-tax revenue from this source in 2004: \$15.8 million, an increase of \$11.4 million over actual recoveries.

The second source of national data on Medicaid estate recoveries comes from a recent Department of Health and Human Services Inspector General (IG) letter report and covers 2011 data.<sup>201</sup> The IG showed that state Medicaid programs collected a total of \$497.9 million from recipients' estates in 2011 or .95 percent of the program's expenditures on skilled nursing facilities (SNF), a slight improvement over the .8 percent recovery rate from 2004.<sup>202</sup> Unfortunately, New Hampshire's estate recovery rate did not improve in the intervening seven years, remaining 1.6 percent and generating \$4.9 million in 2011. Idaho replaced Oregon as the state with the most effective estate recovery program, generating recoveries of 5.4 percent of SNF expenditures. Had New Hampshire matched Idaho's recovery rate, the state's estate recoveries would have been \$16.7 million in 2011, \$11.8 million more than they actually were.

New Hampshire has a relatively effective estate recovery program, probably one of the five best in the country according to an expert we consulted.<sup>203</sup> Nevertheless, as the preceding analysis explains, New Hampshire still leaves a lot of non-tax revenue from estate recoveries on the table compared to states with higher estate recovery effectiveness ratios. The author recently published a report detailing collections and listing best practices in leading estate recovery states titled

**Had New Hampshire matched Idaho's recovery rate, the state's estate recoveries would have been \$16.7 million in 2011, \$11.8 million more than they actually were.**

---

200 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>

201 Department of Health and Human Services Inspector General letter report dated July 7, 2014; [http://centerltc.com/OIG/IG\\_LetterReport.pdf](http://centerltc.com/OIG/IG_LetterReport.pdf)

202 Data and analysis of 2011 estate recoveries as a percentage of SNF expenditures comes from Stephen A. Moses, "LTC Bullet: IG Report Reveals Medicaid Estate Recovery Weakness," Center for Long-Term Care Reform, Seattle, Washington, December 5, 2014, <http://www.centerltc.com/bullets/archives2014/1066.htm>

203 Personal email from Ben Chatman, Operations Manager of the Iowa Estate Recovery Program, July 29, 2015.

**If 80 percent of New Hampshire's elderly population of 109,000 own homes of median value of which 65.3 percent are owned free and clear, then the total home equity that could be redirected to help fund their long-term care is .8 times 109,000 times .653 times \$249,500 or \$14.2 billion, many times New Hampshire Medicaid's total expenditures for long-term care in 2014 of \$281,745,000.**

"Maximizing Non-Tax Revenues from MaineCare Estate Recoveries."<sup>204</sup> New Hampshire's estate recovery program might benefit from considering the best state practices documented in that report. Changes in federal law to encourage estate recoveries could significantly increase this source of non-tax revenue.

**Third: Home equity conversion:** The single biggest asset aging people possess is their homes. As of 2010, 74.9 percent of New Hampshireites owned their own homes compared to only 66.9 percent of all Americans.<sup>205</sup> The elderly (over age 65) tend to have even higher levels of home ownership: 80.5 percent nationally<sup>206</sup> of which 65.3 percent own their homes free and clear of mortgage debt.<sup>207</sup> The median value for owner-occupied housing units in New Hampshire was \$249,700 compared to only \$185,200 nationwide.<sup>208</sup> If 80 percent of New Hampshire's elderly population of 109,000 own homes of median value of which 65.3 percent are owned free and clear, then the total home equity that could be redirected to help fund their long-term care is .8 times 109,000 times .653 times \$249,500 or \$14.2 billion, many times New Hampshire Medicaid's total expenditures for long-term care in 2014 of \$281,745,000.

Of course, it's not that simple. Not all homeowners end up needing long-term care. Many people who do need long-term care were never homeowners. But many past and present home owners do find themselves in need of long-term care and when they do, New Hampshire Medicaid exempts \$552,000 of equity, more than double the median home value of \$249,700. Nevertheless, despite this strong incentive to take advantage of Medicaid, some home equity already contributes to private long-term care financing, as when people sell their homes to generate funds to pay for an assisted living facility. But it is also clear that a lot of home equity disappears before it can be used to fund long-term care as when elders follow advice from Medicaid planners to transfer their homes to their adult children or into a "Medicaid-Qualifying Irrevocable Trust" five years before applying for Medicaid in order to circumvent the five-year lookback rule.

Practically speaking, with different incentives in public policy, how could more home equity be attracted into long-term care financing in a manner that would relieve some of the LTC financing burden 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. If Medicaid's home equity exemption were eliminated or reduced to a more reasonable level, people would have to use the reverse mortgage option before relying on Medicaid with the savings redounding to taxpayers and the poor.

204 Stephen A. Moses, "Maximizing Non-Tax Revenues from MaineCare Estate Recoveries," Center for Long-Term Care Reform, Seattle, Washington, May 15, 2013; <http://www.centerlrc.com/pubs/Maine2013.pdf>.

205 United States Census Bureau, *The 2012 Statistical Abstract*, "Table 993. Homeownership Rates by State: 1990 to 2010"; <http://www.census.gov/compendia/statab/2012/tables/12s0993.pdf>.

206 *Ibid.*, "Table 992. Homeownership Rates by Age of Householder and Household Type: 1990 to 2010"; <http://www.census.gov/compendia/statab/2012/tables/12s0992.pdf>.

207 *Ibid.*, "Table 998. Mortgage Characteristics-Owner-Occupied Units: 2009"; <http://www.census.gov/compendia/statab/2012/tables/12s0998.pdf>.

208 *Ibid.*, "Table 996. Owner-Occupied Housing Units-Value and Costs by State: 2009"; <http://www.census.gov/compendia/statab/2012/tables/12s0996.pdf>.

But the reverse mortgage option ends where mobility, morbidity or mortality begins. Such mortgages become due and payable when the elder mortgagee becomes too ill to remain, moves out, dies or sells. When that happens, families who want to retain the elders' 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 that could pay even when nursing home care becomes necessary. Many variations would be possible, but current public policy exempting a huge amount of home equity discourages all such options from a purely financial standpoint.

Requiring the spend down of home equity prior to eligibility for Medicaid benefits has positive effects that go beyond the state and federal budget savings. The long-term care service delivery system is starved for private financial oxygen. A large increase of private payers spending down their home equity and paying market rates for their care would help long-term care providers at all levels of care to offer enhanced access and quality to everyone, private payers and the remaining, genuinely needy, Medicaid recipients as well. Spouses of Medicaid recipients would be protected by virtue of the fact that reverse mortgages protect their right to remain in their homes until they stop maintaining the property, move out or die.

**Fourth: Private long-term care insurance:** Private long-term care insurance market penetration in New Hampshire is slightly above average: 4.8 percent of the age 40-plus population compared with 4.5 percent nationally.<sup>209</sup> Only ten insurance carriers have in-place long-term care insurance policies in New Hampshire. The three companies with the largest market share are Genworth (24.2 percent), John Hancock (16.7 percent) and Bankers Life & Casualty (13.5 percent).<sup>210</sup> Genworth, however, recently stopped marketing LTC insurance in the state after New Hampshire capped annual premium increases. With no state income tax, New Hampshire obviously does not provide income tax deductions or credits to incentivize the purchase of long-term care insurance as many states do.

New Hampshire does have a Long-Term Care Partnership program. That program encourages the purchase of long-term care 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 benefits from a partnership-qualified policy would be able to qualify for New Hampshire's Medicaid long-term care benefits while retaining \$102,500 in otherwise countable assets instead of the usual \$2,500 limit. Interviewees representing the long-term care

---

209 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. 217, <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>.

210 "National Association of Insurance Commissioners Long-Term Care Insurance Experience Reporting Form 5 Market Share - Top Ten Companies by Actual Earned Premiums, New Hampshire" provided by David Sky, FSA, MAAA, Life, Accident and Health Actuary, New Hampshire Insurance Department on July 21, 2015.

insurance industry said New Hampshire has not promoted its Long-Term Care Partnership program effectively and the market for private long-term care insurance in general is flat or declining.

