

The Realist's Guide to Medicaid and Long-Term Care



Presented by



*Dedicated to ensuring
quality long-term care
for all Americans*

with
The Council for Affordable Health Insurance
and
The American Legislative Exchange Council

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Center for Long-Term Care Financing

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Executive Summary

Most thinking about Medicaid and long-term care is based on a fantasy.

That fantasy is that government can pay for most expensive, formal long-term care for nearly four decades, but people will still, somehow, take personal responsibility and save or insure against this risk.

Reality is that most people will not plan, save, invest or insure for a risk they don't believe they face.

The truth about long-term care is that, starting in 1965, Medicaid and Medicare have paid for the vast majority of all nursing home and home health expenses.

Conventional wisdom that publicly financed care requires impoverishment to the point of destitution is demonstrably false.

The average elderly person in need of long-term care qualifies easily for Medicaid and virtually anyone, almost regardless of income or assets, can qualify quickly without spending down by consulting a Medicaid planner.

With ostensibly good intentions, but perversely counterproductive public policy, government programs have anesthetized the public to the risk of long-term care.

The end result, nearly 40 years after passage of Medicaid and Medicare, is America's severely dysfunctional, welfare-financed, nursing home based long-term care service delivery and financing system.

Long-term care today is plagued by bankruptcies, inadequate revenue, a dearth of capital, staff shortages, access and quality problems, huge tort liability, unaffordable liability insurance, too few full-pay private payers and too many low-pay Medicaid recipients.

This report explains historically how we got into the current mess, documents the facts enumerated above and below, and proposes some simple, straight-forward solutions.

We take the long-term care system apart, examine it realistically, and put it back together in a way that makes more sense.

We analyze 10 state Medicaid long-term care programs in detail, focusing on five that are headed in the wrong direction and five others that are leaning toward the right course.

Federal law does not allow state Medicaid programs to target program benefits to the genuinely needy or to require more affluent people to pay their own way.

So, we explain how federal law must change.

Few states exercise effectively even the limited control they have over program eligibility and estate recovery.

So, we recommend what states should do to improve Medicaid while containing or reducing costs.

Even as state legislatures are struggling with Medicaid-driven budget crises, their Medicaid programs make welfare financing more attractive by offering desirable home and community-based services (HCBS) in place of nursing home care.

So, we explain what states must do first before Medicaid can hope to fund HCBS adequately.

Common sense suggests that when government pays generously for easily obtained long-term care benefits, people are unlikely to take personal responsibility to pay for their own care.

So, we explain how Medicaid can target its scarce resources to the genuinely needy and save millions at the state level and billions nationally, while improving access to and quality of care for everyone.

Conversely, if eligibility for publicly financed long-term care is tighter and estate recovery is more strongly enforced, it only makes sense that people will be more likely to prepare to pay for their own care.

So, we show how to fix Medicaid to unleash the potential of long-term care insurance and home equity conversion in order to breathe financial oxygen into service providers who currently suffocate financially.

Medicaid was never intended to be "long-term care insurance for the middle class" as it has become. As long as it remains "inheritance insurance" for the baby boom generation, Medicaid will continue to fail in its first responsibility—to provide a long-term care safety net for the disadvantaged.

The good news is that America's long-term care problems are self-inflicted by poor public policy and easy to fix.

If we stop doing what we've always done and start administering the program in more rational ways, the long-term care system will right itself rapidly.

If we stay the course we're on, however, disaster will strike with the aging and senescence of the baby boom generation and possibly long before.

Preface

This report recounts the findings and recommendations of a project conducted by the Center for Long-Term Care Financing (www.centerltc.org/) at the request and with the financial support of the Council for Affordable Health Insurance (www.cahi.org) and the American Legislative Exchange Council (www.alec.org).

The Center for Long-Term Care Financing is a 501(c)(3) charitable, nonprofit, nonpartisan think tank and public policy organization "dedicated to ensuring quality long-term care for all Americans."

The Council for Affordable Health Insurance (CAHI) is a research and advocacy association of insurance carriers active in the individual, small group, HSA and senior markets.

The mission of the American Legislative Exchange Council (ALEC) is to advance the Jeffersonian principles of free markets, limited government, federalism and individual liberty among America's state legislators.

CAHI and ALEC intend to publish an abridged version of this report under the title "The Long-Term Care Dilemma: What States Are Doing Right — and Wrong."

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The purpose of this study was to "Identify and publish a list, by state, of prioritized interventions to reduce Medicaid expenditures and increase private LTC financing sources while improving access to and quality of long-term care for all citizens: rich, poor and in between."

The Realist's Guide to Medicaid and Long-Term Care

The project director and author of this report, Stephen A. Moses, is President of the Center for Long-Term Care Financing. He writes, speaks, testifies, publishes and consults widely on the subjects of Medicaid nursing home eligibility, Medicaid estate planning, liens, estate recoveries, long-term care insurance, home equity conversion, and public/private long-term care financing partnerships. He was previously a Medicaid State Representative (nine years) for the federal Health Care Financing Administration (HCFA), a Senior Analyst (two years) for the Office of Inspector General of the U.S. Department of Health and Human Services (IG), and Director of Research (10 years) for LTC, Incorporated. He has directed and authored numerous national and state-level studies for HCFA, the IG, LTC, Inc. and the Center for Long-Term Care Financing on Medicaid and long-term care.

Amy Marohn-McDougall, Executive Director of the Center for Long-Term Care Financing and Damon V. Moses, Administrative Coordinator participated actively in the collection and preparation of data for this report.

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Introduction

In the ancient Greek myth, Theseus entered the Labyrinth, slew the Minotaur and escaped by following a string out of the maze that he had unraveled on the way in.¹

The analogy to Medicaid is apt.

Supreme Court Chief Justice Warren Burger once called Medicaid a "maze," "a morass of bureaucratic complexity."²

Legislators, policymakers and program administrators often get lost in Medicaid's labyrinthine statutory and regulatory convolutions.

Most studies on the subject are little help. They quickly lose their way in the program's mind-bending complexity. They fail to escape the maze with a practical solution to the problem of exploding Medicaid costs.

This report is different.

