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# Financing Long-Term Care: New York's Limited Options and Medicaid's Vast Challenge

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### **Medicaid Institute at United Hospital Fund**

James R. Tallon, Jr.  
President

David A. Gould  
Senior Vice President for Program

Michael Birnbaum  
Vice President

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# Financing Long-Term Care: New York's Limited Options and Medicaid's Vast Challenge

**Sarah Samis**

SENIOR HEALTH POLICY ANALYST

**Michael Birnbaum**

VICE PRESIDENT  
DIRECTOR, MEDICAID INSTITUTE

UNITED HOSPITAL FUND

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## Introduction

Long-term care plays a vital role for the millions of elderly and disabled U.S. residents who need help to perform activities essential for daily life. They and their families face not only the significant challenges of coping with functional limitations but also financial hardship due to a lack of adequate options for defraying the substantial cost of long-term care. This absence of comprehensive long-term care financing for the elderly and disabled stands in stark contrast to our national policy on acute care, in which the federal social insurance program Medicare provides coverage and protects beneficiaries and their families from impoverishing themselves to pay for care.

This report takes a broad look at how long-term care is financed in the United States. We first provide an overview of the role and current scope of long-term care, the differential between family resources and cost, and the major financing options available.

Two subsequent sections cover policy options for financing long-term care. The first, on federal policy, explores Medicare’s extremely limited coverage of long-term care and discusses the enactment and suspension of the Community Living Assistance Services and Supports (CLASS) Act.

The next section examines New York’s regulation of the private long-term care insurance market, the potential significance of alternative financial products as a source of private financing, and, finally, the pivotal role played by Medicaid as the primary payer for long-term care. For each of these, we consider the specific “levers” that New York’s policymakers have or can use, as well as their implications.

### Long-Term Care by the Numbers

More than eleven million adults in the U.S. rely on long-term care services and supports—such as skilled nursing facility, home health, and personal care services—to help address physical limitations and cognitive impairments that impede or preclude activities of daily living such as bathing and dressing.<sup>1</sup> The use of long-term care is not limited to seniors; adults under age 65 account for close to five million service recipients.<sup>2</sup> Nationally, the direct cost of all paid long-term care services and supports exceeded \$200 billion in 2010.<sup>3</sup>

Demand for long-term care services is expected to increase over the next few decades, primarily due to longer life expectancies, the growing number of seniors among the aging

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baby boom generation, and lower birth rates in the generations that have followed them. Accounting for 13 percent of U.S. residents in 2010,<sup>4</sup> seniors are projected to make up 16 percent of the population in 2020.<sup>5</sup> By 2030, seniors will constitute 19 percent of the U.S. population<sup>6</sup> and 20 percent of New York State residents.<sup>7</sup> As the elderly population expands, the number of frail elderly needing assistance with activities of daily living will increase concomitantly. By 2050, 27 million people—19 million seniors and 8 million non-elderly adults—are expected to be receiving long-term care.<sup>8</sup>

## Costs Exceed Family Resources

Many people who need long-term care services and supports find themselves paying for their care, at least at some point, with family income and assets. Recent estimates of the costs paid out of pocket range from 22 to 33 percent of all long-term care spending in the U.S.<sup>9</sup> That adds up to a major burden on family resources.

Long-term care is costly throughout the U.S., with a national average of about \$87,000 for a year's stay in a skilled nursing facility in 2011. It is even more so in New York, where, statewide, the estimated cost was over \$125,000 for a semi-private room in a skilled nursing facility.<sup>10</sup> While home and community-based services are generally less expensive than residential care, their costs, too, can add up if many hours of service are required because family support is limited or unavailable. At an average hourly rate of \$22,<sup>11</sup> a year of home health care at 40 hours per week for a self-pay patient costs close to \$44,000, but it can be much higher for a recipient who requires more hours or a higher level of skilled care. And as with acute care, people paying out of pocket generally pay the highest prices for long-term care, because rates negotiated through private insurers and public programs are typically discounted.

These costs are out of sync with the typically modest income levels of those needing long-term care. In New York, 35 percent of elderly residents had family income of less than \$25,000, and 27 percent had income between \$25,000 and \$50,000 in 2010.<sup>12</sup> Just 17 percent had family income of at least \$100,000<sup>13</sup>—a level at which paying for substantial long-term care out of pocket still remains a real challenge.

When incomes are insufficient, families rely on savings. High long-term care costs paired with modest incomes can mean the depletion of even substantial family assets over the course of a single illness. Alzheimer's patients, for example, typically live eight to ten years after their diagnosis;<sup>14</sup> many need more home care than the average long-term care recipient, particularly as their conditions deteriorate over time. In New York, eight years of home care at an average of ten hours per day and an hourly rate of \$22 would cost over \$600,000, without adjusting for inflation.

The disabled non-elderly and their families also face challenges when paying for long-term care services. While the elderly may have had several decades in which to plan for long-term care needs, younger disabled adults have usually not had this opportunity. Very few non-elderly adults receiving community-based long-term care services are in the workforce,<sup>15</sup> and this population is far more likely to be poor than persons not receiving community-based long-term care.<sup>16</sup> As with seniors, then, non-elderly long-term care recipients face a substantial cost burden.

The high cost of care relative to the low incomes of both the elderly and of non-elderly, non-working disabled persons underscores the challenge of financing long-term care.

### Role of Family Caregiving

Family and other informal caregiving plays a major role in long-term care. In fact, the economic value of long-term care services and supports provided by family caregivers exceeds the cost of all paid long-term care. At any given point during 2009, about 42 million people across the country provided care to a family member.<sup>17</sup> Family caregivers provided an average of 18 hours a week, for an estimated value of \$450 billion<sup>18</sup>—more than twice the level of all paid long-term care services and supports. That included, in New York alone, about 2.8 million family caregivers providing services worth an estimated \$32 billion.<sup>19</sup>

Demographic trends are likely to have an adverse effect on the supply of family caregivers. Because the birth rate declined following the baby boom generation and the average family became smaller, there are relatively fewer younger relations to care for the elderly. Continued improvement in the earnings prospects of women—still the majority of family caregivers—may further decrease the availability of this support.<sup>20</sup> These trends are important because the decline in the availability of family caregivers increases demand for paid long-term care,<sup>21</sup> both through private financing mechanisms such as long-term care insurance and through state Medicaid programs when families cannot pay for long-term care services themselves.

Ultimately, private family resources, including family caregiving, will be totally inadequate to accommodate the inevitable growth in demand for long-term care services and supports. The need for an effective solution to financing long-term care is, therefore, pressing.

### Financing Options

Financing long-term care can be accomplished in several ways. They are not mutually exclusive, but they do reflect two major decision points: whether to pool risk or leave it segmented by individual family units, and whether to rely primarily on government or the private market. This paper analyzes the following options for financing long-term care:

- Pooling risk through a federal government insurance program;
- Promoting private insurance and other financial products through state regulation; and
- Relying on Medicaid, the means-tested state-administered program.

The related issue of policies that advance cost containment and service redesign is beyond the paper's scope.

## Federal Policy Options

A government insurance system for long-term care would serve not only as a mechanism to guarantee the delivery of covered services and supports when needed but also to provide families with a measure of economic security before the need for long-term care arises, and protect their assets and incomes when it does. For consumers, insurance for long-term care makes particular sense because the need arises unpredictably and costs mount rapidly. It is extremely difficult for non-elderly individuals to predict their risk of becoming disabled before they reach old age. Yet estimates indicate that over half the U.S. residents who turned 65 in 2005 will need at least one year of long-term care, and one in five will need more than five years; only three in ten will die without needing any long-term care.<sup>22</sup>

### Current Policy: Medicare and Long-Term Care

Medicare, the nation's social health insurance program for the elderly and disabled, provides acute care services but does not adequately cover long-term care. It does not cover custodial care—non-skilled long-term care that supports activities of daily living—when skilled care is not also required. Yet many long-term care recipients require solely custodial care for the majority of the time they receive long-term care.

The program does provide limited coverage of medically necessary skilled long-term care services, such as nursing home and home health care, but only when triggered by a medical need. For stays in a skilled nursing facility (SNF), also referred to as a nursing home, Medicare pays in full for up to 20 days and partially for days 21 through 100—provided the resident has incurred a hospital stay of at least three days within 30 days prior to admission to the SNF, and provided the stay is related to the medical condition for which she was hospitalized. Even when a nursing home admission follows a qualifying hospital stay, the so-called “single episode of illness” requirement means Medicare often covers only a fraction of a beneficiary's nursing home stay. Thus, Medicare will cover a stay at a skilled nursing facility after a hip replacement involving a three-day hospital admission, but will not provide SNF benefits to a patient with Alzheimer's disease who enters a nursing home straight from home. Past 100 days, there is no Medicare coverage for skilled nursing facility residents, regardless of the pathway into the facility.

Medicare also covers intermittent skilled home care services provided by a nurse or a physical, speech, or occupational therapist, if the recipient is homebound and the visits are prescribed by a physician. In these cases, Medicare will cover limited custodial care activities—bathing, toileting, feeding, and other personal care—as well, if needed as support for skilled nursing care, along with medical social services. No copayment is required for home health services and no limit is imposed on the number of covered visits, as long as the patient continues to meet these criteria. But while the Medicare home health benefit does not have strict limits, as the SNF benefit does, it still requires that a beneficiary need skilled care; custodial care alone does not qualify for coverage.

