

Home equity conversion mortgages and long-term care

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As the nation considers ways of meeting growing costs for long-term care services, there has been growing interest in the possibility that older people without other financial resources could draw on their home equity to help pay for their own care. One mechanism for doing so is a “reverse mortgage,” under which a lender advances money to an older person in return for a future claim on the home. Some older people with functional disabilities might be able to use proceeds from a reverse mortgage to meet costs for personal care, home modifications, or other assistance needed to remain in the home. Those not yet in need of assistance could use the funds to pay premiums for a private long-term care insurance policy.

This report provides an overview of how reverse mortgages work. Using data from the 2000 Health and Retirement Study, it estimates how many older households could qualify for a reverse mortgage, how much money they could borrow, and how much help these might provide in financing long-term care directly or in paying for long-term care insurance premiums.

The results indicate that many middle-income households without other resources might benefit from using reverse mortgages to help pay for needed home care. However, it is not likely that this mechanism will play a major role in financing long-term care. In particular, it cannot be expected that reverse mortgages will help to solve the long-range financing problem for Medicaid. Reverse mortgages could make private long-term care insurance more affordable for many households. But those whose home is their largest asset are unlikely to be motivated to mortgage it for this purpose, because they may have other financial needs and because use of a loan to buy insurance is, under current market structures, very costly relative to the benefits received.

How Reverse Mortgages Work

The most common reverse mortgages are Home Equity Conversion Mortgages (HECMs), which are offered by banks and insured by the Federal Housing Administration. Under an HECM loan, a lender advances money to a homeowner, in the form of a series of fixed monthly payments, a line of credit on which the borrower may draw, or a combination. The borrower is not required to make any payments on the loan so long as he or she remains in the house. The lender collects the loan balance—which includes the accrued interest and other charges as well as the amounts paid out—when the house is sold by the borrower or by his or her estate.

An HECM is available only to homeowners aged 62 or older. If a house is jointly owned, all owners must be 62 or older. Maximum initial loan amounts are subject to two basic limits. First, the amount of home equity that can be borrowed against is subject to a county-level limit based on median local home values. Second, the homeowner can borrow only a fixed percentage of the allowed home equity; this percentage is based on the borrower's age at the time of application and the expected interest rate for the loan. For example, given an expected future interest rate of 5.5 percent, 62-year-olds could borrow up to 63 percent of their home's value, while 80-year-olds could borrow 78 percent. (For couples, the age of the younger member is used in all calculations.)

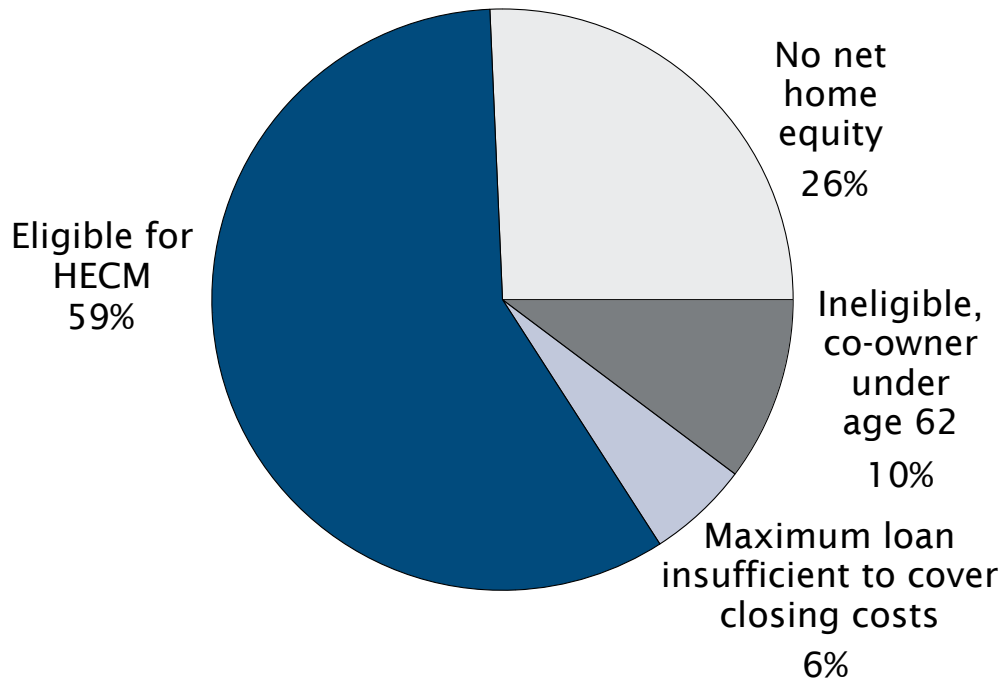
Closing costs for HECMs, including an upfront mortgage insurance premium, are typically financed through the loan. In addition, loan proceeds must be used first to pay off any existing mortgage and to make needed repairs, and there is a set-aside for future bank service charges. For many older homeowners, these charges can reduce the available loan to zero.