Plagued with advisors who told him "on the one hand this, and on the other hand that," Harry Truman exclaimed that what he really needed was a "one-armed economist."³

This report provides a "one-armed" account of the Medicaid and long-term care financing problems. It ends with simple straightforward measures federal and state governments should take to save Medicaid from insolvency and solve the long-term care financing crisis.

We can't take the complexity out of Medicaid or long-term care, but we can give you a lifeline—like the one Theseus had—to take into the programmatic tangle with you.

That lifeline is the Question and Answer format this report follows. If you get lost, just follow the thread of questions backwards or forwards until you find your bearings again.

But remember, you must penetrate the maze deep enough, confronting and defeating all the practical obstacles and theoretical gremlins, to come away with understanding and solutions.

After we emerge from the Medicaid long-term care labyrinth with some national answers and solutions, we'll profile 10 states and see what we can learn from them about fixing Medicaid and long-term care everywhere.

Into the Medicaid Maze

Following are the kinds of questions frustrated legislators, public officials, reporters, and citizens are asking about long-term care all across America.

Q: Medicaid, especially its long-term care component, is killing my state's budget. What's wrong and what can we do about it?

A: There's obviously no simple answer to your question or the problem wouldn't exist. So let's take the question apart and deal with each of its pieces.

Q: What is Medicaid?

A: Medicaid is a means-tested public assistance program, i.e. welfare, intended to finance health care and long-term care for people who could not otherwise pay for their own care. The program is state-administered and federally overseen with each level of government paying part of the cost from general funds, 43% state and 57% federal. By contrast, Medicare is social insurance, not welfare; it is financed largely from "premiums" paid as payroll taxes; and it is 100% federally funded and administered.

Q: What is long-term care?

A: Long-term care is the personal assistance, whether medical, custodial, or both, that people require when they are unable to manage common activities of daily living on their own because of frailty, chronic illness or mental incapacity.

Q: How big a part of Medicaid is long-term care?

A: Huge and growing. As originally conceived, however, Medicaid was mainly intended to be an acute-care safety net for poor women and children. To this day, approximately 75% of Medicaid recipients are poor adults, mostly women, and children. But this group accounts for only about one-third of Medicaid's costs. The remaining 25% of Medicaid recipients are aged, blind or disabled, and they account for two-thirds of the program's costs. The main cost driver for this latter group is long-term care, principally nursing home care. Medicaid spent \$50.9 billion on nursing home care in 2002 and paid for two-thirds of all nursing home residents.⁴ Medicaid also spends a large and rapidly increasing amount for home and community-based long-term care, but more on that later. Long-term care accounts for one-third to one-half of total Medicaid expenditures in most states.

Q: Why does Medicaid play such a big role in financing long-term care?

A: The usual explanation is that long-term care, especially nursing home care is hugely expensive; few American families can afford such costs for long; so, according to conventional wisdom, most people spend down into impoverishment quickly and thus qualify for Medicaid benefits.⁵

If the answer were really this simple, however, surely the public would be scared to death about the high risk (9% chance of a five-year institutional stay after age 65) of catastrophic long-term care costs.⁶ But they're not.

The truth is that the American public is "in denial" about the risk and cost of long-term care.⁷ Truly, something much more complicated is going on. To figure out what it is, we need to delve much deeper and answer more questions.

Q: How is long-term care delivered and financed in the United States?

A: Most long-term care, perhaps as much as 80%, is provided gratis by family or friends of the patient. Obviously, this free care is not a fiscal burden on Medicaid, but it is a huge financial and emotional strain on the informal caregivers. Informal care is also a large and growing problem for employers who must cope with absenteeism caused by long-term caregiving.

Our primary concern here, however, is with formal, paid care. Paid long-term care is usually provided in three venues (the home, an assisted living facility, or a nursing home) and it is financed primarily by three sources (private pay, Medicaid or Medicare.)

In briefest summary, America spent \$36.1 billion on home care in 2002 of which Medicare and Medicaid paid 55.4% and private insurance paid 18.6%; only 18.0% of home health care costs were paid privately "out of pocket."⁸

Assisted living facilities, which cost an average of \$28,548 per year, are 90% private pay.⁹

And nursing homes, which cost Americans \$103.2 billion in 2002, were paid approximately half by Medicaid, one-quarter by private pay, one-eighth by Medicare, and one-sixteenth by private health insurance. Keep these nursing home numbers in mind as we move forward. They are correct, but they are grossly misleading.¹⁰

Q: Why do you say those numbers are misleading?

A: Because they vastly understate the impact of Medicaid and overstate the degree of private financing of long-term care. For example, although Medicaid pays only half the dollars for nursing home care, it covers two-thirds of all nursing home residents, and affects almost 80% of all patient days. That's important because of the impact of low Medicaid reimbursements on nursing homes' ability to provide quality care.

Are you wondering how Medicaid can pay so little of the cost and affect so much of the care? People on Medicaid have to contribute their income toward their cost of care. That's where part of the difference comes from. The rest results from the fact that people on Medicaid tend to be the longest stayers, so they consume more patient days than their percentage of total patients would suggest.

Because Medicaid patients have to contribute their income toward their cost of care, the percentage of nursing home costs paid out of pocket as reported by CMS—as low as it is at 25% which is down from 38.5% 15 years ago—is really much less significant than it appears. Over half of the so-called out-of-pocket costs are really just spend-through of Social Security income. That is to say, what is usually assumed to be spenddown of life savings is mostly just the income from another government program that must be contributed toward the cost of care by Medicaid recipients.¹¹

Q: Are we getting our money's worth? Is America's long-term care service delivery and financing system satisfactory?

A: Actually, it's a huge mess already—a decade before America's aging demographics start to pinch and two decades before Social Security and Medicare approach their nadirs.

- Nursing homes are financially stressed and many have either gone bankrupt or hang on the brink.
- Most assisted living facilities fill too slowly to be profitable.
- Our home and community-based services infrastructure is grossly underdeveloped and starved for revenue.
- A severe dearth of debt or equity capital to build, operate and maintain long-term care facilities threatens the future.
- Staff shortages and high turnover, driven by inadequate compensation for direct caregivers, are rife.
- Quality is questionable at every level of care in spite of heavy regulation that has tied publicly financed providers in knots.
- Tort liability is large, growing and threatens the future viability especially of nursing homes.
- Gigantic punitive damage settlements have caused liability insurance premiums to skyrocket, often putting coverage out of reach entirely.
- Medicaid and Medicare have steadily increased their share of long-term care expenditures over the past 15 years while the proportion contributed by private-payers has plummeted.¹²
- Few people buy private long-term care insurance and fewer still tap the equity in their homes through reverse mortgages to finance long-term care.