### Looking Back: Medicare's History with Long-Term Care

The most recent attempt to enhance the Medicare long-term care benefit occurred more than two decades ago. In 1988 the Medicare Catastrophic Coverage Act (MCCA) eliminated the prior-hospitalization and single-episode-of-illness requirements for Medicare coverage of care in a skilled nursing facility.<sup>23</sup> As a result, during calendar year 1989 Medicare beneficiaries were covered even if they entered a SNF directly from home, and patients already residing in a SNF could claim Medicare benefits toward their stays.<sup>24</sup> The MCCA also significantly reduced the copayments for skilled nursing care and expanded the number of covered days from 100 to 150, covering in full days 9 through 150 per calendar year.<sup>25</sup> But in 1989 the Act was repealed, when a surcharge on higher-income seniors drew opposition. None of the enhancements survived the law's repeal, and in 1990 Medicare rules reverted to their prior state.

Also in 1988, the Health Care Financing Administration (HCFA) issued an administrative directive that effectively expanded the definition of skilled nursing facility care qualifying for Medicare coverage.<sup>26</sup> The clarifications contained in this administrative directive eliminated the requirement that skilled nursing facility residents show rehabilitation potential, thereby expanding Medicare SNF coverage to persons whose health and functional status were not necessarily going to improve.<sup>27</sup> As a result, classes of patients who were previously ineligible for these benefits, such as chronic-care patients requiring tube feeding, gained coverage.<sup>28</sup> In practice, this means that since 1989 Medicare has covered skilled nursing services that fulfill some custodial care needs for certain types of patients. Importantly, though, all SNF benefits remain subject to a medical trigger and 100-day limit.

In the two decades since 1990, there have been no major changes to Medicare long-term care coverage or benefits.

## The ACA and CLASS

As part of the Patient Protection and Affordable Care Act of 2010 (ACA), the Community Living Assistance Services and Supports (CLASS) Act established a limited and voluntary long-term care insurance program, administered by the federal government and separate from Medicare. CLASS would provide a daily cash benefit of at least \$50 for participants to use for a variety of long-term care services and supports—including skilled nursing care, home health aides, family caregiving, home modification, and transportation—should they become functionally disabled for at least 90 continuous days. Unlike the medical triggers under Medicare, eligibility to receive benefits under CLASS was tied to functional status. The requirement to qualify for benefits was the need for assistance with two or more activities of daily living, or requiring comparable assistance due to cognitive impairment. CLASS contained no lifetime limit on benefits.

The ACA specified that any working adult 18 years or older would be able to make premium contributions and participate in CLASS, regardless of health status or preexisting conditions. Premiums would be based solely on age at enrollment and would be fixed at that level for the duration of enrollment; they were to be set annually by the Secretary of Health and Human Services (HHS) and the trustees of a planned CLASS Independence Fund, which would oversee the assets of the program. In addition to meeting CLASS's functional requirement, enrollees would need to pay premiums for a minimum of five years, and to be actively employed or to have received earned income for at least three of the first five years of enrollment, to be eligible for benefits.

The ACA required CLASS to be financially self-sustaining through premium contributions, without any direct federal subsidies. This was an extremely high bar: for comparison, the Medicare Part B premium most beneficiaries pay covers just 25 percent of program costs, with about 75 percent of the program financed through general federal tax revenue. In practice, CLASS premium receipts were unlikely to match the cost of guaranteed benefits, given the probability that individuals more likely to claim benefits would enroll disproportionately. Such adverse selection would likely have been encouraged by the relatively short vesting period of five years. Several revisions to the structure of CLASS were proposed to increase the program's viability, including lengthening the vesting period and changing the premium structure to incentivize enrollment at earlier ages. But the major structural revisions most likely to dramatically increase the program's viability—such as making CLASS mandatory at a certain age—were politically untenable. In October 2011, a year and a half after the ACA's enactment, the administration officially suspended implementation of CLASS.

## Bottom Line: A Lack of Political Consensus

CLASS is the most recent failure at the federal level to create a national program that provides long-term care insurance. Despite positive experiences with social insurance models for long-

term care in other developed nations, there is little political support in the U.S. for a new federally created social insurance program for long-term care, or for adding a comprehensive long-term care benefit to Medicare. The ACA attempted to work around this fact by making CLASS a voluntary and self-sustaining program. Under difficult political constraints, policymakers tried to walk a narrow line: they aimed to offer a substantial benefit while ensuring actuarial soundness. In its enacted form, CLASS would have been fiscally unsustainable and would still have left beneficiaries exposed to substantial costs. On a positive note, however, CLASS brought long-term care back onto the federal policy agenda after a 20-year absence, serving as an important reminder that the nation's current approach to financing long-term care is inadequate.

## New York State Policy Options

As a result of inaction at the federal level, the policy debate about financing long-term care has occurred principally at the state level. Like other states, New York has focused on several options, including private long-term care insurance, alternative financial products, and Medicaid.

### Private Long-Term Care Insurance

A government insurance program is not the only way to finance the cost of long-term care. Another option is to pool risk through a private market, in which insurance companies underwrite and consumers purchase long-term care insurance (LTCI) policies. With the federal government maintaining a light footprint in this area, fostering and regulating a private long-term care insurance market has principally fallen to the states.

This section examines the current market for LTCI in New York, with attention to challenges for both consumers and insurers. It then addresses the State's tax and regulatory policy levers, including promotion of public-private initiatives such as the Partnership for Long-Term Care.

### The Current Market

Long-term care insurance policies guarantee a defined level of support for specified categories of future long-term care services and supports. Premiums are set when policies are issued, based on the policyholder's age and health characteristics. Rates cannot be raised with declines in an individual's health or functional status; insurers can, however, raise premiums for an entire policy class, subject to the approval of State regulators. Policies generally continue to be "in force" as long as the policyholder pays the premiums.

A policyholder becomes eligible for benefits once she meets an appropriate trigger—for nearly all policies sold today, triggers are specified in the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which qualify LTCI plan premiums and benefits for tax preferences.<sup>29</sup> These HIPAA triggers—thresholds based on functional or cognitive impairments—remain the federal government’s major involvement in regulating LTCI.<sup>30</sup>

Once a policyholder qualifies for benefits there is typically an “elimination period” of 90 to 100 days before benefits can be received;<sup>31</sup> the elimination period essentially functions as a deductible. Most policies specify a maximum benefit, often defined as a total number of benefit days or years, or as a maximum dollar amount over the length of the policy. Over time, the proportion of policies with an unlimited or lifetime benefit period has decreased.<sup>32</sup>

The private market for LTCI remains small. In 2009, about seven million people in the U.S. were covered by LTCI policies, representing a market penetration of approximately 7 percent among adults age 50 and over.<sup>33</sup> Only 7 percent of seniors who need help with one or more activities of daily living have private LTCI,<sup>34</sup> and LTCI pays for less than 10 percent of total long-term care expenditures nationwide.<sup>35</sup> The number of people covered by private long-term care insurance has declined over the past few years, with about one million fewer policies in effect in 2009 than several years prior. Some of these policies may have been dropped upon death, but—given the increasing life expectancy of the elderly—personal choice and individuals’ inability to pay are additional reasons for policy lapses.<sup>36</sup>

Nationally, two-thirds of LTCI policyholders in 2009 were covered through the individual market; one-third was covered under group policies purchased through an employer or association.<sup>37</sup> Only 17 percent of workers have access to employment-based long-term care insurance,<sup>38</sup> and that access is much more limited for low-wage workers and for those in small and medium-sized firms.<sup>39</sup> Unlike health insurance, long-term care insurance tends not to be subsidized by employers. But group long-term care premiums are still generally lower than individual market premiums because of the lower administrative costs and the generally younger age of those purchasing LTCI through employment rather than the individual market.<sup>40</sup>

New York’s private long-term care insurance market is generally consistent with the national picture. At the end of 2010, the most recent year for which these privately held data are publicly available, about 440,000 New Yorkers held LTCI policies,<sup>41</sup> representing a market penetration of about 6 percent of residents over age 45.<sup>42</sup> As is the case nationally, individual policies account for the majority of New York’s market.<sup>43</sup>

About 95 percent of LTCI policies in effect in New York cover both skilled nursing facility services and home care,<sup>44</sup> with the latter accounting for a steadily growing majority of claims.<sup>45</sup> In 2004, policies covering both skilled and custodial care in New York provided an average maximum daily benefit of \$183 for nursing home care, \$144 for home care, and \$167 for assisted living<sup>46</sup>—figures that are close to the average maximum daily benefit nationwide.<sup>47</sup> About 65 percent of policyholders in New York have inflation protection built into their policies;<sup>48</sup> one in three policyholders are, therefore, exposed to potentially dramatic out-of-pocket cost increases over time due to the absence of inflation protection.

### **The Consumer Perspective**

Several factors discourage people from buying policies, and prevent the private long-term care insurance market from reaching a critical mass. These include the current and expected future cost of premiums, and the belief that government programs will cover long-term care services.