The combination of upfront charges and compounding interest on the loan means that the final loan balance payable when the home is sold may be considerably more than the borrower has actually received. For example, a 70-year-old borrower with median home equity for that age (\$80,000) might opt for a loan paying about \$380 per month over his or her life expectancy of 15 years. At the end of that period, he or she would have received a total of \$68,392 and would owe \$103,523—\$1.51 for every \$1.00 received. The ratio of the loan balance to actual proceeds is even higher for loans of shorter duration.

Using an HECM to Pay Directly for Long-Term Care

As Figure 1 shows, there are 24 million older households—defined in this report as those headed by a single adult aged 62 or older or a

Figure 1
Eligibility of Older Households for an HECM, 2000



Note: Based on 24.2 million households. Because of rounding, components do not sum to 100%.
 SOURCE: Author's analysis of data from the 2000 Health and Retirement Study.

couple both of whom are 62 or older. Of these, 74 percent have at least some net home equity. However, about one-fifth of the households with home equity—or 16 percent of all older households—are ineligible for an HECM, either because another owner is on the deed or because the available loan is too small to finance closing and other costs. This leaves 14.2 million households, or 59 percent of older households, eligible for an HECM.

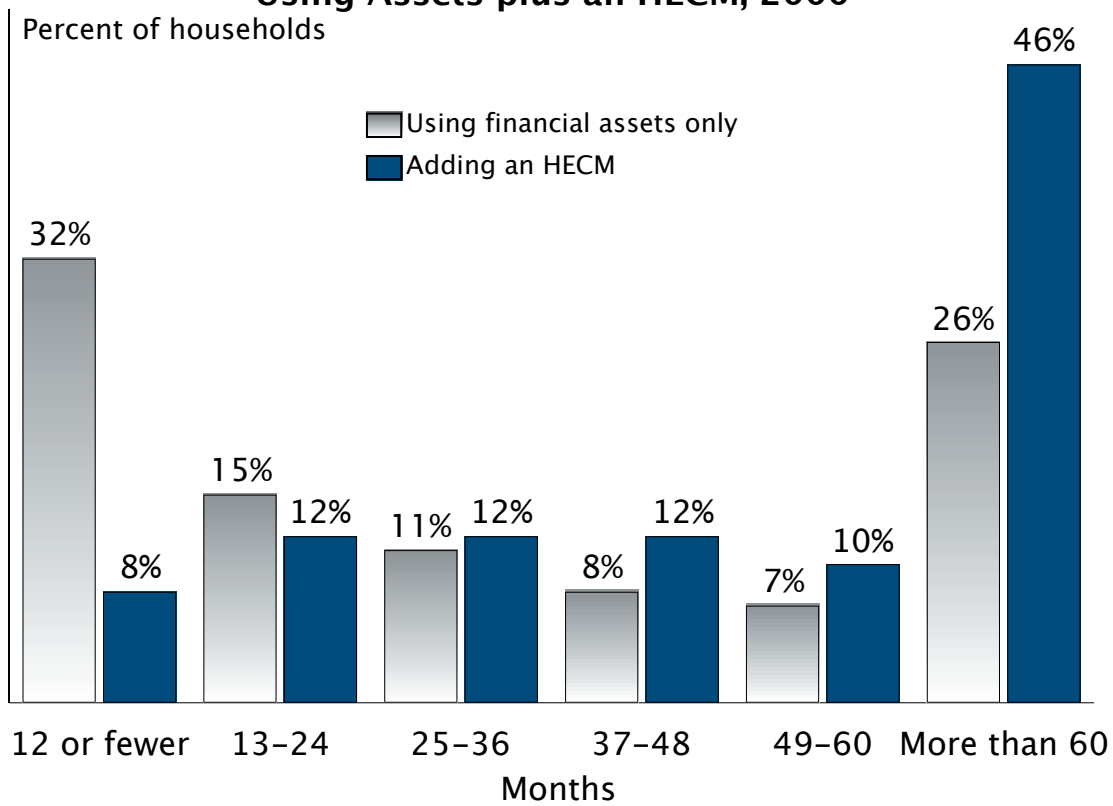
Not all of these households are likely to use an HECM if they should find themselves facing high long-term care costs. On the one hand, 1.6 million potential borrowers have very low incomes and few financial resources other than their home. These households are already Medicaid beneficiaries or might rapidly qualify for Medicaid if they required expensive care and therefore would have little reason to borrow. (Nor, as will be discussed below, would their use of an HECM necessarily save money for Medicaid.) At the other extreme are households whose financial resources are already sufficient to cover their likely long-term care needs. The 3.8 million households in the top quartile by financial assets, those with \$275,000 or more, are treated here as unlikely