A discussion of the many factors inhibiting the market for private long-term care insurance, including lower lapse and interest rates than expected and higher claims, is beyond the scope of this paper. But it is appropriate to observe that demand for private insurance protection against the risk and cost of long-term care might be considerably greater if Medicaid long-term care benefits were not so easy to obtain after the insurable event occurs. If asset spend down rules were stronger and better enforced; if federal restrictions limiting estate recovery were removed and if recovery programs were strengthened; and if home equity became at risk for funding long-term care prior to Medicaid dependency, then demand for long-term care insurance would likely increase substantially and over time private insurance could become a much larger source of LTC funding further relieving the financial pressure on Medicaid.

### Summary and Scoring for Private Financing Alternatives:

*How much private-pay revenue is available to relieve LTC financing pressure on Medicaid?*

	United States	New Hampshire
Asset spend down potential <sup>211</sup>	Higher if easy eligibility can become less easy. <sup>212</sup>	Yes, after MOE. 209-B state <sup>213</sup>
Estate recoveries (2004 data) <sup>214</sup>		
Total	\$361,766,396	\$4,362,641
As a % of SNF spending	U.S. Average: .8%	
Range	From 5.8% (OR) <sup>215</sup> to 0.0% (GA)	1.6%

211 “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>.

212 The Affordable Care Act’s “maintenance of effort” (MOE) requirement prevented states from making Medicaid eligibility rules stricter than they were when the Act became law on March 23, 2010. This requirement expired for adults on January 1, 2014. 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>.

213 For more details on Medicaid long-term care eligibility rules, see “Key Medicaid Information for New Hampshire for 2015,” *ElderLawAnswers*, <http://www.elderlawanswers.com/key-medicaid-information-for-new-hampshire-for-2015-12209>.

214 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>.

215 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.” Therefore, we report Oregon as the top estate recovery state for this report.



Estate recoveries (2011 data) <sup>216</sup>		
Total	\$497,905,382	\$4,933,904
As a % of SNF spending <sup>217</sup>	U.S. Average: .95%	
Range	From 5.4% (ID) to 0.0% (MI)	1.6%
Home equity for LTC financing Medicaid home equity exemption <sup>218</sup>	\$552,000 to \$828,000 (2015)	\$552,000
Private long-term care insurance LTCI market penetration		
Private LTCI policies	6,485,598 <sup>219</sup>	32,516 <sup>220</sup>
Policies per 1000 population	45 <sup>221</sup>	48 <sup>222</sup>
LTC partnership <sup>223</sup>	31 states approved	Yes <sup>224</sup>
LTCI tax incentives <sup>225</sup>	36 states and DC	No <sup>226</sup>
Regional price parities <sup>227</sup>	100	105.9 Rank: 10 <sup>th</sup> highest

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, (4) has less and/or does less to encourage private long-term care insurance, and (5) has a higher cost of living.

216 This data comes from a Department of Health and Human Services Inspector General letter report dated July 7, 2014 available [here](http://centerltc.com/OIG/IG_LetterReport.pdf) ([http://centerltc.com/OIG/IG\\_LetterReport.pdf](http://centerltc.com/OIG/IG_LetterReport.pdf)).

217 Data and analysis of 2011 estate recoveries as a percentage of SNF expenditures comes from Stephen A. Moses, "LTC Bullet: IG Report Reveals Medicaid Estate Recovery Weakness," Center for Long-Term Care Reform, Seattle, Washington, December 5, 2014, <http://www.centerltc.com/bullets/archives2014/1066.htm>.

218 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 2015, those limits have increased with inflation to \$552,000 to \$828,000.

219 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>.

220 *Ibid.*, p. 217.

221 *Ibid.*

222 *Ibid.*

223 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>.

224 "Key Medicaid Information for New Hampshire for 2015," *ElderLawAnswers*, <http://www.elderlawanswers.com/key-medicaid-information-for-new-hampshire-for-2015-12209>.

225 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>.

226 *Ibid.*, p. 9.

227 "Real Personal Income for States and Metropolitan Areas, 2013," Bureau of Economic Analysis, U.S. Department of Commerce, News Release, July 1, 2015, Table: 2013 Regional Price Parities by State (US=100), p. 3; [http://www.bea.gov/newsreleases/regional/rpp/rpp\\_newsrelease.htm](http://www.bea.gov/newsreleases/regional/rpp/rpp_newsrelease.htm).

New Hampshire has very generous Medicaid long-term care eligibility rules, but it is a 209-B state so the state could be more restrictive if it chose following expiration of the “maintenance of effort” rule. The state does a fair job of estate recovery, but its recovery ratio did not improve between 2004 and 2011. New Hampshire wisely set its home equity exemption at the lower \$552,000 level allowed by federal law. The state does have a long-term care insurance partnership program but does not have a state tax incentive for purchase of the product. New Hampshire implemented a debilitating rate cap on LTC insurance premium increases.<sup>228</sup> Its “regional price parity” is 105.9, the tenth highest in the country.

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

---

228 Effective February 13, 2015, the New Hampshire Insurance Department capped long-term care insurance premium increases at 50 percent for consumers age 50 or younger with the maximum increase declining gradually with age so that policyholders who are 90 and older face a maximum annual premium increase of 10 percent. Source: CHAPTER Ins 3600 LONG-TERM CARE INSURANCE, Ins 3601.19 [Premium Rate Schedule Increases \(f\) Table 3601.1 Maximum Permitted](http://www.gencourt.state.nh.us/rules/state_agencies/ins3600.html); [http://www.gencourt.state.nh.us/rules/state\\_agencies/ins3600.html](http://www.gencourt.state.nh.us/rules/state_agencies/ins3600.html). As a direct result of this action, one major long-term care insurance carrier, Genworth, stopped marketing the product in New Hampshire.

## 7. Entitlement Mentality

*How strong has cradle-to-grave dependency on public programs become?*

Arguably, the more people depend on social safety net programs, the less concerned they have to be about personal financial planning. Over the past 80 years, Social Security benefits have become the single biggest source of retirement income for elderly Americans.<sup>229</sup> Medicare is the dominant funding source for the elderly's acute health care.

[A "sleeper" provision when Congress created Medicare in 1965](#) to cover health care for seniors, Medicaid now provides coverage to nearly 1 in 4 Americans, at an annual cost of more than \$500 billion. Today, it is the workhorse of the U.S. health system, covering [nearly half of all births](#), one-third of children and two-thirds of people in nursing homes.<sup>230</sup>

**Medicaid is the largest funding source for long-term care. From birth to death, in one way or another, public funding offsets personal financial responsibility leaving more and more people at risk if the sources of public funding decline.**

Medicaid is the largest funding source for long-term care. From birth to death, in one way or another, public funding offsets personal financial responsibility leaving more and more people at risk if the sources of public funding decline.

The proportion of births paid for by Medicaid has been rapidly increasing. "In 2010, Medicaid financed 48% of all births, an increase of 19% in the proportion of all births covered by Medicaid in 2008."<sup>231</sup> The rate in 2010 was less than one-third in New Hampshire (29.9 percent) but that's up from 28.1 percent in 2008, a 6.5 percent increase.<sup>232</sup> These rates are likely to increase further:

Under federal law, states participating in the Medicaid program are required to cover pregnant women, infants, and young children ages 0 to 5 under 133% of the federal poverty level (FPL) and school-aged children ages 6 to 18 under 100% FPL. Many states have expanded Medicaid eligibility above these thresholds for particular groups of women and children. For example, as of January 2012, 39 states had expanded Medicaid eligibility for pregnant women to 185% FPL and beyond ([Kaiser Commission on Medicaid and the Uninsured, 2012](#)).<sup>233</sup>

Once born, mother and child and possibly the father as well, present or not, depending on income and resource limits, may be eligible for "food stamps," renamed the Supplemental Nutrition Assistance Program or SNAP as of October 2008. Nearly 46 million Americans rely on SNAP, 14.4 percent of the population. They receive \$70 billion in benefits averaging \$125.35 per person per month. New Hampshire depend somewhat less on food stamps. Only 8.4

229 Emily Brandon, "The 4 Most Important Sources of Retirement Income," *U.S. News & World Report*, March 22, 2012; <http://money.usnews.com/money/blogs/planning-to-retain/2012/03/22/the-4-most-important-sources-of-retirement-income>.