Many consumers demonstrate interest in purchasing long-term care insurance but cannot. In a longitudinal study conducted by America's Health Insurance Plans (AHIP) from 1990 to 2005 comparing purchasers and non-purchasers of LTCI who had contact with an insurance broker, non-purchasers consistently cited cost as the most significant barrier to obtaining coverage.<sup>49</sup> The average annual premium, nationally, for a new policy purchased in 2010 was \$2,218,<sup>50</sup> 6 percent of annual income for the median elderly household.<sup>51</sup> The average premium for a policy already in effect was \$1,815.<sup>52</sup>

Recognizing that private long-term care insurance is realistically affordable only at or above certain income and asset levels, the National Association of Insurance Commissioners (NAIC) recommends that premiums not exceed 7 percent of income or that consumers have at least \$35,000 in financial assets.<sup>53</sup> Based on these guidelines, more than four out of ten seniors nationally cannot afford private LTCI coverage with an annual premium of \$2,000.<sup>54</sup>

Potential policyholders are much more likely to meet the NAIC guidelines earlier in life, especially between ages 35 and 59, and the insurance industry has recently been more successful in targeting these younger consumers. Roughly half of new policies are now issued to people aged 55 to 59; the average age of new policyholders is 57 to 58.<sup>55</sup> Because most new policies are being issued to non-elderly adults, the industry estimates that two-thirds of new policyholders are spending no more than 3 percent of family incomes on premiums.<sup>56</sup>

But purchasing LTCI at a younger age may still be problematic. While premiums may be more affordable, potential purchasers face competing financial priorities, including paying a mortgage on a family home, saving for retirement, and purchasing other asset protections,

such as life and disability insurance. Given these competing priorities and resource constraints, increasing the immediate affordability of long-term care insurance would appear to be necessary for significantly growing the market but insufficient in itself.

The premium at the time of purchase is not the only cost concern for prospective buyers of LTCI. Most policies require premiums to be paid throughout the entire life of the policy for it to remain in effect, and these premiums can rise over time. Thus, a policyholder effectively places a bet that she will be able to afford the premiums not only during the years, possibly decades, before LTC is needed but often once she has started to receive long-term care services—a period that may well bring a loss of income and significant new costs associated with deductibles and copayments for LTC services, and potentially for acute care as well. In many circumstances, finding another use for the premium, including retirement savings, could be a more rational economic decision.

Apart from cost concerns, individuals' assessments of their risk of needing long-term care also reduce their demand for insurance. Half of non-purchasers in the AHIP study reported that uncertainty about their need for services in the distant future contributed to their decision to forgo coverage.<sup>57</sup> In a survey of individuals age 50 and older, just one-third thought there was at least a 50 percent chance of needing nursing home care at some point; only half believed there was at least a 50 percent chance of needing home care.<sup>58</sup> These levels of expectation are probably inconsistent with a participation threshold that would allow for a robust private LTCI market.

The belief that government programs will cover the majority of long-term care service costs is another reason often cited by those who do not purchase private LTCI. Among consumers in the AHIP study, those not purchasing policies were twice as likely as purchasers to believe that “the government will pay for most of the costs of LTC, if services are ever needed.”<sup>59</sup> While consumer education may help correct misconceptions about Medicare coverage of LTC services—just as it might better inform the public about the cost of LTC services and the risks of needing them—education will not make private coverage more affordable.

The challenges consumers experience when considering their options in the private LTCI market are considerable. In fact, the vast majority of consumers are behaving rationally when they opt *not* to purchase a policy. Overall, LTCI policies do not provide enough of a return when compared to the actual cost of long-term care services.<sup>60</sup> One study estimated that the typical private long-term care policy covers only about 34 percent of the expected present discounted value of long-term care expenditures.<sup>61</sup> While the elimination period and the maximum benefit period are contributing factors, the maximum daily benefit is the principal determinant of a policy's generosity.<sup>62</sup>

## **The Insurer Perspective**

Insurers participating in the LTCI market face two major challenges affecting the supply and price of policies. First, the risk inherent in an LTCI policy is fundamentally different from the risk under a health insurance policy that covers acute care services. Health insurance typically provides benefits for the year following the purchase of the policy, while LTCI provides for several years of coverage in the future. Assessing the actuarial risk for an insurance contract promising to deliver services in an uncertain, distant future is therefore fraught with difficulty.

As life expectancy has increased and the industry has shifted market share to younger policyholders, LTCI underwriters increasingly find themselves selling policies that may not be used for decades. This presents a level of uncertainty that makes pricing premiums especially challenging. These calculations are based on factors including life expectancy, interest rates, inflation in the costs of long-term care services, and attrition rates among policyholders—all of which can change dramatically over time. To compensate for this uncertainty, insurers may set initial policy premium levels high, and may request premium increases over time as they revise their predictions.

The second challenge faced by insurers is adverse selection—the tendency for people who are more likely to use long-term care services to purchase insurance and maintain coverage, while those less likely to use those services do not. Adverse selection can occur both when individuals first purchase policies and when policyholders decide whether to renew their coverage each year. Over time, as individuals learn more about their health and functional status and can more accurately estimate their chances of needing long-term care, they are more apt to discontinue their policies if and when they believe they will not require LTC. In fact, those who let their policies lapse are one-third less likely to later have a nursing home admission.<sup>63</sup> As a result of adverse selection, insurers can face more claims per policy than they would with a broadly representative risk pool. In the small LTCI market, initial premiums are pushed ever higher to cover this greater service use.

When individuals who are less likely to use long-term care services drop out of the risk pool over time, the insurance carrier is left with fewer incoming premium dollars and a higher likelihood of claims payouts. To compensate, the insurance company—in addition to already adjusting the initial premium to reflect this predictable dynamic—may also need to raise premiums. High premiums that increase over time create a feedback loop that compounds adverse selection.

Adverse selection also affects the size of the LTCI market through insurers' decisions. Insurers typically require information on a potential policyholder's medical history, and can then use this information to exclude people with a high likelihood of needing significant

amounts and levels of long-term care services—people who already have, for example, functional impairments, Alzheimer’s disease, dementia, or many other conditions.

The supply-side challenges of pricing uncertainty and adverse selection have contributed to contraction in an already small market. In 2010, veteran insurer MetLife, which held about 8 percent of the LTCI market nationwide and 27 percent of the New York market, stopped issuing new policies.<sup>64</sup> In 2011, Berkshire stopped issuing new policies after only five years in the business.<sup>65</sup> Overall, 10 of the nation’s 20 largest LTCI underwriters have left the market in the last five years.<sup>66</sup> It’s not only consumers who face compelling challenges to participating in the private LTCI market; the math isn’t working for insurers either.

### **New York’s Policy Levers**

New York State has taken a multifaceted approach to fostering a private long-term care insurance market, including implementing tax incentives to boost demand, regulating minimum benefits on the supply side, and instituting the Partnership for Long-Term Care, which offers a degree of asset protection and a richer benefit package to attract purchasers.

**Tax Incentives.** In an attempt to increase demand for LTCI, New York provides tax preferences for policyholders. The State generally does not count benefits from long-term care insurance policies as taxable income, provided the policy qualifies for such treatment under HIPAA.<sup>67</sup> New York also currently provides a 20 percent tax credit for these federally qualified long-term care insurance premiums.<sup>68</sup>

The impact of these incentives on consumer demand for private LTCI appears to be weak; studies have found that state tax policies have very small effects on rates of long-term care insurance coverage. One found that tax credits accounted for only a 2.3 percentage-point increase in take-up, while deductions had no effect.<sup>69</sup> Another found that credits or deductions accounted for a 2.7 percentage-point increase in coverage, but that those motivated to buy insurance tended to have higher income.<sup>70</sup> Giving tax breaks to higher-income people—who are more likely to buy policies on their own, and less likely to ever spend down to Medicaid eligibility levels—may cost states more money in foregone tax revenue than they ultimately save on reduced expenditures for LTC services.

**Regulating Long-Term Care Insurance Benefits.** States have regulatory jurisdiction over insurance markets, including the market for LTCI. New York requires insurers to classify their LTCI policies according to what they cover—both the level of care and its setting. The State sets minimum benefit standards for each type of policy.

Most policies in effect in New York cover both skilled and custodial levels of care in both institutional settings and at home. For these policies, the benefit must be at least \$100 per day in the New York City metropolitan area and \$70 per day in the rest of the state; home care benefits must be at least 50 percent of those for nursing homes. Policies must cover a minimum of 24 months of services.<sup>71</sup> For custodial-only policies, the State requires a minimum benefit period of at least 12 consecutive months and a benefit of at least \$50 per day for nursing home custodial care or \$25 per day for home-based custodial care.<sup>72</sup> For all policies, insurers must offer consumers an option for inflation protection.

These minimum benefit standards, which date to 1992, illustrate the limited ability of regulators to strengthen the private LTCI market. On the one hand, the floors do not guarantee the comprehensiveness of the policies sold to New Yorkers. For example, the required \$100 daily nursing home benefit covers less than one-third of the statewide average of \$344 daily for self-pay of nursing home care, and the home care minimum benefit covers just two-and-a-half hours of care per day at a statewide average cost of \$22 per hour.<sup>73</sup> On the other hand, any attempt to set minimum standards that would truly approach a comprehensive benefit would significantly increase premiums, further reducing the size of an already small market.