- States are in fiscal crisis, largely driven by rising Medicaid long-term care expenditures, and the federal budget is sinking further and further into deficit.
- Despite valiant efforts by the states and federal government to encourage ostensibly cheaper and more desirable home and community-based care, America's long-term care system remains heavily biased toward nursing home care which few people prefer.
- As bad as our long-term care system is today, it is critical to realize that America's Age Wave has not yet begun to crest, much less crash. Imagine what these problems will be like in 30 years when the baby boomer generation starts needing long-term care in large numbers.

Q: America is the wealthiest nation in the world. How did our long-term care system get so fouled up?

A: It's a good thing you asked, because we don't have a prayer of finding our way to the solution unless we understand how and why we have these problems. Basically, it's the usual story of good intentions leading to unintended consequences . . .

In the beginning . . . By 1965, Americans were living longer, but dying slower, often in nursing facilities at considerable expense. So, when Congress and President Johnson created Medicaid to help poor families afford acute care, they added nursing home care for the elderly to the benefit package, never expecting it to cost very much.

The origin of institutional bias . . . With generous eligibility rules initially unobstructed by transfer of assets restrictions or estate recoveries, however, Medicaid nursing home utilization and costs immediately exploded. If families institutionalized their incapacitated elders, Medicaid would pay. If they tried to manage outside a nursing home, no financial help was available. Thus, without financial oxygen to sustain it, a privately funded continuum of low-cost home and community-based long-term care did not develop. Nor was there a market for private long-term care insurance, because nursing home care was basically free.

Publicly financed care became the norm . . . To take full advantage of the huge new government revenue source, the nursing home industry built more capacity as fast as they could raise the walls of new facilities. The public filled these new beds immediately even when nursing-home level of care was unneeded.¹³ Medicaid-financed nursing homes quickly became the primary venue, almost the very definition, of long-term care. As virtually the sole providers of long-term care, nursing homes developed a strong government lobby influencing the continued growth of publicly financed, institutional long-term care.

Cost shifting grew and hurt private payers . . . By the mid-1970s, with long-term care costs skyrocketing, Medicaid tried to clamp down. First, states required "certificates of need" as a condition of constructing new nursing facilities, on the principle that "they

can't charge us for a bed that doesn't exist." But capping supply led predictably to price increases by Medicaid nursing homes attempting to compensate for the limits on their growth. So Medicaid capped nursing home reimbursement rates too. In response, nursing homes raised their rates for private payers to compensate. Thus began "cost shifting" from Medicaid to private payers and the growing differential between low Medicaid reimbursement rates and high private-pay nursing home charges.

Quality suffered . . . With supply and price capped, existing nursing homes had a virtual monopoly over long-term care services. They could fill their beds at low Medicaid rates practically without regard to the quality of care they provided. Predictably, occupancy jumped to 95% and care quality declined. Congress responded (in the Omnibus Budget Reconciliation Act of 1987) by mandating better care, more nurse's aides, additional training, and intensified regulation, but with no added reimbursement. Nursing homes were caught between the rock of inadequate reimbursement and the hard place of severe regulation.¹⁴ Industry executives claim that Medicaid demands "Ritz Carlton care for Motel 6 rates" while imposing a "regulatory Jihad."¹⁵ State nursing home associations sued for adequate compensation under the "Boren Amendment" until Congress repealed that law in 1997 leaving no floor under reimbursement rates.¹⁶

Staff shortages became severe . . . Over time, low reimbursement from Medicaid took its toll on nursing homes' ability to hire, train and retain competent staff. Direct, hands-on long-term caregivers receive very low compensation as a rule, often less than fast food purveyors, despite the heavy physical and emotional demands of the job.¹⁷ Annual staff turnover approaches 100% in nursing homes. Studies show that adequate staffing is key to care quality. As early as 16 years ago, one professional observer commented: "One way to interpret the current market outcomes in the nursing home sector is to say that, despite protest to the contrary, state Medicaid programs are acting effectively to buy the services they wish to purchase for Medicaid patients—a limited amount of relatively low-cost care of uncertain quality."¹⁸ Similar comments are still common in the professional literature.¹⁹

Medicaid census grew and private pay census declined²⁰ . . . The less Medicaid paid and the more private-payers were charged, the more private-pay census declined and Medicaid nursing home census surged. People found creative ways to qualify for Medicaid without spending down. A special practice of law called Medicaid estate planning developed to stretch Medicaid's elastic long-term care eligibility rules far beyond their original intent. Eligibility bracket creep kept increasing the Medicaid rolls as affluent states and generous politicians expanded access to publicly financed long-term care to more and more people. The public's "entitlement mentality" about long-term care grew. "I paid my taxes; why should I have to pay for nursing home care?" became a predominant attitude.

Efforts to control Medicaid eligibility backfired . . . As costs exploded and recessions pinched government budgets over the years, eight Congresses and three presidents tried repeatedly to constrict Medicaid long-term care eligibility. They struggled to target Medicaid benefits to the needy and to ensure that others, who had sheltered assets, paid

back the cost of their care from their estates. Transfer of assets penalties and estate recoveries were made mandatory.²¹ Liens on homes were authorized.²² And when none of these measures stanching the eligibility hemorrhage, Congress and President Clinton finally made it a crime to transfer assets in order to qualify for Medicaid.²³ But, senior advocates complained bitterly and tagged that measure the "throw granny in jail" law. Congress repealed it a year later and replaced it with the "throw granny's lawyer in jail" law.²⁴ That statute is still on the books but it has been deemed unconstitutional and hence unenforceable. How could you hold a legal advisor legally culpable for recommending a practice like transfer of assets that is legal again since "throw granny in jail" was repealed?