candidates for an HECM. This leaves a net “target” population of 8.8 million households who might use an HECM for long-term care.

These 8.8 million target households would have qualified for a median loan of about \$47,000 in 2000. More than three-quarters could have received \$25,000 or more, and one-quarter could have received \$75,000 or more. Some of these households have other resources that would let them cover their own long-term care, but for many an HECM loan could make a real difference in how long they could afford to receive care at home.

Figure 2 shows how long target households could afford to pay for home care costing \$2,000 per month. Using only their non-housing assets, about one-third of these households could afford to pay only for 12 months or less. When an HECM loan is added in, 92 percent of these households could afford to pay for more than a year of care. Using an HECM, 46 percent could afford to pay for more than five years of care, compared to 26 percent using non-housing assets alone.

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**Maximum Months of Home Care "Target" Households
 Could Pay For, Using Financial Assets or
 Using Assets plus an HECM, 2000**



Note: Based on 8.8 million "target" households. Assumes home care expenses of \$2,000 per month.
 SOURCE: Author's analysis of data from the 2000 Health and Retirement Study.

Much of the current interest in promoting the use of reverse mortgages as a source of long-term care financing stems from the hope that Medicaid long-term care expenditures might be reduced. While it is certainly possible that HECMs could help people postpone the day on which they will need Medicaid, at least two factors limit the likely savings to the Medicaid program. First, nothing prevents someone from receiving an HECM loan and qualifying for Medicaid at the same time. Loan proceeds are not treated as income, no matter what they are spent on, and would affect Medicaid eligibility only if the borrower retained enough loan payments (instead of spending them at once) to exceed limits on non-housing assets. Second, Medicaid already has an ultimate claim on the home equity of older people who receive long-term care. There are some circumstances in which it would be more cost-effective for Medicaid to pay for care and recover its expenditures later on, than for the person needing care to use an HECM, because HECMs divert so much of the equity to interest and other loan costs.