New York's policymakers have recognized their limitations in shaping the private LTCI market, and have recommended against changing State regulations. In 2004, a legislatively mandated work group, led by the State's Insurance Department in consultation with the Department of Health and the Office of the Aging, considered proposals to raise minimum benefit standards and to mandate inflation protection for all policies, but rejected them because the increased requirements would "remove flexibility of choice from the consumer."<sup>74</sup> The work group also recommended against instituting a single standardized LTCI benefit, on the grounds that it could drive insurers out of New York if the required benefit differed significantly from the policies being underwritten in other states.

**The Partnership for Long-Term Care.** The Partnership program started in the early 1990s as a set of demonstration projects in four states, including New York, designed to prevent people from spending all of their family resources on long-term care and, once impoverished, enrolling in Medicaid. To attract consumers, Partnership policies meet higher benefit standards and cover a wider array of services than other LTCI products. Perhaps most importantly, they allow policyholders to qualify for Medicaid while retaining a higher level of assets, if and when their Partnership plan benefits are exhausted.

The New York Partnership initially offered only a total-asset-protection model that allowed consumers to protect all of their family assets when applying for Medicaid. Starting in 2006,

the State also began to offer dollar-for-dollar plans, in which the total insurance benefit purchased conveyed an equal amount of asset protection for a future Medicaid application. The two models of asset protection are designed to attract different types of consumers. With their greater benefits and higher premiums, total-asset-protection plans are geared toward families with higher incomes and asset levels; the dollar-for-dollar model promotes policies that are more affordable and potentially attractive to people with less wealth, who are at higher risk of spending down to Medicaid eligibility. Total asset policies account for almost all of the Partnership market; the dollar-for-dollar plans have not caught on in New York, and make up less than 1 percent of all Partnership policies sold to date.<sup>75</sup>

Partnership policies have higher minimum standards than other LTCI policies for a range of features. Policies are required to cover a broad range of institutional and community-based long-term care services, including assisted living, adult day care, and respite care. The minimum benefit periods are generally longer, ranging from 18 months to 48 months. The floor for the daily SNF benefit—\$241 in 2011—is more than twice the \$100 minimum for non-Partnership policies; for home care, the floor covers about six hours daily, compared to less than three in other LTCI policies.<sup>76</sup> Partnership policies are also required to include compound annual inflation protection of 5 percent.

But as a result of this more robust coverage, Partnership policies are more costly, and remain a hard sell. The average annual premium for a Partnership policy in 2004 was \$4,037, compared to \$3,324 for an individual non-Partnership policy and \$2,306 for a group non-Partnership policy.<sup>77</sup>

While the Partnership program has attracted New Yorkers who would not otherwise have purchased LTCI coverage,<sup>78</sup> these policies accounted for less than 16 percent of LTCI policies in effect in New York in 2010.<sup>79</sup> Ultimately, the program generates little in Medicaid savings for the State—about \$18 million in State fiscal year 2010-2011.<sup>80</sup> To put that figure in context, New York's Medicaid program spent \$13.4 billion on long-term care in 2010.<sup>81</sup>

### **Bottom Line: A Structurally Flawed Option**

The private LTCI market is unattractive for many New Yorkers who will, eventually, require long-term care services and supports. Those potential purchasers who are more likely to need long-term care are also more likely to be denied coverage. Individuals who do qualify for coverage may find the premiums unaffordable. If premiums are affordable at the time of purchase, they may become unsustainable as they increase over time—especially during retirement and once policyholders begin to rely on long-term care. Finally, when benefits are claimed they may not be comprehensive enough to significantly protect assets, and it is likely

that policyholders will spend much of their life savings on care—despite the investment they have made in purchasing LTCI and sustaining it over decades.

State policymakers have limited options for making the LTCI market larger and more effective. Recent efforts have focused on increasing enrollment in Partnership plans. In 2011, the State adopted a Medicaid Redesign Team proposal to add another type of total-asset-protection Partnership plan, with a reduced maximum benefit period, in an attempt to make lower-premium plans available for potential policyholders.<sup>82</sup> The offer of a lower rate of inflation protection—3.5 percent, as an alternative to the current 5 percent requirement—could also lower premiums.<sup>83</sup> Finally, New York’s expanded participation in Partnership program reciprocity with other states may make these policies more attractive; policyholders who relocate to another state with a Partnership program will now retain asset protection and be eligible for Medicaid coverage in that state.<sup>84</sup> Even with these measures, though, demand for Partnership policies is unlikely to rise significantly. Nor does the State have additional resources or levers with which to increase demand for LTCI more broadly.

Even if the State could increase demand for LTCI, a major structural flaw in the market would remain. While a broader risk pool would help address the problems created by adverse selection, it would not solve the issues associated with contracts being held over long periods of time, which will continue to make LTCI premiums unaffordable and unattractive for so many potential beneficiaries. On the supply side, with the business remaining fundamentally unattractive for insurers, there is little that policymakers can do short of directly subsidizing these products. Other than such a dramatic and costly measure, policymakers have no effective levers. Under these circumstances, providing broad coverage for long-term care through the private LTCI market appears unfeasible.

### Alternative Financial Products

For individuals with adequate economic resources, financial products promoted as guaranteeing future coverage for long-term care services, and protecting family assets, are available. These alternatives to standard LTCI include reverse mortgages and hybrids of life insurance or annuities and long-term care benefits. The market for the majority of these products has remained very small, in part because they are expensive and require high asset levels.

A reverse mortgage is a home equity loan for which the repayment obligation is deferred until the home is no longer used as the principal residence. Most are Home Equity Conversion Mortgages (HECMs), administered by the U.S. Department of Housing and Urban Development. To take out an HECM, an individual must be age 62 or older and either own the home outright or have a mortgage balance that is low enough to be paid off with proceeds

from the loan. In 2011, about 73,000 HECMs were issued, down from a high of about 115,000 in 2009.<sup>85</sup>

Hybrid products that add coverage of long-term care expenses to annuities or life insurance are another option. When based on annuities, they provide dedicated funding for long-term care services or LTCI premiums. With life insurance, these products include an optional benefit rider that pays for long-term care services or LTCI premiums through an accelerated death benefit—a feature that allows access to part of the death benefit before the policyholder's death.

Hybrids may be more attractive than LTCI for those with enough resources to purchase them. People with pre-existing conditions that generally disqualify them from obtaining LTCI may be eligible for hybrid products, which may not require medical underwriting. Additionally, the heirs of policyholders who did not require long-term care services receive value from unspent funds through death benefits for hybrid life insurance and some types of hybrid annuities.

Purchasing a long-term care annuity obviates concerns that long-term care insurance premiums will rise in the future, since the entire premium is paid up front. Some long-term care annuities even include inflation protection for benefits. But long-term care annuities tend to have shorter benefit periods than long-term care insurance—typically between two and three years—and the required up-front lump-sum payment usually runs between \$75,000 and \$150,000.<sup>86</sup>

Similarly, the hybrid life insurance policies that most middle-class people can afford also tend to provide less coverage than standalone long-term care insurance policies, and accelerated benefits may be capped. Most life insurance policies carry death benefits of no more than \$500,000, with a nationwide average of \$173,000.<sup>87</sup> At that level, coverage for future long-term care needs would not be comprehensive. Thus, hybrid products that offer substantial protection are accessible primarily to people with high asset levels. These products generally work best for those between ages 55 and 75 with \$300,000 to \$500,000 in investable assets that will not be necessary for retirement.<sup>88</sup>

Given the high asset levels required to purchase them, the small size of the market for hybrid products is predictable. In 2008, life insurance and annuities with long-term care benefit riders accounted for an estimated \$660 million in first-year premium sales, about 10 percent more than first-year premium sales for LTCI.<sup>89</sup> Approximately 26,000 hybrid life insurance policies were sold in 2010, representing just 6 percent of new sales of individual life insurance policies.<sup>90</sup> Very few companies sell hybrid life insurance or annuity products.<sup>91</sup>

### **New York's Policy Levers**

New York State policymakers have employed a variety of approaches to encourage people to use their private resources to pay for long-term care. These include allowing residents with life insurance policies to use some of their projected payouts to cover long-term care through an accelerated death benefit, and encouraging people to pledge a defined amount of their assets toward future long-term care expenses through the Long-Term Care Compact.

**Accelerated Death Benefit.** New York State recently made it easier for life insurance policies' accelerated death benefits to cover the costs of long-term care services. A 2010 law, which brings New York in line with every other state, allows an accelerated life insurance payout to cover long-term care costs if a person is confined to a nursing home for at least three months and is expected to remain in a nursing home for the rest of her life.<sup>92</sup> Previously, New York allowed accelerated death benefits to finance long-term care only if beneficiaries met one of the triggers established by HIPAA, and either required “continuous care for the remainder of the insured’s life” or had tax-qualified long-term care insurance.<sup>93</sup>

The 2010 law significantly broadens the use of accelerated death benefits for LTC by including a nursing home stay without a designation of chronic illness, and by allowing accelerated death benefits to be used by people without LTCI policies. The intent is to ease the burden on Medicaid by encouraging the use of these riders and their benefits, since approximately eight million New York State residents have life insurance<sup>94</sup>—as opposed to the fewer than 450,000 with LTCI. In light of the higher coverage rates for life insurance, in 2011 the State expanded this new three-month trigger beyond nursing home services to all types of long-term care.<sup>95</sup>

**The Long-Term Care Compact.** Another New York State policy—enacted, but not implemented—to encourage the use of private resources to finance long-term care services and supports is the Long-Term Care Compact. As originally proposed in 2005 by the New York State Bar Association, the Compact would allow people who are at the beginning of a long-term care episode and who are not enrolled in Medicaid to pledge a defined amount toward their long-term care. In exchange for their pledge to use private resources, Compact participants would benefit from limited overall long-term care costs and protection for their remaining assets and income.