Tort liability skyrocketed . . . Whether based on the reality or the perception of poor quality in nursing homes, tort liability suits—especially against the large nursing home chains—have grown rapidly. Lawyers and law firms specialize in suing nursing homes on behalf of the adult children of allegedly mistreated seniors whose care was paid for by Medicaid. Watch for their ads on television, on freeway billboards, and in the print media. Settlements often reach many millions of dollars. Consequent increases in liability insurance premiums for long-term care facilities have made coverage unavailable in some parts of the country and extremely expensive everywhere. Even facilities in areas that have not experienced large punitive damages settlements are affected by the burgeoning liability insurance premiums.²⁵

Q: Let me see if I've got this right. You're saying Medicaid co-opted the market for long-term care almost 40 years ago with the result that a welfare-financed, nursing home based system—with all its accompanying deficiencies—has become entrenched?

A: Well, in a nutshell, yes.

Q: But if Medicaid is welfare, why are so many seniors dependent on it for long-term care? Doesn't Medicaid require impoverishment? Don't all these middle class people we hear about spending down their life savings create a private market for long-term care?

A: Great question. That's the nub of the issue. But to give you an answer we'll have to delve into Medicaid eligibility, a subject judges have called "an aggravated assault on the English language, resistant to attempts to understand it" and "a Serbonian bog from which the [Medicaid] agencies are unable to extricate themselves."²⁶ We'll keep it as simple as possible, but hold on to your "Theseus' string" in case we get lost.

To qualify for Medicaid's long-term care benefits, someone must be aged, blind or disabled and medically in need of nursing-home level of care. Beyond that, there are two kinds of financial tests that must be passed: one is based on income and the other is based on assets.

Income eligibility is determined in two ways. Thirty-four states and the District of Columbia have "**medically needy**" income eligibility systems.²⁷ In those states, eligibility workers deduct Medicaid applicants' medical expenses—including private nursing home costs, insurance premiums, medical expenses not covered by Medicare, etc.—from their income. If they have too little income to pay for all of this, they are eligible for Medicaid—not just for their long-term care but for the full array of Medicaid services which stretch far beyond what Medicare covers.

The remaining states have "**income cap**" Medicaid eligibility systems.²⁸ In those states, anyone with income over \$1,692 per month (300% of the SSI monthly benefit of \$564) is ineligible for long-term care benefits.²⁹ But \$1,692 is not enough to pay privately for nursing home care and one dollar more is too much to qualify for Medicaid, a Catch 22. So Congress approved "Miller Income Trusts" in OBRA '93 that allow people to siphon excess income into the trust and become eligible for Medicaid.³⁰ The trust proceeds must then be used to offset their cost of care and any balance in the trust at death reverts to Medicaid. Nevertheless, Miller income trusts allow people with incomes substantially over the limit to qualify for Medicaid, enjoy the program's low reimbursement rates, and receive its extensive range of additional medical services.

All you really need to remember about Medicaid income eligibility for long-term care is this: whether you're in a "medically needy" or an "income cap" state, you don't have to be poor to qualify. You only need a *cash flow problem*. There is no set limit on how much income you can have and still qualify as long as your private medical expenses are high enough and, if you are in an "income cap" state, you have a Miller income diversion trust.

Q: That's a far cry from what I usually hear. Everyone says that Medicaid pays for long-term care only for people with "low" or "poverty-level" incomes. How come?

A: Bottom line, income is rarely an obstacle to Medicaid long-term care benefits. Only the top 10% or 15% of seniors would have too much income to qualify assuming their medical expenses are high enough. That's rarely a problem when nursing home care is involved. The confusion comes in because, after they pay for their medical expenses, most of their income has been consumed before they're eligible.

The reason this is so important is that people with significant incomes, but high medical expenses, are not poor. They just lack enough cash flow to cover current expenses. With a little more income, many of them could pay privately for long-term care and delay or avoid Medicaid nursing home institutionalization altogether.

Hold that thought, because it will be critically important when we talk about "asset eligibility," especially the home equity exemption, next and later when we examine the consequences for nursing homes of so many people qualifying for Medicaid benefits.

Q: All right, so income isn't much of an obstacle. What about assets? Don't people have to spend themselves into impoverishment before they qualify for Medicaid? Everything I read says you cannot have more than \$2,000.

A: That is true. But it's not the whole story. Most states allow individual Medicaid applicants to retain at least \$2,000 worth of otherwise nonexempt liquid assets. What you don't hear so often is that Medicaid also exempts the home and all contiguous property regardless of value. Simply express a subjective "intent to return" to the home and it remains exempt, whether or not there is any medical possibility you'll ever be able to return.³¹

Medicaid also exempts one business, including the capital and cash flow, of unlimited value.³²

A prepaid burial space for "the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value."³³

You can hold unlimited term life insurance with no effect on eligibility.³⁴

Home furnishings are officially excluded only up to \$2,000 but are rarely counted in practice.³⁵

One car of unlimited value is exempt assuming it's used for the benefit of the Medicaid recipient.³⁶ And because it is exempt, giving it away is not a transfer of assets to qualify for Medicaid, so you can give one car away, buy another, give it away, and so on until you reach the \$2,000 eligibility threshold. That's called the "two Mercedes" rule.

Bottom line, there is no limit to how much wealth people can stash in exempt assets without impeding their Medicaid long-term care eligibility.

Q: Do people really do that?

A: You bet they do. Long-term care is expensive. Families are usually caught off guard by a sudden care crisis. After they look for help from Social Security, Medicare and their Medicare Supplemental insurance policies and find none, they tend to become very concerned.

Sooner or later, they find their way to a Medicaid office. Medicaid eligibility workers are just that; they are not "ineligibility workers." They care about people and want to help. The workers have a legal responsibility to explain the terms of eligibility. Sometimes, they explain much more than the minimal requirements.

Frustrated by well-to-do applicants who have gamed the system to qualify with the help of professional "Medicaid planners," eligibility workers will often recommend simple ways that marginal applicants can become eligible while preserving at least a little wealth. This may not amount to much in each individual case, but overall, throughout the

entire Medicaid long-term care caseload, it can total many millions of dollars in a state and billions nationwide.

Q: You mentioned "Medicaid planners" who help people qualify for Medicaid without spending down. How big a problem is that?

A: It is a huge problem in it's own right, but in the greater scheme of things, Medicaid planning is just the tip of the iceberg. Very few seniors have hundreds of thousands of dollars to protect so really egregious examples of artificial impoverishment are limited. But some millionaires and many upper middle class people do qualify for Medicaid by consulting legal specialists. They use myriad qualification techniques including the purchase of annuities, irrevocable income-only trusts, life care contracts, and many others. You'll find an extensive literature on the subject spanning decades at any law library.