230 Phil Galewitz, "5 Challenges Facing Medicaid At 50," *Kaiser Health News*, July 27, 2015; available [here](#) at a very long URL.

231 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, [http://www.whjournal.com/article/S1049-3867\(13\)00055-8/fulltext#sec3.1](http://www.whjournal.com/article/S1049-3867(13)00055-8/fulltext#sec3.1).

232 *Ibid.*, "Table 3: Percent Change in Number of Births Financed by Medicaid, 2008 to 2010."

233 *Ibid.*, "Introduction and Background."

percent of them or 111,701 people receive SNAP benefits costing \$163 million or \$105 per person per month.<sup>234</sup>

### *Incentives Matter*

Surely working and paying for one's own food and other necessities would be preferable to relying on means-tested public benefit programs. But sometimes that is not the direction incentives in the public programs lean. According to the Cato Institute:

Welfare benefits continue to outpace the income that most recipients can expect to earn from an entry-level job, and the balance between welfare and work may actually have grown worse in recent years. The current welfare system provides such a high level of benefits that it acts as a disincentive for work.<sup>235</sup>

Welfare benefits, ranging from \$5.36/hour in Idaho to \$29.13 per hour in Hawaii, exceed the minimum wage in 35 states.<sup>236</sup> The hourly wage equivalent of welfare benefits in New Hampshire is \$19.11, the pre-tax equivalent of \$39,750 per year, making New Hampshire the ninth most generous of the United States.<sup>237</sup> In fact, the state's pretax wage equivalent actually exceeds its median salary of \$35,339 by 12.5 percent.<sup>238</sup>

Generous welfare benefits are not the only impediment to the work incentive. Huge growth in the Social Security Disability Insurance program has had a similar effect, placing the program at dire risk of insolvency.

Over the last 30 years the number of disabled workers who received benefits from the Social Security Disability Insurance (SSDI) program increased nearly three-fold, rising from 2.9 million in 1980 to 8.6 million in 2011. Although population growth explains some of this increase, SSDI caseloads as a share of the working age population (20-64) have also risen rapidly . . . Growth in the program has put considerable pressure on program finances. Absent policy action, the SSDI program is projected to be insolvent by 2016 according to projections from the Social Security Board of Trustees and the Congressional Budget Office.<sup>239</sup>

---

234 United States Department of Agriculture, Food and Nutrition Service, Program Data, Supplemental Nutrition Assistance Program, Annual State Level Data: FY 2010-2014, <http://www.fns.usda.gov/pd/snapmain.htm>.

235 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, p.1; [http://object.cato.org/sites/cato.org/files/pubs/pdf/the\\_work\\_versus\\_welfare\\_trade-off\\_2013\\_wp.pdf](http://object.cato.org/sites/cato.org/files/pubs/pdf/the_work_versus_welfare_trade-off_2013_wp.pdf).

236 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](http://object.cato.org/sites/cato.org/files/pubs/pdf/the_work_versus_welfare_trade-off_2013_wp.pdf).

237 *Ibid.*

238 *Ibid.*, "Table 4: Pretax Wage Equivalents Compared to Median Salaries," p. 10.

239 Mary C. Daly, Federal Reserve Bank of San Francisco; Brian Lucking, Federal Reserve Bank of San Francisco; and Jonathan Schwabish, Congressional Budget Office, "Explaining the Rapid Growth in Social Security Disability Insurance Rolls," Federal Reserve Bank of San Francisco, undated; available [here](#) at a very long URL.

Why are SSDI participation rates increasing so fast? Are aging baby boomers succumbing to work-related disabilities? Apparently not according to economists David Autor and Mark Duggan writing presciently in the February 2003 edition of the *Quarterly Journal of Economics*:

Between 1984 and 2001, the share of nonelderly adults receiving Social Security Disability Insurance income (DI) rose by 60 percent to 5.3 million beneficiaries. Rapid program growth despite improving aggregate health appears to be explained by reduced screening stringency, declining demand for less skilled workers, and an unforeseen increase in the earnings replacement rate. We estimate that the sum of these forces doubled the labor force exit propensity of displaced high school dropouts after 1984, lowering measured U. S. unemployment by one-half a percentage point. **Steady state calculations augur a further 40 percent increase in the rate of DI receipt.**<sup>240</sup> (Emphasis added.)

According to *US News & World Report*, “The country’s labor force participation rate – which measures the share of Americans at least 16 years old who are either employed or actively looking for work – dipped last month to a [38-year low](#), clocking in at an underwhelming 62.6 percent.”<sup>241</sup> Avik Roy, writing in *Forbes*, makes the key point bluntly: “It’s not just about the fact some people are taking advantage of the system. It’s about the fact that taxpayers are paying able-bodied Americans to drop out of the work force, increasing the burden on those who are still working.”<sup>242</sup> We have fewer pulling and more riding in the economic wagon.

### ***Pension Fund Shortfalls***

With so many fewer people working and paying into the country’s pension funds, won’t those funds be in jeopardy also? We’ve already covered the massive unfunded liabilities of the federal Social Security and Medicare programs. What about state and local pension funds? In November 2014, *State Budget Solutions* (SBS) reported that state public pension plans are underfunded by \$4.7 trillion, up from \$4.1 trillion in 2013. Overall, the combined plans’ funded status has dipped three percentage points to 36%. Split among all Americans, the unfunded liability is over \$15,000 per person.<sup>243</sup> SBS found that New Hampshire’s “funding ratio,” the percentage of its liabilities met, was seventh worst in the United States at 28 percent.<sup>244</sup>

---

240 David H. Autor and Mark G. Duggan, “The Rise in the Disability Rolls and the Decline in Unemployment,” *Quarterly Journal of Economics*, February 2003; available [here](#) at a very long URL.

241 Andrew Soergel, “Where Are All the Workers?,” *US News & World Report*, July 16, 2005; <http://www.usnews.com/news/the-report/articles/2015/07/16/unemployment-is-low-but-more-workers-are-leaving-the-workforce>.

242 Avik Roy, “How Americans Game the \$200 Billion-a-Year ‘Disability-Industrial Complex,’” April 8, 2013, *Forbes*; <http://www.forbes.com/sites/theapothecary/2013/04/08/how-americans-game-the-200-billion-a-year-disability-industrial-complex/>.

243 Joe Luppino-Esposito, “Promises Made, Promises Broken 2014: Unfunded Liabilities Hit \$4.7 Trillion, the Betrayal of Retirees and Taxpayers Continues as State Governments Fail to Change Their Faulty Pension Accounting,” *State Budget Solutions*, November 12, 2014; <http://www.statebudgetsolutions.org/publications/detail/promises-made-promises-broken-2014-unfunded-liabilities-hit-47-trillion>.

244 *Ibid.*

But SBS uses a very strict accounting methodology to determine pension funding ratio.<sup>245</sup> Even applying a more lenient methodology, however, and recognizing the revenue gains as more years of relative prosperity are added to the average and the bad years of the Great Recession recede, “In the aggregate, the actuarial value of assets amounted to \$3.2 trillion and liabilities amounted to \$4.3 trillion, producing the funded ratio of 74 percent.”<sup>246</sup> Nor is the New Hampshire Retirement System’s ratio of pension assets to liabilities especially encouraging under this more generous methodology having declined from 85.0 percent in 2001 to 60.7 percent in 2014.<sup>247</sup>

### ***Cradle to Grave Dependency***

From the beginning of life to the end, financially stressed public programs are already struggling to keep their promises to recipients while arguably deflating the same beneficiaries’ incentives to plan and manage financially for themselves. From Medicaid’s paying for nearly half of all births to food stamps for one in seven Americans to welfare benefits topping median salaries in eight states including New Hampshire to surging SSDI rolls bankrupting the disability insurance system and sapping the incentive to work to unfunded pension liabilities in the trillions of dollars, this socialized house of cards is severely vulnerable to any bad economic wind that may, and likely will, come its way.