Compact participants would agree to pay either a “maximum pledge amount” equivalent to the cost of three years of skilled nursing facility care at an average private-pay regional rate, or a “dollar pledge amount” of half of their assets.<sup>96</sup> Once a Compact participant spent her pledged amount on qualified long-term care services, she would receive partial asset protection and payment assistance for long-term care services, either through a subsidy or through Medicaid coverage.<sup>97</sup> Compact participants would also be entitled to protected income

at amounts similar to those under Medicaid; if their annual income were above this protected threshold, they would be required to contribute 25 percent as a participation fee.<sup>98</sup>

Two design features of the Compact program would limit participants' total long-term care costs. First, once they met their pledge amount, Compact participants would receive a subsidy for qualifying long-term care services. Second, the Compact would cap the amount that long-term care service providers could charge Compact participants. Similar to LTCI, the Compact asset protection, subsidy, and rate cap would serve as a financial cushion for people needing several years of long-term care, which could otherwise be a severe financial burden.

Since 2005, several Compact bills have been introduced in New York; none has been enacted into law, however. In 2011, a Compact bill passed the Senate but not the Assembly.<sup>99</sup>

In 2010, the State authorized a Long-Term Care Financing Demonstration Project, a modified version of the Compact, allowing up to 5,000 people to qualify for Medicaid while retaining all or part of their remaining assets and income, provided they have spent their initial pledge amount on qualified long-term care services.<sup>100</sup> Participants in the demonstration project would be enrolled directly in Medicaid, rather than in a subsidy program. Those enrollees would incur lower long-term care costs because qualifying care would be covered entirely by Medicaid—but they would be limited to using Medicaid providers. By comparison, in the original Compact program, designed in part to encourage development of the private market for long-term care services, higher reimbursement rates would encourage more providers to participate, which in turn would offer Compact enrollees greater choice.

Funding for the Demonstration Project has not been allocated, and the project has not been implemented. Notably, federal approval is required to implement either the Long-Term Care Financing Demonstration Project or a full Compact program.

### **Bottom Line: Limited Resources, Limited Options**

Relatively few families have sufficient private resources to self-finance the entirety of their long-term care needs. Alternative financial products tend to be within reach of only those with considerable investable assets, and tend to provide less comprehensive coverage than LTCI. New York's innovative Compact approach may help encourage private financing if it is ever implemented in its original form, but the Financing Demonstration Project may increase costs for the State, since it enrolls people directly in Medicaid. In any event, New York faces a distinct challenge in trying to encourage individuals to devote significant private resources to obtaining sufficient long-term care protection—in part because families know that depleting their assets on long-term care services and supports may well make them eligible for Medicaid.

## Medicaid

For all but the very wealthy, depleting family resources is a normal and predictable consequence of going without long-term care coverage and relying on private resources to cover costly services and supports. Once people have expended their private resources, they can qualify for Medicaid to cover long-term care. Consequently, as the means-tested program that plays a diverse range of health-related roles for people with limited resources, Medicaid has become the default payer for long-term care in New York and across the country.

Medicaid is not always a separate financing system for long-term care, but often part of a continuum, and families relying on Medicaid are not necessarily distinct from those using private assets. Many middle-class and working families, while initially relying on their savings to cover long-term care costs, are essentially pre-Medicaid. As families exhaust their resources on long-term care, Medicaid enrollment is often an inevitable second stage for a large share of the private-pay population. With baby boomers now beginning to reach old age, policymakers are deeply concerned about the even larger role Medicaid may have to play as a significant share of this aging cohort—including large numbers of the middle class—could eventually enroll in Medicaid, once they are unable to self-finance their long-term care needs.

Because states have a substantial amount of flexibility in determining what long-term care services Medicaid should cover, and significant leeway on which elderly and disabled residents should be eligible, they are essentially deciding where to draw the line between private and public financing mechanisms. This role is unique to the long-term care side of Medicaid. On the acute care side, it is far less common for families that start out with substantial incomes and assets to move to public means-tested coverage.

### **Medicaid as the Primary Payer**

Thanks to the absence of any other comprehensive financing mechanism, Medicaid—theoretically the payer of last resort—has become the default primary payer for long-term care services and supports. Medicaid spent \$129 billion on long-term care in 2010, 62 percent of all direct spending nationwide.<sup>101</sup>

Relative to other states, New York takes an inclusive and comprehensive approach to covering long-term care supports and services under Medicaid. Elderly and disabled residents with income below 85 percent of the federal poverty level (FPL) for individuals or below 92 percent FPL for couples can receive coverage,<sup>102</sup> and New York's Medicaid program offers one of the nation's most comprehensive benefit packages.<sup>103</sup> In 2010, long-term care for the frail elderly and physically disabled accounted for \$13.4 billion in Medicaid spending in New York, over one-fourth of all program expenditures.<sup>104</sup>

### **New York State Policy Context**

New York is a national leader in providing a comprehensive long-term care benefit under Medicaid. While the federal government requires Medicaid to cover only nursing home care and home health services, New York’s Medicaid State Plan has long included a broad array of home- and community-based services for the elderly and disabled. These include personal care, adult day care, assisted living, and integrated service delivery programs such as the Program of All-inclusive Care for the Elderly (PACE). New York’s Medicaid program covers a broader array of long-term care services and supports than most private LTCI policies, and has no limits on the benefit period or amount of services covered.

Unlike the situation in many states, where nursing homes are the dominant setting for long-term care, in New York most elderly and disabled Medicaid beneficiaries receive services in the home or in community settings.<sup>105</sup> This balance puts New York in good standing relative to the Supreme Court’s 1999 *Olmstead* decision, which clarified that under the Americans with Disabilities Act of 1990, states “shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”<sup>106</sup> This ruling extends to Medicaid long-term care services, and the State has repeatedly affirmed its commitment to maintaining its broad array of community-based long-term care services and supports, and to ongoing implementation of the *Olmstead* decision.

### **New York’s Remaining Policy Lever: Financial Eligibility**

Medicaid eligibility for long-term care services and supports is based on a means test that takes into account income and assets. In New York, people with resources above the eligibility limits can qualify for Medicaid through several avenues, including “spend-down” programs, estate planning techniques, or, for married couples, spousal refusal. The rules allowing beneficiaries to retain limited amounts of assets are designed to prevent high long-term care costs from wiping out family assets and leading to spousal impoverishment, leaving well spouses with few resources for their own care and subsistence. Inevitably, though, policies allowing families with significant private assets to benefit from a means-tested program will be called into question. It is unsurprising, therefore, that recent Medicaid debates in New York have focused on the long-term care eligibility rules for families with significant resources—and in particular on spousal refusal.

**Spousal Impoverishment and Spousal Refusal.** Inherent in Medicaid eligibility policy is the need to find the delicate balance between maintaining program integrity and protecting families from impoverishment due to long-term care costs. Spousal impoverishment protections in federal and state law allow the well spouse of a Medicaid long-term care beneficiary to retain some assets and income above the Medicaid limits, without jeopardizing the care-seeking spouse’s Medicaid eligibility.

Under federal law, states must allow the well spouse of a nursing home resident to retain a Community Spouse Resource Allowance (CSRA) of half or more of the couple's joint assets up to an annually adjusted cap. New York's 2012 CSRA cap is \$113,640,<sup>107</sup> the maximum allowed under federal law. New York does not apply these protections to spouses of community-based long-term care recipients unless they are in certain waiver programs.

Federal law also requires states to allow the well spouse a Minimum Monthly Maintenance Needs Allowance (MMMNA). Again, New York's is the maximum allowed—\$2,841 per month in 2012, the equivalent of 122 percent FPL.<sup>108</sup> Federal law further dictates that if a well spouse's income is less than the MMMNA the spouse residing in a nursing home can contribute the difference without compromising Medicaid eligibility.<sup>109</sup>

The allowances specified under the spousal impoverishment protections may still not leave a well spouse with the necessary resources for daily expenses, particularly if she lives for many years. Moreover, spending down to the Medicaid asset threshold can require the depletion of the vast majority of a couple's life savings.

Spousal refusal allows the well spouse to keep far more resources than under spousal impoverishment protections, by redefining how assets and income are held within the marriage. Under spousal refusal, the well spouse signs a legal document stating a refusal to contribute material support to the care of the spouse seeking Medicaid coverage for long-term care. As a result, when the care-seeking spouse applies for Medicaid, the refusing spouse's assets and income do not count toward Medicaid eligibility limits. In New York, spousal refusal is allowed for both nursing facility and home care, provided the recipient requires a nursing home level of skilled care. Outside New York, the spousal refusal policy is in effect only in Connecticut and Florida.