But if you want to learn about Medicaid planning, why not make it easy on yourself? Do an internet search for "Medicaid estate planning" and you'll find hundreds of websites for law firms and financial planners who specialize in the practice. Or next time you see an ad in the newspaper promoting a seminar on "how to keep your life savings from going to a nursing home," sign up and attend. You won't find out exactly how they do it without paying for a consultation, but you'll get a comprehensive education on what a sucker you'd be to pay for your own long-term care.

Q: Why do you say Medicaid planning is just the tip of the iceberg?

A: Remember what we said about how easy it is for people with substantial income and assets to qualify for Medicaid long-term care benefits? It's not the small minority of elderly people with megabucks who are ruining Medicaid, although they do tip the scale in the wrong direction. Rather, the big problem is that the majority of middle-class families—people with median-valued homes owned free and clear, with moderate incomes (mostly from Social Security), and small savings easily convertible to exempt assets—walk right onto Medicaid when they need long-term care. Income is no obstacle as we explained. Their homes are exempt. And their savings are easily converted to exempt assets or quickly spent down for care.

Q: I don't see why that's a problem. Don't we want our social safety net programs to protect people like that?

A: Some protection! We've convinced people not to worry about long-term care nor to buy insurance for it, but when they need it, all we have to offer is nursing home care financed by a bankrupt welfare program that pays too little to ensure quality. The current system serves no one well, especially the poor.

Q: Why do you say "especially the poor?"

A: Ironically, Medicaid is a much better program for the savvy well-to-do elderly than it is for poor or financially marginal seniors. That's because people with money can get into the best nursing homes, i.e. the homes with fewer Medicaid residents, and still get Medicaid to pay. Here's how that works.

Elder law attorneys routinely advise their Medicaid planning clients to retain enough "key money" to pay privately for at least a year of nursing home care. That's because it's common knowledge nowadays that you cannot count on getting into a quality nursing home unless you can pay privately for an extended period of time. Once you're in, however, state and federal laws prohibit nursing homes from kicking you out just because you convert from private-pay to Medicaid. So, the well-to-do divest or shelter most of their wealth, but save out enough to pay privately for a year, lock into a good nursing home, and later flip the switch to transfer the financial burden to Medicaid, tax payers, and nursing homes.

Here's the tragic irony. Poor people don't have key money, so they end up in the least desirable 100%-Medicaid facilities, while the lawyers' clients occupy the scarcer Medicaid beds in nicer nursing homes.

Q: Why do you say that people converting prematurely to Medicaid hurt nursing homes?

A: Medicaid reimburses nursing homes on average only 70% of the private-pay rate. According to the accounting firm BDO Seidman, Medicaid under-funded nursing homes \$4.1 billion dollars in 2001, with the shortfall averaging \$11.55 per Medicaid patient day. With two-thirds of their residents on Medicaid, nursing homes struggle to provide quality care with reimbursements so low.³⁷ Arguably, low Medicaid reimbursements translate into poor nursing home outcomes. The old saw is true: "You can't make a silk purse out of a sow's ear." And when they're losing money on every patient, they certainly can't make up for it in volume.

The consequences for nursing homes, as we described earlier, have been devastating. Inadequate revenue has spawned bankruptcies, staff shortages, and quality problems which have in turn led to tort liability suits, giant punitive settlements, and skyrocketing liability insurance premiums. Aon Risk Consultants recently reported that nursing home litigation has skyrocketed in the past few years resulting in a 51% increase in malpractice liability insurance premiums. The average cost of liability insurance per bed in 2003 was \$2290, but in Florida, with its high elderly population, per-bed liability costs have reached \$8170. Aon concludes: "The cost crisis has caused many nursing homes to either cut back on insurance coverage or to drop it altogether, in a practice known as 'going bare.' Others have closed their doors in states with high premiums. Because Medicaid and Medicare fees are set at an average of \$118 a day, most litigation coverage costs cannot be passed on."³⁸

These facts have real life consequences. Fire killed 18 residents last year in a Tennessee nursing home that was heavily dependent on Medicaid and had no liability insurance.

Q: All right, you said we'd find some answers and solutions before we're done. So far, I can't find the "pony" in here. Where are we headed?

A: The notorious bank robber Willy Sutton was asked why he robbed banks. He responded: "Because that's where the money is." Pretty obvious really. Maybe we should take a lesson from him and ask, "Where is the money that could help pay for long-term care and relieve Medicaid of some of that burden?"

The answer to that question is no secret. Eighty-one percent of seniors own their homes. Seventy-three percent of elderly homeowners own their homes free and clear.³⁹ There are nearly two trillion dollars worth of home equity held by seniors that could go to offset the cost of long-term care.⁴⁰ This is more than enough money to solve the long-term care financing crisis now and in the future.

Yet, little or no hard evidence suggests that people are using their home equity to pay for long-term care. Why should they when Medicaid exempts the home and pays for most formal long-term care?

Q: Are you suggesting that we force people to sell their homes before they get any help from Medicaid? That's a political non-starter.

A: No, of course not. There is a much better way. The solution is to give people a means to use the value, otherwise locked up illiquid in their homes, to purchase long-term care services in the private market. With this assistance, they could remain in their homes longer and delay or avoid Medicaid nursing home care altogether.

Home equity conversion is a hot topic these days. In essence, it works like this. People age 62 or older can obtain a reverse annuity mortgage (RAM) that pays them either a lump sum or monthly payments indefinitely, as long as they remain in their home. There are no upfront charges or monthly payments due. Fees are built into the loan and paid off with the loan when the home is sold or transferred.

Proceeds of a reverse mortgage can be used for any purpose. They've become more popular lately. When interest rates plummeted, many seniors turned to RAMs as a way to replace lost income. Most recently, the Centers for Medicare and Medicaid Services (CMS) and the National Council on the Aging (NCOA) have encouraged the use of home equity to pay for long-term care. But RAMs could also help older people afford the higher, age-rated cost of private long-term care insurance.⁴¹ We've known this for a long time. The following quote is from 17 years ago: "Estimates reveal that 57% of all homeowners could pay the premium of the prototype LTC policy with their RM [reverse mortgage] disbursement."⁴²

Q: All right, so home equity is a huge, mostly untapped resource for long-term care. How do we get more seniors to use it?