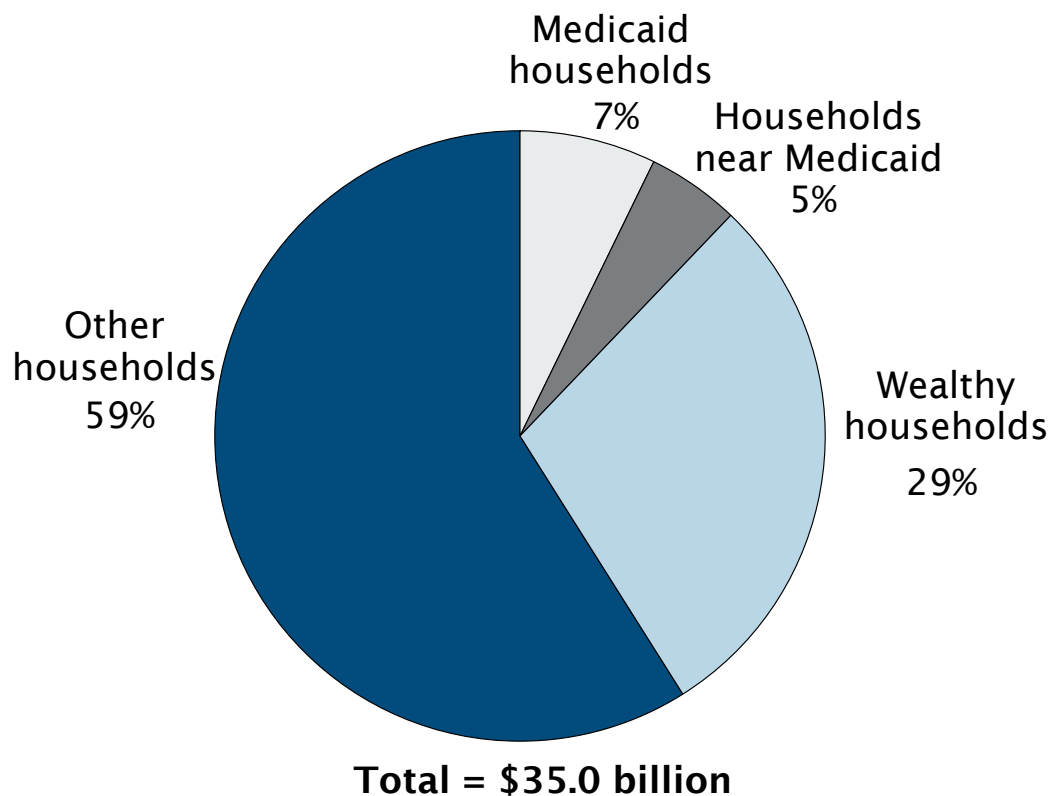
Even if Medicaid could achieve some savings by promoting the use of HECMs, this mechanism is unlikely to have a major effect on spending because current or likely beneficiaries simply don't have enough equity. Figure 3 shows annual available loan proceeds for all households with any member reporting difficulty or receiving assistance with activities of daily living (ADLs). (The figure includes the low-income households and high-wealth households previously excluded from the "target" population.) Overall, HECMs could have yielded \$35 billion in 2000. But nearly a third of these funds would have gone to wealthier households, while only 12 percent (\$4.2 billion) would have been available for Medicaid households or those near Medicaid eligibility. This compares with an estimated \$42 billion in Medicaid spending for long-term care for the elderly in 2001.

HECMs and Long-Term Care Insurance

A second possible use of an HECM is to pay premiums for private long-term care insurance. For many households, this could provide better protection than use of an HECM to pay for care directly, because not everyone will ultimately need long-term care and the risks can be spread across a pool of purchasers.

A private long-term care insurance policy provides payment towards the cost of necessary long-term care services, such as nursing home care or home care. Typically the policy makes fixed dollar payments for each day of care, regardless of the actual cost of the service. Long-term care insurance generally pays benefits only for a fixed period—e.g., two years of nursing home care, three years, and so on; the

Figure 3
Distribution of Potential Annual HECM Proceeds for Households with a Member Reporting or Receiving Assistance with Activities of Daily Living, 2000



Note: Based on 3.0 million households. Assumes 60 monthly term payments. Medicaid households had a member currently or recently receiving Medicaid. Households near Medicaid had income below the poverty level and non-housing assets of less than \$15,000. Wealthy households had non-housing assets greater than \$275,000.

SOURCE: Author's analysis of data from the 2000 Health and Retirement Study.

longer the coverage, the more costly the policy. Most purchasers of long-term care insurance do not expect to need long-term care services until some time in the future; they pay premiums over a period of some years in return for a promise of future protection. Although it is understandable that the elderly are most interested in this protection, long-term care insurance is expensive for those who buy it at older ages, because there is less time to accumulate funds before services are needed.