In an effort to curtail asset transfers for the purpose of gaining Medicaid eligibility, the federal Deficit Reduction Act of 2005 (DRA) imposed a penalty waiting period for coverage of nursing home care if assets have been transferred within the five years preceding an application for Medicaid. Spousal refusal can circumvent the DRA's penalty waiting period, however. Once spousal refusal is invoked, the spouse in need of long-term care can transfer all assets to the well spouse, up to one month before applying for Medicaid, without incurring any penalty.

Invoking spousal refusal in New York does not fully guarantee asset protection. New York's local governments—its 57 counties and New York City—can bring suit against the well spouse for reimbursement of Medicaid costs, by proving that she has the ability to pay for her spouse's long-term care services. But there remains a strong financial incentive to invoke spousal refusal: Medicaid nursing home rates are often half of private-pay rates, so care at the

Medicaid rate is likely to be significantly less costly than under private pay, even if a recovery case is successful and interest imposed.<sup>110</sup> Moreover, recovery lawsuits can be settled for significantly less than the cost of care to Medicaid, and payment to the local government can sometimes be deferred until the well spouse dies.

Spousal refusal has often been a focus of Medicaid long-term care policy discussions. Several gubernatorial administrations over the last 20 years have proposed revoking the policy, as did the Governor's Executive Budget in both 2011 and 2012, but it remains intact. The debate typically centers on the ethics of families being allowed to shelter substantial assets to qualify for Medicaid faster—or, reframed, on whether well spouses should be forced to deplete their life savings, perhaps to the point of impoverishment. But there's also a more practical question: would revoking spousal refusal realize Medicaid savings for the State?

The proportion of applicants for Medicaid long-term care coverage invoking spousal refusal is less than 1 percent in New York City,<sup>111</sup> which is home to a majority of the State's Medicaid long-term care recipients and spending.<sup>112</sup> Thus, revoking spousal refusal would likely yield inconsequential budget savings for the State. Relatively few potential Medicaid beneficiaries would initially face a denial of eligibility. Among them, new asset protection strategies—including divorce—would doubtless arise, and many would still likely find a way to access Medicaid coverage for long-term care. To the extent that elimination of spousal refusal succeeded in keeping a small number of elderly and disabled New Yorkers off Medicaid, it would lead to the depletion of assets and potential impoverishment of spouses—making them, ironically, more likely to rely on Medicaid for their own future long-term care needs.

### **Bottom Line: Weak Policy Levers**

State policymakers technically have broad latitude and great flexibility in setting Medicaid policy under federal law and defining New York's involvement in financing long-term care. The State can set eligibility requirements that allow far fewer New Yorkers to receive long-term care services and supports through Medicaid. And, because many of the Medicaid long-term care services that New York offers are categorized as optional under federal law, the State can also make the benefits package less comprehensive and, therefore, less costly. These choices require evaluation as Medicaid policy options with budget implications; they also merit consideration as part of the larger national debate over financing for long-term care.

When it comes to long-term care, Medicaid is not only “the payer of last resort.” It is also the primary and dominant payer. But this role says less about Medicaid itself than about the absence of a coherent financing mechanism, public or private, that pools risk and prevents unpredictable and catastrophic long-term care costs from sinking middle-class and working families into poverty. While today's deeply constrained fiscal environment makes it difficult to

look beyond narrowly defined policy questions—such as who and what to cover—and to see beyond one- or two-year budget targets, New York is a high-cost state with many seniors and disabled adults in low- and moderate-income families. Whatever Medicaid’s eligibility rules and covered benefits, many of these New Yorkers will face long-term care needs even after they have exhausted their private resources. For most of these families, Medicaid is and will remain the only option.

## Conclusion

The current financing system for long-term care creates a variable and uncertain level of coverage—and estate protection—based on key diagnoses toward the end of life, over which care recipients have little control. When an elderly New Yorker faces a multi-year battle with heart disease or cancer, Medicare will play an important role—providing comprehensive coverage of acute care services, and protecting an individual’s assets while services are being delivered. But when the challenge is not heart disease or cancer, but a multi-year struggle with dementia, Medicare does not cover long-term care services and supports. The resulting question—how much of one’s life savings must be exhausted before Medicaid can play a role in covering long-term care?—has no good answers or policy solutions.

Taking stock of how we finance long-term care—especially with the baby boom generation beginning to retire—it is clear that we are not where we need to be. Medicare, the nation’s social insurance program for the elderly and disabled, excludes almost all forms of custodial long-term care from its benefit. The federal government suspended the CLASS program, but did not resolve the problem CLASS sought to address. In the near future, with a major national debate on deficit reduction looming, another federal attempt at long-term care reform looks very unlikely.

As in many areas of health policy, federal stasis begets state responsibility. New York’s policymakers have thoroughly explored, and perhaps exhausted, opportunities to encourage private-sector financing for long-term care, both through an insurance market and through alternative financial planning instruments. The State lacks the jurisdiction, resources, and policy levers necessary to craft an effective long-term care financing mechanism for New Yorkers—except those who qualify for Medicaid. As a result, Medicaid is the principal locus for New York’s long-term care policy debate. And given the State’s commitment to a comprehensive Medicaid benefit that includes home- and community-based services, in accordance with the Supreme Court’s *Olmstead* decision, options for reducing Medicaid’s obligations are extremely limited.

Very few New Yorkers have the comprehensive private long-term care insurance coverage and/or extremely high asset levels required to plan for hypothetical long-term care needs far into the future. For the vast majority, a potential consequence of there being no effective public policy solution to the long-term care problem is family impoverishment, in some form, at some level. The unpredictable need for significant long-term care services makes planning akin to a lottery in which nobody wants their numbers to come up—but everybody must play. Paying for long-term care remains a major unresolved challenge in New York State and the nation.

## Notes

- 1 National Health Policy Forum. February 23, 2012. *The Basics: National Spending for Long-Term Services and Supports (LTSS)*. Washington, DC: National Health Policy Forum. [https://www.nhpf.org/uploads/announcements/Basics\\_LongTermServicesSupports\\_02-23-12.pdf](https://www.nhpf.org/uploads/announcements/Basics_LongTermServicesSupports_02-23-12.pdf)
- 2 National Health Policy Forum, *Basics* (see note 1).
- 3 National Health Policy Forum, *Basics* (see note 1).
- 4 U.S. Census Bureau. 2011. *Statistical Abstract of the United States: 2012 (131st Edition)*. Table 7. Resident Population by Sex and Age: 1980-2010. Washington, DC: U.S. Census Bureau. <http://www.census.gov/compendia/statab/2012/tables/12s0007.pdf>
- 5 U.S. Census Bureau, *Statistical Abstract*. Table 9. Resident Population Projections by Sex and Age: 2010 to 2050. <http://www.census.gov/compendia/statab/2012/tables/12s0009.pdf>
- 6 U.S. Census Bureau, *Statistical Abstract*, Table 9 (see note 5).
- 7 U.S. Census Bureau. April 21, 2005. *Interim State Population Projections 2005*. Table B1. Interim Projections of the Population by Selected Age Groups for the United States and States: April 1, 2000 to July 1, 2030. <http://www.census.gov/population/www/projections/files/SummaryTabB1.pdf>
- 8 Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation, Centers for Medicare and Medicaid Services, and Health Resources and Services Administration; and Department of Labor's Office of the Assistant Secretary for Policy, Bureau of Labor Statistics, and Employment and Training Administration. May 14, 2003. *Report to Congress: The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boom Generation*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation. <http://aspe.hhs.gov/daltcp/reports/lcwork.pdf>
- 9 National Health Policy Forum, *Basics* (see note 1); Congressional Budget Office. April 2004. *Financing Long-Term Care for the Elderly*. Washington, DC: Congressional Budget Office. <http://www.cbo.gov/ftpdocs/54xx/doc5400/04-26-LongTermCare.pdf>
- 10 MetLife Mature Market Institute. October 2011. *The 2011 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs*. Westport, CT: MetLife Mature Market Institute. <http://www.metlife.com/assets/cao/mmi/publications/studies/2011/mmi-market-survey-nursing-home-assisted-living-adult-day-services-costs.pdf>
- 11 MetLife Mature Market Institute, *Market Survey* (see note 10).
- 12 U.S. Census Bureau. *Current Population Survey, Annual Social and Economic Supplement, 2011*. Accessed via CPS Table Creator, <http://www.census.gov/cps/data/cpstablecreator.html>
- 13 U.S. Census Bureau, *Current Population Survey* (see note 12).
- 14 National Institutes of Health. 2007. Understanding Alzheimer's. *NIH Medline Plus* 2(3): 8-10. <http://www.nlm.nih.gov/medlineplus/magazine/issues/pdf/fall2007.pdf>
- 15 Spector WD, JA Fleishman, LE Pezzin, BC Spillman. January 2001. *The Characteristics of Long-term Care Users*. Rockville, MD: Agency for Healthcare Research and Quality. <http://www.ahrq.gov/research/lcusers/>
- 16 Spector et al., *Characteristics* (see note 15).
- 17 Feinberg L, SC Reinhard, A Houser, R Choula. June 2011. *Valuing the Invaluable: 2011 Update—The Growing Contributions and Costs of Family Caregiving*. Washington, DC: AARP Public Policy Institute. <http://assets.aarp.org/rgcenter/ppi/lc/i51-caregiving.pdf>
- 18 Feinberg, *Valuing the Invaluable* (see note 17).
- 19 Feinberg, *Valuing the Invaluable* (see note 17).
- 20 Johnson RW, D Toohey, JM Wiener. May 2007. *Meeting the Long-Term Care Needs of the Baby Boomers: How Changing Families Will Affect Paid Helpers and Institutions*. Washington, DC: Urban Institute. [http://www.urban.org/UploadedPDF/311451\\_Meeting\\_Care.pdf](http://www.urban.org/UploadedPDF/311451_Meeting_Care.pdf)
- 21 Johnson et al., *Meeting Needs* (see note 20).
- 22 Kemper P, HL Komisar, L Alecxih. 2005. Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect? *Inquiry* 42:335-350. [http://www.inquiryjournalonline.org/doi/pdf/10.5034/inquiryjrnl\\_42.4.335](http://www.inquiryjournalonline.org/doi/pdf/10.5034/inquiryjrnl_42.4.335)