A: There's the rub. Merely encouraging people to use their home equity for long-term care has not worked and won't. After so many years of easy access to publicly financed long-term care, the entitlement mentality is too deeply rooted. People don't think about long-term care until it's too late for private insurance and, by then, care costs have already become prohibitively high.

At that point, frail, infirm, and cognitively impaired seniors are usually no longer making their own health care and financial decisions. Those decisions are being made for them by their adult children, who are also their heirs. When the heirs see their inheritances being consumed by long-term care costs, they face a choice. Use the biggest asset in their parents' estate for long-term care. Or follow the advice that permeates the media and take advantage of government-financed nursing home care.

Getting something for nothing is just too tempting for most people. For home equity to assume its proper role in financing long-term care, Medicaid eligibility will have to become conditional upon and subsequent to home equity conversion.

Q: So, you're saying we should make Medicaid long-term care available to people only after they consume their home equity with a reverse mortgage. Doesn't that fly in the face of past public policy that has used Medicaid to protect the home?

A: No, actually, it doesn't at all. When Congress authorized transfer of assets penalties, liens and estate recoveries in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82), legislative history indicates they did so with the intent "to assure that all of the resources available to an institutionalized individual, *including equity in a home* [emphasis added], which are not needed for the support of a spouse or dependent children will be used to defray the cost of supporting the individual in the institution."⁴³ Reverse mortgages make it possible for surviving spouses to retain the use of their home while the equity is being used for long-term care and even after all the equity has been consumed.⁴⁴

The goal of TEFRA '82 was to change Medicaid from a long-term care grant for middle class and affluent people into a loan. States could penalize people for transferring assets in order to qualify, place liens on homes to ensure home values would remain in the estate, and recover benefits paid from the estate of deceased recipients. Originally, all of these authorities were voluntary. Later, transfer of assets penalties were made mandatory in the Medicare Catastrophic Coverage Act of 1988 (MCCA '88) and the "look back" period was extended to three years, five for transfers to trusts in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). Medicaid estate recoveries were also made mandatory by OBRA '93.

Thus, the way Medicaid is supposed to work is that people should get nursing home care when they need it without being financially devastated, but they should pay the cost of their care back out of their estates after the death of their last surviving, exempt,

dependent relatives, usually a spouse. But that's not how it has turned out in practice. Rather, as explained above, transfer of assets penalties are easy to dodge and eligibility is routinely available to almost anyone regardless of income or assets. Hence, Medicaid has become a fiscal black hole pulling most people into its ambit when they need long-term care.

Q: But you said states can put liens on homes and they're required to recover from estates. Isn't the home equity really at risk already therefore?

A: Practically speaking, no. Although state Medicaid programs have been required since OBRA '93 to recover benefits correctly paid from the estates of deceased recipients—and arguably from the estates of the spouses they predecease—few states do so efficiently and effectively.

Three states—Georgia, Michigan and Texas—have not implemented estate recoveries to this day. Most states make only a half-hearted effort. CMS reports that state Medicaid programs recovered only \$350 million from estates in 2002 while spending \$46.5 billion on nursing home care, an almost negligible return of only .75%.⁴⁵

Even states that pursue estate recoveries aggressively, like Oregon, are hamstrung by restrictions in federal law that protect large amounts of money from recovery.⁴⁶ Nevertheless, Oregon recovered \$13.7 million from estates in 2002, which is 6.9% of what the state spent on Medicaid nursing home benefits in the same year.⁴⁷

If every state in the country recovered from estates at the same rate as Oregon, total recoveries would be \$3.2 billion.⁴⁸ That's starting to look like real money but it's only a drop in the bucket compared to the savings that could come from mandating reverse mortgages.

Q: So, why don't we just compel the states to enforce the federal statutory authorities that are already in place?

A: Bottom line: we've been there, tried that, and it doesn't work. As explained above, current rules are generous, elastic, and easy to evade. Even if people don't jettison their bigger assets in the process of qualifying for Medicaid, there is no guarantee they will still have them when they pass away. A General Accounting Office study in 1989 found that, although more than 80% of seniors own homes, only 14% still own them once they're on Medicaid.⁴⁹

Besides, the transfer of assets, lien and estate recovery rules are complicated, difficult to enforce, and punitive. People don't even become aware of these obstacles until they need care and by then it's too late to save, invest or insure against the risk. Every incentive in the current system is for the public is to circumvent the rules and take advantage of Medicaid.

From the standpoint of states and the federal government, political sensitivity prevents aggressive enforcement of eligibility and recovery rules when economic times are good. When economic times are bad, states control Medicaid expenditures first by cutting provider reimbursements, then by curtailing benefits, and finally by restricting coverage. Only as a last resort, when times are really tough—like now—do states look seriously at discouraging Medicaid planning and expanding estate recoveries. Usually, the economy improves, tax revenues increase, the fiscal pressure declines, business as usual returns and we find ourselves a few years closer to the end game—when boomers will overwhelm the system and make any solution much tougher or impossible altogether.

Q: Well then, what's the answer?

A: Federal law should require that homeowners consume their home equity by paying for long-term care through a reverse annuity mortgage before they become eligible for assistance from Medicaid.

That would prevent Medicaid from being "inheritance insurance" for baby boomer heirs as it is now. It would wake the boomers up to the risk and cost of long-term care. With home equity genuinely at risk, most people would plan early to save, invest or insure for long-term care. They would be less likely to ignore the problem until it's too late as they do now, because if they did, they would have to consume their biggest asset before receiving public assistance.

Families would pull together to help Mom and Dad afford long-term care insurance or pay for cost-effective long-term care instead of being torn apart as now, fighting over the Medicaid planning spoils.

With fewer people dependent on Medicaid, that program would be able to do a better job for its proper clientele, the needy. Medicaid could afford to offer home and community-based care, not just nursing home care, and perhaps it could even pay long-term care providers something closer to market rates.

Obviously, the market for home equity conversion loans and private long-term care insurance would explode. That means more jobs and more tax revenues to help sustain Medicaid and other government programs.