Medicaid, which pays for nearly two-thirds of all nursing home residents and a growing proportion of home and community-based long-term care, is possibly the most vulnerable of all. By exempting prepaid burial plans for a large majority of its long-term care recipients, Medicaid bookends the entitlement system from birth to death. The unlimited exemption for prepaid burial plans is no trivial matter. Nearly two (1.9) million elderly Medicaid recipients receive long-term services and supports<sup>248</sup> of whom 60 percent to 80 percent, based on interviews by the author with many eligibility workers in numerous states over the years, shelter an average of \$8,000 to \$12,000 each in prepaid burial plans. Taking the low range estimate of 60 percent and \$8,000, that amounts to \$9.1 billion diverted from potential private LTC financing to a Medicaid-financed windfall for the funeral industry.

---

245 “State Budget Solutions uses fair market valuation to determine the unfunded liabilities of public pension plans. Outside of the small world of public pensions, there is [near-universal agreement](#) that discount rates based on the assumed rate of investment return are far too risky. The approach SBS uses is to [discount liabilities](#) based on the approximate equivalent of a 15-year U.S. Treasury bond yield. This year’s number is derived from the 2013 calendar year average of the 10 and 20 year bond yields.”

246 Alicia H. Munnell and Jean-Pierre Aubry, “The Funding of State and Local Pensions: 2014-2018,” *State and Local Pension Plans*, Number 45, June 2015, Center for Retirement Research; <http://crr.bc.edu/briefs/the-funding-of-state-and-local-pensions-2014-2018/>.

247 *Ibid.*, “Appendix: Ratio of Assets to Liabilities for State/Local Plans 2001, 2004, 2007-2013, and 2014 Estimates,” p. 11.

248 Erica L. Reaves and MaryBeth Musumeci, “Medicaid and Long-Term Services and Supports: A Primer,” Kaiser Family Foundation, May 2015, “Figure 5: Among Beneficiaries Who Use Long-Term Services and Supports, a Larger Share of Non-Elderly People with Disabilities Live in the Community Than Seniors”; <http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>.

## Summary and Scoring for Entitlement Mentality:

*How strong has cradle-to-grave dependency on public programs become?*

	United States	New Hampshire
Births financed by Medicaid (2010) <sup>249</sup> Range:	47.8% From 69% (LA) to 24% (HI)	29.9% <sup>250</sup>
Supplemental Nutrition Assistance Program (Food Stamps), 2014 <sup>251</sup> Participants (ave. per month) Percent of population <sup>253</sup> Total annual benefits Ave. benefit per person per month:	45,972,533 <sup>252</sup> 14.4% \$69,999,805,422 <sup>254</sup> \$125.35	111,701 8.4% \$162,970,800 <sup>255</sup> \$104.98
Welfare exceeds minimum wage <sup>256</sup> in . . .	35 states and ranges from \$5.36/hr. in Idaho to \$29.13 in Hawaii	\$19.11 Rank: 9
Social Security Disability Insurance	\$145.1 billion, trust fund depleted in 2016 <sup>257</sup>	
SSDI replaces work <sup>258</sup> SSDI Beneficiaries, Ages 18-64 <sup>259</sup>	8,624,654	47,094

249 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).

250 *Ibid.*

251 United States Department of Agriculture, Food and Nutrition Service, Program Data, Supplemental Nutrition Assistance Program, Annual State Level Data: FY 2010-2014, <http://www.fns.usda.gov/pd/snapmain.htm>.

252 FY 2015 data as of July 10, 2015.

253 United States population as of July 29, 2015: 319,060,104. 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>.

254 FY 2014

255 FY 2013

256 “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](http://object.cato.org/sites/cato.org/files/pubs/pdf/the_work_versus_welfare_trade-off_2013_wp.pdf).

257 “Social Security’s Disability Insurance (DI) Trust Fund now faces an urgent threat of reserve depletion, requiring prompt corrective action by lawmakers if sudden reductions or interruptions in benefit payments are to be avoided. . . . DI Trust Fund reserves expressed as a percent of annual cost (the trust fund ratio) declined to 40 percent at the beginning of 2015, and the Trustees project trust fund depletion late in 2016, the same year projected in the last Trustees Report.” Source: “A Summary of the 2015 Annual Reports: Social Security and Medicare Boards of Trustees,” Social Security Administration, <http://www.ssa.gov/oact/trsum/>. See Table 2: Program Cost (in Billions) for cost figure.

258 “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](http://object.cato.org/sites/cato.org/files/pubs/pdf/pa733_web.pdf).

259 “2014 Annual Disability Statistics Compendium,” Institute on Disability, University of New Hampshire, Table 9.7 Social Security Disability Insurance and Supplemental Security Income—Number of Total and Concurrent Beneficiaries, Age 18 to 64: December 2012, p. 90; [http://www.disabilitycompendium.org/docs/default-source/2014-compendium/2014\\_compendium.pdf](http://www.disabilitycompendium.org/docs/default-source/2014-compendium/2014_compendium.pdf).

Percent of population <sup>260</sup>	2.7%	3.5%
Unfunded pension liabilities of state and local governments	\$3 trillion <sup>261</sup>	Funding ratio: 56.2% \$4.6 billion <sup>262</sup>
To fully fund would require:	\$1,385 tax increase per household per year for 30 years <sup>263</sup>	\$1,010 tax increase per household per year for 30 years <sup>264</sup>
Nursing facility residents with . . . <sup>265</sup>		
Medicaid as primary payer,	63%	64%
Medicare as primary payer,	14%	15%
Other as primary payer	22%	21%
Medicaid recipients with prepaid burial plans that avoid spend down requirements	Approx. 80% <sup>266</sup>	80% <sup>267</sup>

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.

New Hampshire’s unfunded pension fund liabilities are very high and the state’s pension system is only 56.2% funded. Nevertheless, the extra taxes needed to fund the pension liabilities are roughly one-third lower than the national average. The state has fewer births financed by Medicaid and fewer people dependent on food stamps than most other states. But New Hampshire has more people proportionately dependent on Social Security Disability Income (SSDI) and a very high welfare compensation rate compared to minimum wage, which disincentivizes work.

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

260 United States population as of July 29, 2015: 319,060,104. 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>.

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

262 “Public pensions in New Hampshire,” *BallotPedia*, undated, [http://ballotpedia.org/Public\\_pensions\\_in\\_New\\_Hampshire](http://ballotpedia.org/Public_pensions_in_New_Hampshire). “Between fiscal years 2008 and 2012, the funded ratio of New Hampshire’s state-administered pension plans decreased from 68 percent to 56.2 percent. The state paid 100 percent of its annual required contribution, and for fiscal year 2012 the pension system’s unfunded accrued liability totaled \$4.6 billion. This amounted to \$3,470 in unfunded liabilities per capita.<sup>[213]</sup>”

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

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

265 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>.

266 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.

267 *Ibid.*



## Summary

America's LTC-prone, 85- plus population will more than triple by 2050 (+224 percent); New Hampshire's will nearly quadruple (+267 percent). Over one-third of the elderly already have a disability (37 percent); just under one-third in New Hampshire do (32 percent). Nearly half of nursing home residents suffer from dementia nationally (46 percent); well over half do in New Hampshire (55 percent). More people are living longer and the longer they live, the more likely they are to succumb to the chronic illnesses of old age and to require extended care.