- 23 Aaronson WE, JS Zinn, MD Rosko. 1994. The Success and Repeal of the Medicare Catastrophic Coverage Act: A Paradoxical Lesson for Health Care Reform. *Journal of Health Politics, Policy and Law* 19:753-771. <http://jhpl.dukejournals.org/cgi/reprint/19/4/753.pdf>
- 24 Aaronson et al., Success and Repeal (see note 23).
- 25 Aaronson et al., Success and Repeal (see note 23).
- 26 Aaronson et al., Success and Repeal (see note 23).
- 27 Aaronson et al., Success and Repeal (see note 23).
- 28 Liu K and G Kenney. 1993. Impact of the Catastrophic Coverage Act and New Coverage Guidelines on Medicare Skilled Nursing Facility Use. *Inquiry* 30:41-53.
- 29 Johnson RW and CE Uccello. March 2005. *Is Private Long-Term Care Insurance the Answer?* Boston: Center for Retirement Research. <http://www.urban.org/uploadedpdf/1000795.pdf>
- 30 Cohen MA, J Gordon, J Miller. 2011. The Historical Development of Benefit Eligibility Triggers Underlying the CLASS Plan. Long Beach, CA: The SCAN Foundation. [http://www.thescanfoundation.org/sites/scan.Imp03.lucidus.net/files/TSF\\_CLASS\\_TA\\_No2\\_History\\_Benefit\\_Eligibility\\_FINAL.pdf](http://www.thescanfoundation.org/sites/scan.Imp03.lucidus.net/files/TSF_CLASS_TA_No2_History_Benefit_Eligibility_FINAL.pdf)
- 31 Thau C, D Helwig, A Schmitz. July 2011. 2011 Individual Long-Term Care Survey. *Broker World Magazine*. Overland Park, KS: Insurance Publications Inc.
- 32 Thau et al., Individual LTC Survey (see note 31).
- 33 National Health Policy Forum. April 15, 2011. Private Long-Term Care Insurance: Where Is the Market Heading? (forum session announcement). Washington, DC: National Health Policy Forum. [http://www.nhpf.org/library/forum-sessions/FS\\_04-15-11\\_PrivateLTCI.pdf](http://www.nhpf.org/library/forum-sessions/FS_04-15-11_PrivateLTCI.pdf)
- 34 The SCAN Foundation. December 2010. *DataBrief: Long-Term Care Insurance by Income*. Long Beach, CA: The SCAN Foundation. <http://www.thescanfoundation.org/sites/scan.Imp03.lucidus.net/files/Long-Term-Care-Insurance-by-Income-DataBrief-No9.pdf>
- 35 The SCAN Foundation. November 2010. *The Financing of Long Term Care*. Long Beach, CA: The SCAN Foundation. [http://www.thescanfoundation.org/sites/scan.Imp03.lucidus.net/files/LTC\\_Fundamental\\_3.pdf](http://www.thescanfoundation.org/sites/scan.Imp03.lucidus.net/files/LTC_Fundamental_3.pdf); Kaiser Commission on Medicaid and the Uninsured. March 2011. *Medicaid and Long-Term Care Services and Supports*. Washington, DC: The Henry J. Kaiser Family Foundation. <http://www.kff.org/medicaid/upload/2186-08.pdf>
- 36 National Health Policy Forum, Private LTC Insurance (see note 33).
- 37 National Health Policy Forum, Private LTC Insurance (see note 33).
- 38 Bureau of Labor Statistics. March 2011. *National Compensation Survey*. Table 42. Health-Related Benefits: Access, Civilian Workers. Washington, DC: Bureau of Labor Statistics. <http://www.bls.gov/ncs/ebs/benefits/2011/ownership/civilian/table39a.htm>
- 39 Bureau of Labor Statistics, *National Compensation Survey* (see note 38).
- 40 The SCAN Foundation. December 2010. *DataBrief: Group Long-Term Care Insurance*. Long Beach, CA: The SCAN Foundation. <http://www.thescanfoundation.org/sites/scan.Imp03.lucidus.net/files/Group-Long-Term-Care-Insurance-DataBrief-No8.pdf>
- 41 New York State Department of Financial Services. December 31, 2011. *A Report by the Superintendent of Financial Services to the Governor and the Legislature on the Implementation of Legislation Permitting Approval of Certain Long Term Care Health Insurance Plans*. Albany: Department of Financial Services. <http://www.dfs.ny.gov/reportpub/insurance/ltrcpt2011.pdf>
- 42 United Hospital Fund (UHF) analysis of New York State Insurance Department data and U.S. Census Bureau population estimates.
- 43 New York State Insurance Department. 2005. *Long Term Care Insurance Options in New York State: A Report to the Governor and Legislature*. Albany: Insurance Department. <http://www.dfs.ny.gov/insurance/ltrcpt05.pdf>
- 44 New York State Insurance Department, *LTCI Options* (see note 43).
- 45 New York State Insurance Department, *LTCI Options* (see note 43).
- 46 New York State Insurance Department, *LTCI Options* (see note 43).
- 47 Thau et al., Individual LTC Survey (see note 31).

- 48 New York State Insurance Department, *LTCI Options* (see note 43).
- 49 LifePlans, Inc. April 2007. *Who Buys Long-Term Care Insurance? A 15-Year Study of Buyers and Non-Buyers, 1990-2005*. Washington, DC: America's Health Insurance Plans. [http://www.ahipresearch.org/PDFs/LTC\\_Buyers\\_Guide.pdf](http://www.ahipresearch.org/PDFs/LTC_Buyers_Guide.pdf)
- 50 Thau et al., Individual LTC Survey (see note 31).
- 51 UHF analysis of U.S. Census Bureau *Current Population Survey* data. Accessed via CPS Table Creator, <http://www.census.gov/cps/data/cpstablecreator.html>
- 52 Thau et al., Individual LTC Survey (see note 31).
- 53 Merlis M. 2003. *Private Long-term Care Insurance: Who Should Buy It and What Should They Buy*, p. viii. Washington, DC: Kaiser Family Foundation. <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14370>
- 54 UHF analysis of U.S. Census Bureau *Current Population Survey* data (see note 51).
- 55 Thau et al., Individual LTC Survey (see note 31).
- 56 LifePlans, Inc., *Who Buys LTCI?* (see note 49).
- 57 LifePlans, Inc., *Who Buys LTCI?* (see note 49).
- 58 LifePlans, Inc., *Who Buys LTCI?* (see note 49).
- 59 LifePlans, Inc., *Who Buys LTCI?* (see note 49).
- 60 Brown JR and A Finkelstein. March 2009. The Private Market for Long-Term Care Insurance in the U.S.: A Review of the Evidence. *Journal of Risk and Insurance* 76(1): 5-29.
- 61 Brown JR and A Finkelstein. August 2004. *Supply or Demand: Why is the Market for Long-Term Care Insurance So Small?* NBER Working Paper Number 10782. Cambridge, MA: National Bureau of Economic Research. [www.nber.org/papers/w10782.pdf](http://www.nber.org/papers/w10782.pdf)
- 62 Brown and Finkelstein, *Supply or Demand* (see note 61).
- 63 Finkelstein A, K McGarry, A Sufi. 2005. Dynamic Inefficiencies in Insurance Markets: Evidence from Long-Term Care Insurance. *American Economic Review* 95(2): 224-228, cited in Brown and Finkelstein, Private Market (see note 60).
- 64 Holm E and A Tergesen. November 12, 2010. MetLife Steps Back From Long-Term Care Market. *Wall Street Journal*. <http://online.wsj.com/article/SB10001424052748704756804575608472482348634.html>; New York State Department of Financial Services, *Implementation of Legislation* (see note 41).
- 65 Mercado D. February 7, 2011. Yet another insurer bows out of LTC biz. *InvestmentNews*.
- 66 Greene K. March 9, 2012. Long-Term Care: What Now? *Wall Street Journal*. <http://online.wsj.com/article/SB10001424052970203961204577269842991276650.html>
- 67 New York State Partnership for Long-Term Care. [No date] Purchasing a Partnership Policy. <http://www.nyspltc.org/purchasing.htm>
- 68 New York State Tax Law § 606(aa).
- 69 Stevenson DG, RG Frank, J Tau. 2009. Private Long-Term Care Insurance and State Tax Incentives. *Inquiry*, 46(3): 305-321.
- 70 Goda GS. September 2010. *The Impact of State Tax Subsidies for Private Long-Term Care Insurance on Coverage and Medicaid Expenditures*. NBER Working Paper No. 16406. Cambridge, MA: National Bureau of Economic Research. <http://www.nber.org/papers/w16406>
- 71 New York State Department of Financial Services. [No date] Basics of Long Term Care Insurance: Classifications of Insurance Policies Covering Long Term Care Services. [http://www.dfs.ny.gov/insurance/ltc/ltc\\_ins\\_cov\\_class\\_nys.htm](http://www.dfs.ny.gov/insurance/ltc/ltc_ins_cov_class_nys.htm)
- 72 New York State Department of Financial Services, Classifications (see note 71).
- 73 MetLife Mature Market Institute, *Market Survey* (see note 10).
- 74 New York State Insurance Department, *LTCI Options* (see note 43).
- 75 New York State Department of Health. 2011. *NYS Partnership for Long-Term Care: Quarterly Report, 1st Quarter 2011*. Albany: Department of Health. [http://www.nyspltc.org/docs/update\\_1stqtr\\_2011.pdf](http://www.nyspltc.org/docs/update_1stqtr_2011.pdf)