Buttressed by more private payers, the long-term care service providers would become more financially healthy as well, thus generating more jobs and more tax revenue.

When people spend their own money, or their insurer's money, they are much less likely to go to nursing homes until they need that high level of care medically. That fact will breathe financial oxygen into the home and community-based services infrastructure and, over time, eliminate the system's institutional bias.

Everyone would benefit, with the single exception of the professional parasites who profiteer on the status quo by squeezing big fees from middle class people to put them in nursing homes on welfare.

Q: Sounds interesting, but what's to stop people from gaming that system just like they do the one we have now?

That's the advantage of focusing on real estate equity instead of worrying about personal income and assets. Their home is most people's biggest asset. If they are made aware early that it is at risk for long-term care, people will be more likely to plan for that risk as they do for other financial uncertainties. Thus, because more families will prepare well in advance for long-term care, fewer will be caught in the bind that traps so many now—too sick or too old for insurance, and too cash-poor to pay their own way.

Furthermore, real property ownership and transfers are publicly recorded and easy to track. A transfer of assets look-back period of eight to 10 years would be easy to enforce. The problem with today's three-year look-back is that people can transfer unlimited assets as soon as an elder's decline becomes obvious and he or she will be eligible for Medicaid without spending down a mere 36 months later.

New York, for example, imposes no transfer of assets penalty for Medicaid home care so people routinely transfer their assets, receive three years of generous home care from Medicaid, and then qualify immediately for nursing home care without any spenddown liability.

In Nebraska, families routinely pass their property—especially farms, businesses, and homes—from the older to the younger generation in their late 60s or early 70s.⁵⁰ Even if such transfers are not done to qualify for Medicaid, the net effect is that people are eligible for Medicaid when they need long-term care.

We desperately need federal and state rules that encourage aging people to hold onto their wealth and protect it with private insurance so that they do not become dependent on public programs intended for the needy. Without such rules and incentives, public programs like Medicaid will not be able to serve the poor adequately, much less the middle class and affluent, in the future.

Q: So, we extend the transfer of assets look-back period to a decade and require home equity spenddown with a RAM up front. Can states do that?

A: Not under current federal law, but there are several ways to fix that problem. We'll list them here in descending order of preference.

Congress could take the bull by the horns and remove the perverse incentives in Medicaid that discourage responsible long-term care planning by amending the Social Security Act along the lines we've proposed.

Short of that, the Bush Administration has offered states an interesting alternative for funding Medicaid.⁵¹ If they're willing to forego open-ended Medicaid reimbursement and accept a capped amount over a set number of years, they can get extra money up front during the current fiscal pinch and exercise much greater control over Medicaid eligibility than they have now.

A third possibility is to ask CMS for a waiver to extend the look-back period and amend other eligibility rules. Three states—Minnesota, Connecticut, and Massachusetts—have requested "1115" waivers to extend their Medicaid long-term care look-back periods and to tighten up eligibility in other ways as well.⁵²

Finally, failing all the above, there are still many things states can do under existing federal law to tighten their long-term care eligibility systems and enhance estate recoveries. Such measures will save money that can be used to fund campaigns to educate the public about long-term care and/or to pay for tax and other incentives to persuade the public to plan ahead through insurance and/or home equity conversion. We'll have more to say about those alternatives very shortly in the "state profiles" section of this report.

Q: Isn't there an easier, less politically sensitive way to handle this problem? For example, we're encouraged constantly by the feds and by academics to cut costs AND improve our long-term care programs by paying for cheaper home and community-based care instead of expensive nursing home care.

A: You're right about the pressure for more home care. That's the main thrust of federal policy from all three branches of government. Congress authorized waivers of the Social Security Act to encourage home care in 1981.⁵³ Medicaid-financed home care and assisted living have been growing rapidly, especially since the early 1990s.⁵⁴ The Bush Administration has pushed hard for "de-institutionalization" through its "New Freedom" initiative.⁵⁵ Even the judiciary has a hand in this issue because of the "Olmstead" court decision that states must offer home care as an alternative to nursing homes whenever possible.⁵⁶ Several states have pushed hard for more home care and nearly all states have made some moves in that direction.⁵⁷

Who can object? Nobody wants to go to a nursing home. Everyone would prefer to receive long-term care at home in familiar surroundings. But does it save money? Obviously not. All the empirical evidence available suggests that when Medicaid provides home and community-based alternatives to nursing home care, total long-term care costs go up, not down.⁵⁸

Care for people at home and they'll be happier, more independent, and live longer, but sooner or later many will end up in a nursing home anyway. The total cost of their care will be greater than if they went straight to a nursing home, became discouraged, depressed, and dependent and died quicker. Obviously, more home care is desirable and we should make financing it our goal, but it does not save money.⁵⁹

Instead of struggling to retrofit a home and community-based care system onto the current bankrupt, welfare-financed, nursing home based system, we should be looking for new sources of private financing. If more home and community-based long-term care were privately financed, Medicaid would have to serve fewer recipients, and it could then afford to pay more adequately for home care and assisted living.

Unfortunately, the current push to divert Medicaid dollars from nursing homes to home and community-based care has had exactly the opposite effect. Home care is more attractive to consumers. The more Medicaid conveys the idea that it will pay for home care, not just nursing facility care, the more the public wants to use Medicaid for their long-term care.⁶⁰ People come out of the "woodwork" to take advantage of the program.

Unless and until we stanch the hemorrhage in Medicaid long-term care eligibility, expansions of the program into more desirable service delivery modalities will increase utilization and costs in a program that is already stretched far too thin financially.

But that's not all. The more attractive Medicaid becomes, the more people will seek creative ways to qualify for the program. Hence, we've seen startling growth in the practice of Medicaid estate planning in the past few years.

Similarly, the more attractive Medicaid becomes, the less incentive people have to take personal responsibility by purchasing private insurance or using their home equity to fund their long-term care. Hence, we see disappointingly low market penetration rates for those products.

Until we change Medicaid eligibility to encourage private financing of long-term care, Medicaid-financed home and community-based services will continue to be a hopelessly expensive sinkhole for state budgets.

Change the rules to require spenddown of home equity, however, and three things will happen immediately.

First, a huge new private financing source will pump desperately needed revenue into the long-term care service delivery system.