Medicaid is the dominant payer for long-term care consuming nearly 17.8 percent of state budgets (much more including federal matching funds); 40.4 percent in New Hampshire. Long-term care, especially for dual eligibles and the aged, blind and disabled, consumes a disproportionate share of Medicaid expenditures. State efforts to rebalance from institutional to home care have made Medicaid more attractive and increased expenditures. Easy access to Medicaid after people need long-term care has crowded out private LTC financing alternatives such as home equity conversion and private long-term care insurance. Low Medicaid reimbursement has diminished care access and quality for poor and affluent alike. Medicaid consumes a larger and larger proportion of state budgets and tends to crowd out other spending priorities over time. Expansion of Medicaid eligibility under the Affordable Care Act (AKA ObamaCare) will exacerbate all these problems.

To survive as the principal funder of long-term care, Medicaid is heavily dependent on federal (57%) and state (43%) funds. The ratio is 50/50 for New Hampshire. But the availability of sufficient federal funds in the future is dubious. Federal debt is huge and growing, nearly \$19 trillion as of January 20, 2016.<sup>268</sup> Infinite horizon unfunded liabilities of Social Security and Medicare are \$73.4 trillion. Federal Medicaid lacks even the artifice of a borrowed "trust fund" to obscure its unlimited general fund liability. Federal reserve policy has expanded the money supply tremendously and forced interest rates to near-zero creating a risk of higher, possibly hyper-inflation. Aging boomers have not saved enough. Low interest rates reduce their retirement incomes, making them more dependent on safety net programs that threaten to explode in cost.

State funds needed to match the federal Medicaid funds are also vulnerable. Each new economic bubble bursting—most recently the dot.com (2000) and housing (2008) busts—has brought worsening recessions that devastate state tax revenues and reserves. Economists worry that the latest bubble, inflated by extremely loose monetary (credit expansion) and fiscal (spending) policy, will bring on a

---

268 U.S. National Debt Clock as of January 20, 2016, <http://www.usdebtclock.org/>.

much worse downturn than the Great Recession.<sup>269</sup> Worst of all, “Policy makers worry fiscal and monetary tools to battle a recession are in short supply .... The U.S. generally injects cash into the economy through interest-rate cuts, tax cuts or ramped-up federal spending. Those tools could be hard to employ when the next dip comes: Interest rates are near zero, and fiscal stimulus plans could be hampered by high levels of government debt and the prospect of growing budget deficits to cover entitlement spending on retired baby boomers.”<sup>270</sup>

If the Age Wave and financing pressures are too great for Medicaid to sustain long-term care financing, where can the country and states like New Hampshire turn? Unfortunately, potential private sources of LTC financing have been largely crowded out by the relatively easy access to Medicaid in the past. Medicaid income and asset eligibility rules make it feasible for people with substantial wealth to qualify. Mandatory estate recovery goes largely unenforced. Medicaid's out-sized home equity exemption eliminates reverse mortgages as a major source of LTC funding. A main reason so few people purchase private LTC insurance is that for the past 50 years Americans have been able to ignore the risk and cost of LTC, wait to see if they need extended care and, if they do, qualify easily for public financing while protecting most or all of their estates. This perverse incentive has discouraged responsible LTC planning and impeded the market for private insurance products that could have relieved the financial pressure on Medicaid.

Underscoring all these practical problems is a broader socio-political malaise. Over the past eight decades more and more Americans have become dependent on government programs. Arguably, a growing entitlement mentality has substantially impaired the country's traditional reliance on personal responsibility, self-sufficiency, independence, and freedom, the building blocks of our earlier economic success.

Public assistance (Medicaid) pays for nearly half of all births in the U.S. (47.8 percent), though less than a third (29.9 percent) in New Hampshire. Food stamps sustain one in seven (14.4 percent) of Americans; only one in 12 (8.4 percent) New Hampshire residents. Welfare pays more than work in 35 states, over \$19 per hour in New Hampshire, the ninth most generous state. The nearly bankrupt Social Security Disability Income (SSDI) program crowds out work. SSDI supports 2.7 percent of Americans, 3.5 percent in New Hampshire. State and local pensions, on which many depend, are unfunded \$3 trillion nationally, \$4.6 billion in New Hampshire. Fully funding them would require tax increases of \$1,385 per household per year for 30 years nationally; \$1,010 in New Hampshire, which has pre-funded only 56.2% of its pension liability. Medicaid is the primary payer for 63 percent of nursing home residents; 64 percent in New Hampshire and up-

---

269 “We demonstrate that what makes some bubbles more dangerous than others is credit. When fueled by credit booms, asset price bubbles increase financial crisis risks; upon collapse they tend to be followed by deeper recessions and slower recoveries. Credit-financed housing price bubbles have emerged as a particularly dangerous phenomenon.” Source: Óscar Jordà, Moritz Schularick, and Alan M. Taylor, “Leveraged Bubbles,” National Bureau of Economic Research (NBER) Working Paper 21486, <http://www.nber.org/papers/w21486>.

270 Jon Hilsenrath and Nick Timiraos, “U.S. Lacks Ammo for Next Economic Crisis,” *Wall Street Journal*, August 17, 2015; <http://www.wsj.com/articles/u-s-lacks-ammo-for-next-economic-crisis-1439865442>.

wards of 80 percent of all Medicaid nursing home residents have prepaid burial insurance funded by assets exempted from the program's resource spend down requirements. This cradle-to-grave public safety net creates a moral hazard, "a situation in which a party is more likely to take risks because the costs that could result will not be borne by the party taking the risk."<sup>271</sup>

## Conclusion

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

The future prospects for private long-term care financing alternatives are better than they currently appear. When economic conditions compel Medicaid and Medicare to back off from LTC financing, real asset spend down will rapidly increase; spend down of home equity to fund LTC will accelerate; and as retirement savings and home equity are consumed to pay for long-term care, more and more people will begin to plan early and insure privately for that risk and cost. Private LTC insurance can become a mainstream financial planning tool, losing its reputation as the "poor relative" of insurance products, as demand and distribution increase.

---

<sup>271</sup> Wikipedia definition of "moral hazard," [http://en.wikipedia.org/wiki/Moral\\_hazard](http://en.wikipedia.org/wiki/Moral_hazard). The definition cited in the text is no longer at this source, but remains an accurate description of moral hazard.

## Recommendations

### *Federal Recommendations*

1. Change federal monetary policy (low interest rates, credit expansion, easy money) which has enriched the affluent by increasing equity and real estate values but hurt the poor and middle class by impeding job creation and nearly eliminating safe income from savings.
2. Change federal fiscal policy (deficit spending) which has grown the national debt from \$10.8 trillion in January 2009 to \$18.9 trillion today, undermined social safety net programs with trillions of dollars in unfunded liabilities, and diverted capital away from productive private uses thus damaging the economy and inhibiting job creation.
3. Change the Federal Medical Assistance Percentage (FMAP) system of funding Medicaid so that it does not incentivize excessive program expenditures and disproportionately benefit wealthier states and people at the expense of poorer states and people.
4. Block grant Medicaid or cap federal funding with fewer mandates and controls in order to encourage and enable states to experiment with new, potentially more cost-effective approaches to long-term care service delivery and financing.
5. Let states target Medicaid to the needy by allowing them more freedom to set their own Medicaid long-term care eligibility standards. For example, eliminate or radically reduce the mandatory home equity exemption currently set at between \$552,000 and \$828,000 while retaining reasonable protections for community spouses.
6. Review federal restrictions on Medicaid estate recovery, encourage and publicize the responsibility of recipients with exempt wealth to repay Medicaid for their care from their estates, and use some of the savings to educate consumers about long-term care planning, home equity conversion, and long-term care insurance as options to fund LTC.
7. Reassess waiver and incentive programs that encourage rebalancing from institutional to home-based care. Programs that make Medicaid more attractive should await successful re-targeting of LTC benefits to the truly needy so they do not discourage private financing and overwhelm the publicly funded system.
8. Reduce future numbers of Medicaid's most expensive users, the dual eligibles, by tightening financial eligibility rules, including much longer transfer of assets lookback restrictions, so people will know they need to plan for long-term care many years before they become eligible for Medicare and vulnerable to Medicaid dependency.