- 76 New York State Partnership for Long-Term Care. January 2011. Policy Benefits. <http://www.nyspltc.org/docs/policysummaryhandout.pdf>
- 77 New York State Insurance Department, *LTCL Options* (see note 43).
- 78 Kissinger M. March 20, 2007. Correspondence to JE Dicken, Government Accountability Office (GAO) director of health care, in GAO. May 2007. *Long-Term Care Insurance: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings*, GAO-07-231, Appendix IV: Comments from the Four States with Partnership Programs, California, Connecticut, Indiana, and New York. Washington, DC: Government Accountability Office. <http://www.gao.gov/new.items/d07231.pdf>
- 79 New York State Department of Financial Services, *Implementation of Legislation* (see note 41).
- 80 New York State Department of Health, *Partnership Quarterly Report* (see note 75).
- 81 UHF analysis of CMS 64 and New York State Department of Health MARS data.
- 82 New York State Partnership for Long-Term Care. 2012. Changes to the Partnership for Long Term Care Insurance Program. [http://www.nyspltc.org/docs/partnership\\_changes.pdf](http://www.nyspltc.org/docs/partnership_changes.pdf)
- 83 New York State Partnership for Long-Term Care, Changes to the Partnership (see note 82).
- 84 New York State Partnership for Long-Term Care, Changes to the Partnership (see note 82).
- 85 U.S. Department of Housing and Urban Development. February 29, 2012. Home Equity Conversion Mortgage [Endorsed Cases\_State spreadsheet]. Washington, DC: Department of Housing and Urban Development. <http://portal.hud.gov/hudportal/documents/huddoc?id=hecm0212.xls>
- 86 Friedrich C, cited in Ransom D. October 13, 2009. Long-Term-Care Annuities to Go Tax Free. *SmartMoney*. <http://www.smartmoney.com/retirement/planning/long-term-care-annuities-to-go-tax-free/>
- 87 Orestis C. March 15, 2011. Universal Life: How Life Insurance Can Help with LTC Costs. *LifeHealthPro*. Reproduced from March 1, 2011, *Life Insurance Selling*. <http://www.lifehealthpro.com/2011/03/15/universal-life-how-life-insurance-can-help-with-lt>
- 88 Hersch WS. August 8, 2011. Linked Benefit Products Breathe New Life into LTC Market. *LifeHealthPro*. Reproduced from August 8, 2011, *National Underwriter Life & Health Magazine*. <http://www.lifehealthpro.com/2011/08/08/linked-benefit-products-breathe-new-life-into-ltc>
- 89 Friedrich C and S Saip. July 2009. *Annuity/Long-Term Care Insurance Combination Products*. Seattle: Milliman. <http://publications.milliman.com/research/life-rr/pdfs/annuity-long-term-care-RR.pdf>
- 90 Burns C. June 17, 2011. 2010 Good Year for Combination Life Insurance Products. *Insurance Networking News*. [http://www.insurancenetworking.com/news/Annuities\\_life\\_insurance\\_long\\_term\\_care\\_limra-28195-1.html](http://www.insurancenetworking.com/news/Annuities_life_insurance_long_term_care_limra-28195-1.html)
- 91 Tumicki EF. 2011. The Cost of Living. *LIMRA's MarketFacts Quarterly* 2. <http://www.limra.com/MarketFacts/Commentaries/Products816.pdf>
- 92 New York State bill S7196A-2009: Prohibits accelerated payment of death benefits or special surrender value pursuant to a life insurance policy because of residency in a nursing home. <http://open.nysenate.gov/legislation/bill/S7196A-2009>
- 93 New York State Insurance Department, *LTCL Options* (see note 43).
- 94 Life Insurance Council of New York. *Life Insurance Facts & Figures*. New York: Life Insurance Council of New York. <http://www.licony.org/new-york-state-facts-a-figures-on-life-insurance.html>
- 95 New York State Medicaid Redesign Team. February 24, 2011. LTC Insurance, Proposal #1462, Part C. In *Descriptions of Staff Proposals to Redesign Medicaid*, p. 222. [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/descriptions\\_of\\_recommendations.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/descriptions_of_recommendations.pdf)
- 96 Holubinka S. February 2005. A proposal for a New York State LTC Compact. *Report of the Long-Term Care Reform Committee, New York State Bar Association Elder Law Section*, Chapter 6. Albany: New York State Bar Association. <http://www.nysba.org/Content/NavigationMenu7/ElderLawResources/ArticlesReportsandResources/ElderLaw2005LongTermCareReformReport/elderlcreport2columnnewer.pdf>; New York State bill S2185-2011: Establishes the New York state compact for long term care. <http://open.nysenate.gov/legislation/bill/S2185-2011>
- 97 Holubinka, Proposal for an LTC Compact (see note 96).
- 98 New York State bill S2185-2011 (see note 96).
- 99 New York State bill S2185-2011 (see note 96).

- 100 New York State bill A9708C-2009: Enacts into law major components of legislation necessary to implement the health and mental hygiene budget for the 2010-2011 state fiscal plan. <http://m.nysenate.gov/legislation/bill/A9708C-2009>
- 101 National Health Policy Forum, *Basics* (see note 1).
- 102 New York City Human Resources Administration. March 19, 2012. 2012 NYS Income and Resource Standards and Federal Poverty Levels (FPL). New York City: Human Resources Administration. [http://www.nyc.gov/html/hra/downloads/pdf/MICSA/MAP/income\\_level.pdf](http://www.nyc.gov/html/hra/downloads/pdf/MICSA/MAP/income_level.pdf)
- 103 Fossett JW and CE Burke. August 2010. *Medicaid Policy and Long-Term Care Spending: An Interactive View*. Albany: The Nelson A. Rockefeller Institute of Government, University at Albany. [http://www.rockinst.org/pdf/health\\_care/2010-08-Medicaid\\_Policy.pdf](http://www.rockinst.org/pdf/health_care/2010-08-Medicaid_Policy.pdf)
- 104 UHF analysis of CMS 64 data. This figure does not include specialized long-term care services and supports for individuals with developmental disabilities and mental illness.
- 105 UHF analysis of New York State Department of Health data and CMS MSIS data.
- 106 28 CFR § 35.130(d), quoted in *Olmstead v. L.C.*, 527 U.S. 581 (1999).
- 107 Arnold J. November 23, 2011. 2012 Medicaid Only Income and Resource Levels. GIS 11 MA/027 (memo to local district commissioners and Medicaid directors from director, Division of Coverage and Enrollment, Office of Health Insurance Programs). [http://www.health.ny.gov/health\\_care/medicaid/publications/docs/gis/11ma027.pdf](http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/11ma027.pdf)
- 108 Arnold, Medicaid Only Levels (see note 107).
- 109 New York State Department of Health, Office of Health Insurance Programs. September 24, 2007. Spousal Impoverishment – Increasing the Community Spouse Resource Allowance. Transmittal 07 OHIP/INF-3 (informational letter to commissioners of social services). Albany: Department of Health. [http://www.health.ny.gov/health\\_care/medicaid/publications/docs/inf/07inf-3.pdf](http://www.health.ny.gov/health_care/medicaid/publications/docs/inf/07inf-3.pdf)
- 110 Fish DG. December 17, 2001. Medicaid Spousal Refusal Lawsuits: ‘Commissioner v. Mandel.’ *New York Law Journal*. [http://www.ffglaw.com/pdfs/2001\\_MedicaidSpousalRefusal.pdf](http://www.ffglaw.com/pdfs/2001_MedicaidSpousalRefusal.pdf)
- 111 UHF analysis of New York City Human Resources Administration data, October 2011 through March 2012.
- 112 UHF analysis of New York State Department of Health data.



**Medicaid Institute at United Hospital Fund**

1411 Broadway

12th Floor

New York, NY 10018-3496

(212) 494-0700

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