Relatively few older households can afford to pay these premiums using retirement income. While there are varying ideas of how much people could afford to pay, this report assumes that coverage is affordable if premiums amount to no more than 5 percent of income. Under this criterion, 14 percent of older households can afford long-term care

insurance. To encourage the private insurance option, a 2000 change in the federal HECM law permits a waiver of required upfront mortgage insurance premium if the borrower uses the loan solely to pay for long-term care insurance. This waiver would increase potential loan proceeds by an average of 6.7 percent.

Assuming that people at or close to Medicaid eligibility levels and people with substantial financial assets would not buy coverage (or could afford it without an HECM), the population likely to be interested in an HECM/insurance arrangement might be about the same target group identified above. (It would be slightly larger—8.9 million households instead of 8.8 million—because of the mortgage insurance waiver.) Some of these households would be unable to obtain coverage, because insurers use underwriting, screening out high-risk applicants by reviewing medical history and functional status.

As Figure 4 shows, of the 8.9 million target households, 72 percent would qualify, using less stringent underwriting criteria than those ordinarily applied by insurers. Of these, 10 percent could already afford coverage without using an HECM. Premiums for a reasonably comprehensive policy (providing a \$100 daily benefit for three years, with a 90-day waiting period and compound inflation protection) would be less than 5 percent of income for this group. For 34 percent of the target population, available HECM proceeds would be sufficient to pay the entire long-term care insurance premium; for another 11 percent, loan proceeds would reduce the net premium to less than 5 percent of income.

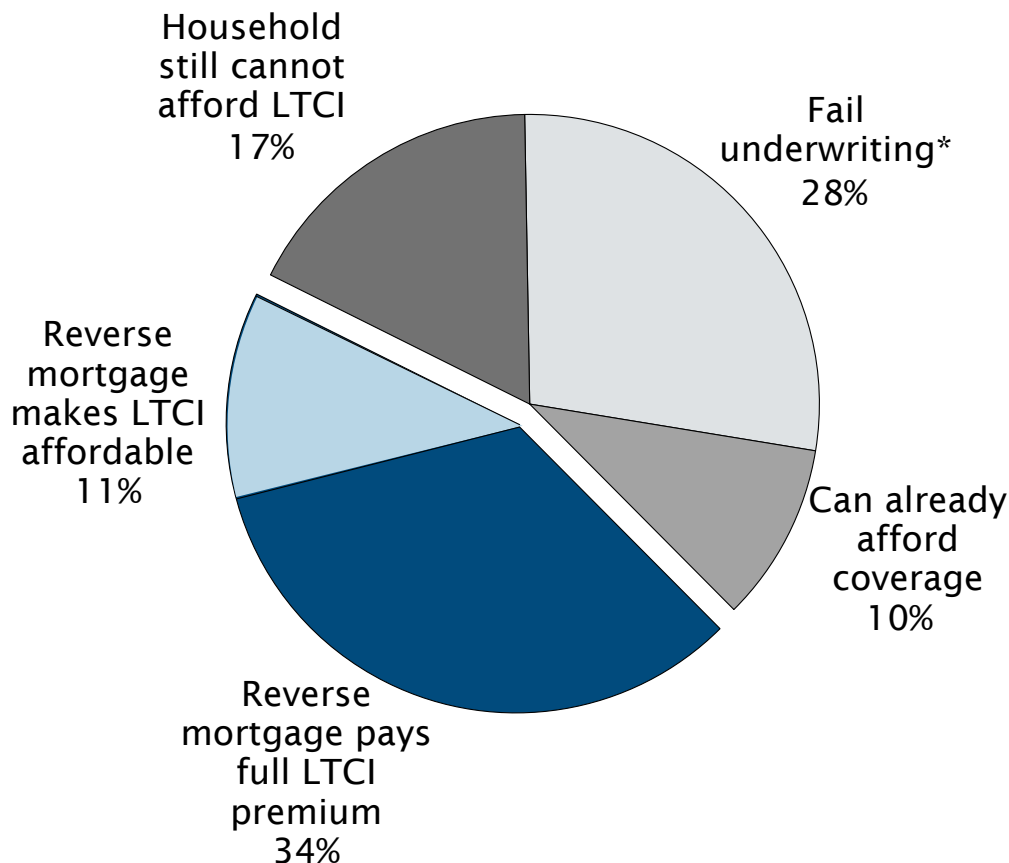
Some analysts contend that, because many of these households have limited financial assets to protect, they are unlikely to be interested in long-term care insurance. This may not be so; while asset protection is the most commonly cited reason for buying long-term care insurance, many have other concerns, such as avoiding dependence on children and protecting living standards. Still, there are some major barriers to development of an HECM/insurance market:

Even if they would value insurance, people with limited financial wealth are likely to be reluctant to surrender their largest asset.

Many of the people who might use an HECM to buy long-term care insurance would be mortgaging most or all of their major asset. In doing so, they might deprive themselves of a potential cushion to meet risks other than a need for long-term care. People might need to draw on an HECM for other purposes—for example, to keep up their home or to maintain their standard of living if their retirement income should prove

Figure 4

Effect of an HECM on Affordability of Long-Term Care Insurance Premiums for "Target" Households, 2000



*For couples, at least one person fails underwriting.

Note: Based on 8.9 million "target" households. Total households greater than in Figure 2 because additional households qualify through waiver of upfront private mortgage insurance premium.

SOURCE: Author's analysis of data from the 2000 Health and Retirement Study.

inadequate. In addition, many people with limited financial assets hope to leave their home to children or other heirs.

Different households give different weights to the value of leaving an inheritance versus maintaining current life style. Some people feel strongly about leaving a bequest, while others care much less about leaving an estate and are more willing to trade equity for consumption. Even these people, however, might not be as ready to trade equity for insurance against what is a real but fairly distant risk.

The dual transactions of taking out a loan and then buying insurance are inefficient and costly.

The borrower/buyer must separately cover administrative costs and profit requirements of both the bank and the insurer, as well as interest costs for the loan. A typical long-term care insurance policy pays benefits averaging 60 percent to 70 percent of premiums, with the rest retained by the insurer; HECM costs may be nearly as high. The result could be that the average value of actual long-term care benefits would be just 36 cents for every dollar of equity ultimately surrendered.

Costs might be reduced considerably if one financial institution sold a single product that provided long-term care insurance in return for a direct future claim on the home. This might lower administrative costs and reduce the need for underwriting. A combined product could also have much lower interest costs than an HECM alone, since the interval between pay-out of benefits and recovery of equity would usually be shorter.

Long-term care insurance has a history of rate instability and may be especially risky for people barely able to afford it.

Long-term care insurance is supposed to have “level premiums”: insurers are supposed to set their initial premium rates at levels sufficient to cover their ultimate projected costs. However, an insurer may raise premiums if it can show regulators that more revenue is needed to cover current or future costs. While stronger regulations now being adopted by states may deter abusive pricing practices, rate-setting remains subject to forecast errors, investment income fluctuations, and other uncertainties. While rate increases are a risk for any long-term care insurance purchaser, the marginal buyers who could afford insurance only by using an HECM would certainly be more seriously affected.

Conclusion

While HECMs are costly, they could help finance long-term care for a substantial number of households. Use of this funding source could help some disabled people remain at home and enhance their ability to direct their own care. However, because available funds for many potential borrowers are limited, many would exhaust their loans if they needed intensive care or required services for a long period. For these borrowers, the HECM would merely postpone, rather than obviate, the need for Medicaid assistance.

HECMs could also improve the affordability of long-term care insurance, but this way of paying for coverage is costly, inefficient, and unattractive. Major changes, such as development of a combination loan/insurance product and further modifications of HECM rules, are likely to be needed before this would be a workable option for many people.

About the Project

The *Georgetown University Long-Term Care Financing Project* pursues analysis designed to stimulate public policy discussion about current long-term care financing and ways to improve it. The project is supported by a grant from the Robert Wood Johnson Foundation. Additional publications are available at <http://ltc.georgetown.edu>.



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