9. Reassess incentives for expanding LTC managed care and delay implementation, especially for dually eligible recipients, until demonstrations show more conclusively that Managed Care Organizations can handle the special challenges such patients entail.
10. Recognize the damage done by the growing entitlement mentality and start weaning Americans, especially the non-poor off the dole in all its forms.

### ***State Recommendations***

1. Advocate for the federal changes described above.
2. Eschew complacency. Take aging demographics much more seriously. Focus on preparing for 2050 and 2025 will take care of itself.
3. Review New Hampshire's 209-B status for ways to tighten eligibility for Medicaid long-term care benefits.
4. Enhance private LTC revenue sources by tightening eligibility, disallowing Medicaid planning wherever possible, encouraging personal responsibility for long-term care, publicizing estate recovery responsibility, and endorsing reverse mortgages and private long-term care insurance as preferable to Medicaid dependency.
5. Reduce Medicaid LTC participation, utilization and costs so that the program can afford to pay adequately for a continuum of care for a smaller number of genuinely needy recipients. In the meantime, don't discourage "free" care by making Medicaid home and community-based care more attractive and easier to get.
6. Recognize the roles of Social Security and Medicare in sustaining Medicaid long-term care at sub-cost reimbursement rates. Account for those programs' fiscal vulnerability so that the state is not surprised and devastated by potential, and increasingly likely, federal cutbacks.
7. Reduce dependency on federal funds in general. End provider taxes specifically.
8. Drop out of the Affordable Care Act, ObamaCare program before it makes new Hampshire even more dependent on dubious future federal funding.
9. Take managed care for the aged, blind and disabled slowly, especially for duals. Reduce future duals by stronger eligibility controls and early consumer education.
10. Enhance state revenue prospects by aspiring to better scores on economic rating systems. Stop New Hampshire's economic freedom slide. Encourage economic activity by lowering taxes. End Medicaid LTC financing by county property taxes or give counties a much stronger role in eligibility and other policies. Fund the state pension system.

## Appendix 1: Long Term Care Complacency and a Wake-Up Call

Recent *LTC Bullets* have focused on academics' and policy-makers' complacency about unusually small health and long-term care expenditure increases over the past few years. See [LTC Bullet: Cassandra's Quandary](#) (7/17/15)<sup>272</sup> and [LTC Bullet: Pandora Meets Rosy Scenario in CMS Projections](#) (7/31/15).<sup>273</sup> The following analysis of New Hampshire's vulnerability to rapidly increasing Medicaid long-term care expenditures is modified from an earlier version that appeared in [LTC Bullet: Long-Term Care Wake-Up Call](#) (8/7/15).<sup>274</sup>

Everyone seems to agree that the recent moderate medical inflation will not continue indefinitely. But few people in a position to do something about it appear to be taking full cognizance of the potential risk and cost. Just as consumers are enabled to be in denial about long-term care because government has indemnified them against most catastrophic LTC costs over the years, so public officials and too many of the experts who advise them have allowed mild health and LTC inflation recently to dull their level of concern about the future.<sup>275</sup>

The Granite State is interesting on this topic for many reasons. It has a lot of old people already and its over-65 and over-85 cohorts are growing faster than they are in most other states. New Hampshire is also suffering from a "birth dearth" with declining rates of child-bearing and in-migration suggesting a future shortage of workers, including LTC caregivers. As elsewhere, Medicaid strains the state budget despite notoriously low reimbursement rates for providers. And, of course, being the first-in-the-nation presidential primary state, New Hampshire offers a unique opportunity to push hard questions about Medicaid and LTC financing into the faces of an unusually large number of presidential candidates this year.

---

272 Stephen A. Moses, "LTC Bullet: Cassandra's Quandary," Center for Long-Term Care Reform, Seattle, Washington, July 17, 2015; <http://www.centerlrc.com/bullets/latest/1093.htm>.

273 Stephen A. Moses, "LTC Bullet: Pandora Meets Rosy Scenario in CMS Projections," Center for Long-Term Care Reform, Seattle, Washington, July 31, 2015; <http://www.centerlrc.com/bullets/latest/1095.htm>.

274 Stephen A. Moses, "LTC Bullet: Long-Term Care Wake-Up Call," Center for Long-Term Care Reform, Seattle, Washington, August 7, 2015; <http://www.centerlrc.com/bullets/latest/1096.htm>.

275 Latest indications are that recent mild health care cost inflation is abating sooner than expected: "Federal spending on Medicare, Medicaid, the Children's Health Insurance Program and exchange subsidies will rise from 5.2% of the country's economic output in 2015 to 6.2% in 2025, the Congressional Budget Office said Tuesday in [updated budget projections \(PDF\)](#)." Source: Bob Herman, "Federal healthcare spending projections inch upward," *Modern Healthcare*, August 25, 2015; <http://www.modernhealthcare.com/article/20150825/NEWS/150829930>.

So, given New Hampshire's vulnerability to LTC risk and cost, why aren't thought-leaders and decision-makers in the "live free or die state" more concerned? I think a decade of relatively tame Medicaid LTC expenditure increases has desensitized them. For example, from 2005 to 2014 New Hampshire's Medicaid long-term care expenditures for the elderly in . . .

- **Nursing Homes** only increased from \$174,491,000 to \$192,854,000 or **10.5%**.
- **Home Nursing Services** (Choices for Independence Waiver) increased more rapidly from \$26,086,000 to \$43,512,000 or **66.8%**, but these services help recipients stay out of a nursing home and in their own homes at less cost, so they're presumed to explain the low inflation in nursing home expenditures.
- Likewise **Mid-Level Care (Choices for Independence Waiver, AKA residential care or assisted living)** grew from \$1,497,000 to \$9,327,000 or **523.0%**, but again this increase is considered to be in lieu of higher institutional costs.
- **Medical Services** to support home care declined from \$50,536,000 to \$36,052,000, a **28.7% decrease**, but they have leveled out around \$36,000.
- **Total Medicaid LTC expenditures for the elderly** increased from \$252,610,000 in 2005 to \$281,745,000 in 2014, an increase of only **11.5%** over a ten-year period!

Together, these LTC expenditure data convey a message that rebalancing from institutional to home and community-based care is working to keep overall cost increases moderate. For the sake of argument, let's assume that this is true and that over time nursing home costs will continue to increase only slowly while increases in home care costs will moderate some, other factors remaining equal. Should that give us peace of mind about the future?

No! Because other factors will decidedly not remain the same. For now, never mind the potential inflation in the market price of all levels of long-term care services. Set aside any concerns about the financial viability of Medicaid or the risk of another national economic downturn. Let's look only at the predictable growth of the elderly population in New Hampshire. This is not speculation. Most of the baby boomers in the state who will need long-term care in the future are already there. Of course, some will move out but demographers predict the future holds more, many more, not fewer aged people in New Hampshire. What's the potential impact?

We draw on AARP's "[Across the States—2012](#)" publication for these estimates of aging in New Hampshire.<sup>276</sup> Expenditure data come from the State of New Hampshire Office of Legislative Budget Assistant. The "Source Data" section below lays out more details. But here are the highlights . . .

---

276 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. 216; <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>.

### ***Nursing Homes***

- Nursing homes cost New Hampshire Medicaid \$145 per state resident; \$979 per resident over age 65; and \$6,888 per resident over age 85 for a total of **\$192,854,000 in 2014**
- Taking into account only growth in the aging population, nursing homes will cost New Hampshire Medicaid . . .
- **\$364,171,000 in 2032**, an 88.8% increase and **\$392,980,000 in 2050**, a 103.8% increase based on age 65-plus growth from 197,000 in 2012 to 372,000 in 2032 and 401,000 in 2050
- **\$344,382,000 in 2032**, a 78.6% increase and **\$716,560,000 in 2050**, a 271.6% increase based on age 85-plus growth from 28,000 in 2012 to 50,000 in 2032 and 104,000 in 2050

### ***Home Nursing Services (Choices for Independence Waiver)***

- Home Nursing Services cost New Hampshire Medicaid \$32.79 per state resident; \$221 per resident over age 65; and \$1,554 per resident over age 85 for a total of **\$43,512,000 in 2014**
- Taking into account only growth in the aging population, home nursing services will cost New Hampshire Medicaid . . .
- **\$82,163,640 in 2032** and **\$88,568,870 in 2050** based on age 65-plus growth
- **\$77,700,000 in 2032** and **\$161,616,000 in 2050** based on age 85-plus growth

### ***Mid-Level Care (Choices for Independence Waiver)***

- Mid-Level Care (assisted living) costs New Hampshire Medicaid \$7.03 per state resident; \$47.35 per resident over age 65; and \$333.11 per resident over age 85 for a total of **\$9,327,000 in 2014**.
- Taking into account only growth in the aging population, mid-level care will cost New Hampshire Medicaid . . .
- **\$17,612,406 in 2032** and **\$18,987,350 in 2050** based on age 65-plus growth
- **\$16,655,357 in 2032** and **\$34,643,440 in 2050** based on age 85-plus growth

### ***Medical Services***

- Medical Services for home care recipients cost New Hampshire Medicaid \$27.17 per state resident; \$183.00 per resident over age 65; and \$1,287.57 per resident over age 85 for a total of **\$36,052,000 in 2014**.
- Taking into account only growth in the aging population, medical services will cost New Hampshire Medicaid . . .
- **\$68,076,000 in 2032** and **\$73,383,000 in 2050** based on age 65-plus growth
- **\$64,378,571 in 2032** and **\$133,907,280 in 2050** based on age 85-plus growth



### ***Total Medicaid Long-Term Care for the Elderly***

- Nursing homes plus home nursing plus mid-level plus medical services: **\$281,745,000 as of 2014**
- Taking into account only growth in the aging population, total long-term care for the elderly will cost New Hampshire Medicaid . . .
- **\$531,934,560 in 2032** and **\$574,196,310 in 2050** based on age 65-plus growth
- **\$503,196,570 in 2032** and **\$1,046,964,420** based on age 85-plus growth

**LTC Comment:** It is interesting to note how the estimate of growth in expenditures through 2032 is higher based on age 65+ population growth than it is based on age 85+ population growth. Even more remarkable is that costs would increase only slightly between 2032 and 2050 based on growth in the 65+ population (from \$532 million to \$574 million) whereas they skyrocket (from \$503 million in 2032 to over \$1 billion) based on growth in the 85+ population. That's true because the age 85+ population growth is expected to accelerate considerably between 2032 and 2050 growing from 3.2 percent of the population to 5.9 percent. But in the same period, the percentage of the population aged 65+ decreases from 8.0 percent to 7.4 percent. For the same reason, and because 85 is the age at which the incidence of dementia begins to spike causing the highest long-term care expenses, the growth in the 85-plus population is probably the better factor to consider in estimating likely future costs.

Bottom line, the take away from this analysis is that other things being equal New Hampshire's Medicaid long-term care expenditures may nearly quadruple over the next 35 years to more than one billion dollars based on nothing other than highly predictable increases in the "old-old" (85+) population.

### ***Ceteris Non Paribus***

Unfortunately, other things are never equal. Much more than aging demographics goes into reasonably predicting future Medicaid LTC expenditures. In our report titled "[Apply the LTC Vulnerability Index to Your State: The New Hampshire Example](#),"<sup>277</sup> we identified six additional critical factors:

- Morbidity or how sick future aged cohorts will be
- Medicaid viability as a long-term care payer
- Reliability of federal revenue to fund Medicaid LTC
- Reliability of state revenue to fund Medicaid LTC
- Potential of currently untapped private LTC payment sources
- Deleterious impact of growing dependency on public programs (Entitlement Mentality)

---

<sup>277</sup> Stephen A. Moses, "Apply the LTC Vulnerability Index to Your State: The New Hampshire Example," Center for Long-Term Care Reform, Seattle, Washington, April 21, 2015; [http://centerlrc.com/pubs/Apply\\_the\\_LTC\\_Vulnerability\\_Index\\_to\\_Your\\_State--The\\_New\\_Hampshire\\_Example.pdf](http://centerlrc.com/pubs/Apply_the_LTC_Vulnerability_Index_to_Your_State--The_New_Hampshire_Example.pdf).

The current report on Medicaid and long-term care financing in New Hampshire expands on all of these factors and integrates them into a reasonable prognostication of what the state can expect to happen going forward. It also contains recommendations for state and federal policy changes to correct the dangerous course New Hampshire and the country are pursuing currently.

### **Source Data**<sup>278</sup>

- New Hampshire population: 1,326,813<sup>279</sup>

### **Nursing Homes**

- From 2005 to 2014: Nursing homes \$174,491,000 to \$192,854,000 or 10.5% increase. As of 2014: \$145.35 per state resident;
- \$978.95 per 197,000 age 65+ in 2012; 372,000 age 65+ in 2032 without inflation = \$364,171,000 or 88.8% increase; 401,000 age 65+ in 2050 without inflation = \$392,980,000 or 103.8% increase;
- \$6,887.64 per 28,000 age 85+ in 2012; 50,000 85+ in 2032 without inflation = \$344,382,000 or 78.6% increase; 104,000 85+ in 2050 without inflation = \$716,560,000 or 271.6% increase

### **Home Nursing Services**

- From 2005 to 2014: Home Nursing Services \$26,086,000 to \$43,512,000 or 66.8% increase. As of 2014: \$32.79 per state resident;
- \$220.87 per 197,000 age 65+ in 2012; 372,000 age 65+ in 2032 without inflation = \$82,163,640 or 88.8% increase; 401,000 age 65+ in 2050 without inflation = \$88,568,870 or 103.6% increase;
- \$1,554 per 28,000 age 85+ in 2012; 50,000 age 85+ in 2032 without inflation = \$77,700,000 or 78.6%; 104,000 age 85+ in 2050 without inflation = \$161,616,000 or 271.4% increase

### **Mid-Level Care**

- From 2005 to 2014: Mid-Level Care \$1,497,000 to \$ 9,327,000 or 523.0% increase. As of 2014: \$7.03 per state resident;
- \$47.35 per 197,000 age 65+ in 2012; 372,000 age 65+ in 2032 without inflation = \$17,612,406 or 88.8% increase; 401,000 age 65+ in 2050 without inflation = \$18,987,350 or 103.6% increase;
- \$333.11 per 28,000 age 85+ in 2012; 50,000 age 85+ in 2032 without inflation = \$16,655.357 or 78.6%; 104,000 age 85+ in 2050 without inflation = \$34,643,440 or 271.4% increase

---

<sup>278</sup> Source for Medicaid LTC expenditure data: Office of Legislative Budget Assistant, State of New Hampshire. See Appendix 2.

<sup>279</sup> From the U.S. Census Bureau QuickFacts: <http://quickfacts.census.gov/qfd/states/33000.html>

### **Medical Services**

- From 2005 to 2014: Medical Services \$50,536,000 to \$36,052,000 or 28.7% decrease, but has leveled out around \$36,000. As of 2014: \$27.17 per state resident;
- \$183.00 per 197,000 age 65+ in 2012; 372,000 age 65+ in 2032 without inflation = \$68,076,000 or 88.8% increase; 401,000 age 65+ in 2050 without inflation = \$73,383,000 or 103.6% increase;
- \$1,287.57 per 28,000 age 85+ in 2012; 50,000 age 85+ in 2032 without inflation = \$64,378,571 or 78.6%; 104,000 age 85+ in 2050 without inflation = \$133,907,280 or 271.4% increase

**Appendix 2: State of New Hampshire Expenditure History<sup>280</sup>**

LBAO  
07/09/15

State of New Hampshire										
Expenditure History by Category - Total Funds										
(\$\$ In Thousands)										
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Category 1- General Government	\$ 331,651	\$ 353,814	\$ 358,060	\$ 420,367	\$ 495,720	\$ 568,119	\$ 525,152	\$ 467,022	\$ 428,738	\$ 425,806
Percent of Total	8.0%	8.4%	8.4%	9.1%	10.1%	10.4%	9.9%	9.8%	8.8%	8.4%
Category 2 - Administration of Justice and Public Protection	\$ 288,737	\$ 345,779	\$ 341,501	\$ 420,120	\$ 438,273	\$ 474,095	\$ 506,824	\$ 520,958	\$ 528,734	\$ 480,720
Percent of Total	6.9%	8.2%	8.0%	9.0%	8.9%	8.7%	9.6%	11.0%	10.9%	9.5%
Category 3 - Resource Protection and Development	\$ 130,113	\$ 131,812	\$ 139,096	\$ 138,215	\$ 139,574	\$ 178,406	\$ 132,690	\$ 142,153	\$ 156,148	\$ 140,316
Percent of Total	3.1%	3.1%	3.3%	3.0%	2.8%	3.3%	2.5%	3.0%	3.2%	2.8%
Category 4 - Transportation	\$ 383,435	\$ 416,518	\$ 411,475	\$ 443,258	\$ 518,415	\$ 587,542	\$ 456,652	\$ 310,736	\$ 410,758	\$ 541,316
Percent of Total	9.2%	9.9%	9.6%	9.5%	10.5%	10.8%	8.6%	6.6%	8.4%	10.7%
Category 5 - Health and Social Services	\$1,785,525	\$1,681,182	\$1,714,445	\$1,877,924	\$1,980,286	\$2,162,636	\$2,177,806	\$1,959,017	\$2,009,403	\$2,153,341
Percent of Total	43.0%	39.8%	40.1%	40.4%	40.3%	39.7%	41.2%	41.3%	41.3%	42.4%
Category 6 - Education	\$1,235,183	\$1,289,684	\$1,310,261	\$1,343,253	\$1,346,221	\$1,469,926	\$1,484,909	\$1,342,002	\$1,329,015	\$1,335,566
Percent of Total	29.7%	30.6%	30.7%	28.9%	27.4%	27.0%	28.1%	28.3%	27.3%	26.3%
State Totals	4,154,644	4,218,789	4,274,838	4,643,137	4,918,489	5,440,724	5,284,033	4,741,888	4,862,796	5,077,065
<b>Long Term Care - Medicaid</b>										
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nursing Homes	\$ 174,491	\$ 180,253	\$ 186,405	\$ 187,767	\$ 181,772	\$ 182,714	\$ 169,339	\$ 187,159	\$ 178,166	\$ 192,854
Home Nursing Services	\$ 26,086	\$ 29,248	\$ 34,146	\$ 26,531	\$ 46,141	\$ 49,717	\$ 45,358	\$ 43,266	\$ 43,697	\$ 43,512
Mid- level care	\$ 1,497	\$ 2,109	\$ 3,646	\$ 5,204	\$ 5,387	\$ 6,239	\$ 7,247	\$ 7,668	\$ 7,840	\$ 9,327
Medical Services	\$ 50,536	\$ 44,517	\$ 27,835	\$ 29,362	\$ 31,094	\$ 36,637	\$ 36,569	\$ 36,991	\$ 29,497	\$ 36,052
Other Nursing Homes	\$ 3,882	\$ 3,573	\$ 3,363	\$ 3,311	\$ 3,735	\$ 3,787	\$ 3,309	\$ 3,541	\$ 3,192	\$ 4,043
Proportionate Share Payments (ProShare)	\$ 23,431	\$ 19,090	\$ 11,087	\$ 18,210	\$ 14,631	\$ 9,814	\$ 22,967	\$ 23,231	\$ 83,469	\$ 49,257
State Phase Down - (Medicare Part D -Claw back)	\$ -	\$ 3,441	\$ 9,667	\$ 10,161	\$ 10,176	\$ 7,458	\$ 9,028	\$ 11,211	\$ 11,945	\$ 11,025
Medicaid Quality Incentive Payments (Bed Tax used to generate federal funds)	\$ 105,787	\$ 64,969	\$ 67,454	\$ 69,372	\$ 75,576	\$ 87,860	\$ 106,501	\$ 44,208	\$ 52,903	\$ 73,604
Totals	\$ 385,709	\$ 347,199	\$ 343,602	\$ 349,917	\$ 368,511	\$ 384,226	\$ 400,319	\$ 357,275	\$ 410,709	\$ 419,674
LTC as a percentage of Health & Social Services above.	21.6%	20.7%	20.0%	18.6%	18.6%	17.8%	18.4%	18.2%	20.4%	19.5%
Sources:										
Expenditures by Category from 2014 CAFR pages 118-119										
LTC Medicaid Expenditures from year end statements of appropriation.										

280 Michael W. Hoffman of the New Hampshire Office of Legislative Budget Assistant provided this “State of New Hampshire Expenditure History” by email on July 9, 2015.

### **Appendix 3: Table of Long-Term Care Vulnerability**

The Table of Long-Term Care Vulnerability worksheet allows a user to apply weights to each of the seven categories of long-term care vulnerability and to assign scores within each of the categories and sub-categories. In time, we hope to have similar 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.

Open the Table of Long-Term Care Vulnerability worksheet and instructions here: <http://centerltc.com/pubs/TLTCV-Blank.xlsx> and follow the instructions to complete it.

You can save your filled out worksheet to your own file without changing the blank version online.

View the author's completed worksheet for comparison here [http://centerltc.com/pubs/TLTCV-NH-comp\\_by\\_author.xlsx](http://centerltc.com/pubs/TLTCV-NH-comp_by_author.xlsx). (If you are asked for a user name and password, just click "cancel" and the worksheet will appear. If the worksheet appears minimized, simply enlarge it by clicking on the rectangular icon at the top right of the page.)

#### **Appendix 4: Interviewees**

Tom Argue, CEO, Webster at Rye, Rye, New Hampshire

Charles M. Arlinghaus, President of the Josiah Bartlett Center for Public Policy, Concord, New Hampshire

Gina Balkus, CEO, Home Care Association of New Hampshire, Concord, New Hampshire

Patricia Bennett, President, Longevity Planning, Portsmouth, New Hampshire

State Representative Frank Edelblut, Finance and Pension Reform Committees, Wilton, New Hampshire

Senator Jeanie Forrester, Senate Finance Committee Chair, Senate District 2, Meredith, New Hampshire

Lisa Henderson, Executive Director, LeadingAge Maine & New Hampshire, Newmarket, New Hampshire

Michael W. Hoffman, Office of Legislative Budget Assistant, Concord, New Hampshire

Kenneth M. Johnson, Senior Demographer, Carsey School of Public Policy, University of New Hampshire, Durham, New Hampshire

State Representative Neal Kurk, Chairman, House Finance Committee, Weare, New Hampshire

Michael Lehrman, Vice President of Healthcare Services, Catholic Charities New Hampshire, Manchester, New Hampshire

Phillip B McDonough, The Insurance Shoppe, Hampton, New Hampshire

Eldon R. Munson, Jr., Board President, New Hampshire Association of Residential Care Homes, Frankestown, New Hampshire

Stephen A. Norton, Executive Director, New Hampshire Center for Public Policy Studies, Concord, New Hampshire

John Poirier, President and CEO, New Hampshire Health Care Association, Pembroke, New Hampshire

Lori Shibinette, Administrator, Merrimack County Nursing Home Administrator, Boscawen, New Hampshire

Stacy Anne Shill, Director of LTC and DI Marketing, Shield Brokerage, Exeter, New Hampshire

David Sky, Life, Accident and Health Actuary, New Hampshire Insurance Department, Concord, New Hampshire

Alain Valles, President, Direct Finance Corp., Norwell, Massachusetts