Second, Medicaid costs will plummet, thus allowing that program to pay more adequately for a wider range of long-term care services.

And third, to protect their home equity, more people will buy long-term care insurance and that large new private financing source will come online much faster than is happening already.

Q: Some of the other "solutions" we keep hearing about are public education campaigns about long-term care, tax incentives for long-term care insurance, and forgiving the Medicaid spenddown requirement for people who buy private insurance. What do you think of those ideas?

A: All three have three things in common: they've been tried, they haven't worked very well and they cost money. But that is not to say they won't work in the future. They will, but not until we solve the Medicaid eligibility problem first. Here's why.

People don't fail to plan, save, invest or insure for long-term care because they lack education, can't get a tax deduction, or fear Medicaid spenddown. They don't prepare for long-term care because they don't think they need to.

Ironically, as far as paying for care is concerned, they're right. People can ignore the risk of long-term care, avoid the premiums for private insurance, and get the government to pay if and when they need it. Studies show most people don't know who pays for long-term care—Medicaid, Medicare or Santa Claus—but they do know someone must pay. They don't see many Alzheimer's patients dying in the gutter. They figure somebody is taking care of the old, frail and infirm. And it's true. Bottom line, the public has been anesthetized to the risk of long-term care.

Therefore, public officials can and do spend a fortune to educate people about the risk and cost of long-term care and it has little effect as long as the current publicly financed system prevails.

The state and federal governments can offer generous tax deductions or credits, as many states have, and it will not pique the public's appetite for private financing alternatives as long as public financing is so easy to obtain.

State legislatures can forgive Medicaid spenddown liability as the Long-Term Care Partnership Program has done in several states, and get only mediocre increases in LTC insurance sales as long as spenddown rules are so lenient and easy to evade.

On the other hand, change Medicaid eligibility in the ways we've proposed, and you will immediately draw the public's attention to long-term care. Education, marketing and advertising campaigns will influence consumer behavior in positive ways. Tax incentives will work. And spenddown forgiveness will persuade many more people to buy private insurance.

With the money government saves by targeting Medicaid more effectively to people truly in need, states will finally have the resources required to fund education campaigns, tax incentives, and spenddown forgiveness. A positive cycle with a leveraging, multiplier effect will replace the current downward spiral.

Q: What you're saying seems to make sense but it is complicated. There are just too many variables swimming in and out of focus in my mind. Can you boil it down to a more simplified model? For example, how would you analyze a specific state and decide what to recommend?

A: The foregoing analysis is necessarily complicated, but the following model is very simple and intuitive. Six related key variables affect Medicaid and long-term care financing. Three are independent and three are dependent. These aren't the only factors or variables involved, but we think they are the primary ones. Here they are:

Independent variables:

1) **How easy is Medicaid long-term care eligibility to obtain?** For reasons discussed in general above and specifically by state below, Medicaid LTC eligibility is easy to obtain everywhere in the United States. Thus, we have no measurable objective proxy for this variable except to say it is high everywhere and will remain so unless and until federal eligibility rules are changed. (Nevertheless, we've assigned some best-guess subjective ranks to the target study states discussed below.)

2) **How attractive are Medicaid long-term care services?** The proxy for this variable is a state's Medicaid-financed home and community-based services (HCBS) spending (excluding MR/DD waivers) per capita.⁶¹ The more a state spends for HCBS, which people prefer, as compared to nursing home care, which people shun, the more attractive its Medicaid program.⁶²

3) **To what extent does Medicaid recover from estates?** We use "probate recoveries" in 2002, as reported by the Centers for Medicare and Medicaid services to measure this variable.⁶³

Dependent variables:

4) **Long-term care insurance market penetration.** We use LTCi market penetration as reported by America's Health Insurance Plans (AHIP; this data was formerly published by the Health Insurance Association of America, which is now part of AHIP).⁶⁴

5) **Home equity conversion market penetration.** We use a compilation from various sources of data to estimate HEC market penetration.⁶⁵

6) **Medicaid nursing home census.** The percentage of nursing home residents for whom Medicaid is the primary source of funding was derived from the CMS' Online Survey and Certification and Reporting (OSCAR) data base.⁶⁶

Q: How are these variables related and why does it matter?

A: If a state Medicaid program offers generous eligibility, highly desirable home and community-based services, and recovers little or nothing from recipients' estates, then we would expect the state to experience low market penetration for private financing alternatives like long-term care insurance and home equity conversion, and a relatively high Medicaid nursing home census.

In other words, the more attractive Medicaid is in terms of eligibility and services, the less likely people will be to take personal responsibility for long-term care and the more likely they will be to become dependent on Medicaid.

Conversely, if a state Medicaid program enforces stricter long-term care eligibility, offers primarily the less desirable nursing facility services, and recovers aggressively from recipients' estates, then we would expect the state to experience higher market penetration for private insurance and home equity conversion and to have a relatively lower Medicaid nursing home census.

In other words, the less attractive Medicaid is in terms of eligibility and services, the more likely people will be to take personal responsibility for long-term care and the less likely they will become dependent on Medicaid.

Of course, no state is a pure case. Every state has some characteristics that tend in opposite directions. For example, a state with strong estate recoveries (which discourage Medicaid dependency and encourage private financing) may also have generous home and community-based services (which encourage Medicaid dependency and discourage private financing).

Q: Are you suggesting that we may need to make Medicaid less attractive in order to encourage private long-term care financing alternatives?

A: Yes and no. Yes, in the sense that we need to target Medicaid to genuinely needy people and ensure that others pay their own way through spenddown (including home equity) or private insurance. No, in the sense that if we do divert middle and upper-middle class people to private financing, Medicaid will be able to offer more attractive services to a smaller clientele of truly needy people. The key is to control eligibility.

Here's the dilemma. Many states have tried to reduce costs and improve service delivery by de-emphasizing nursing home care and encouraging home and community-based services. But in so doing, they've made their Medicaid programs more attractive and private financing less attractive. If they could control eligibility, however, so that people would access Medicaid only after consuming home equity, fewer people would become dependent on Medicaid, and the state could afford to provide the most attractive services (HCBS) and pay adequately for them.

Q: How about some examples?

A. All right. For this study, we took a close look at 10 state Medicaid programs. We chose five states because they appeared superficially to encourage Medicaid dependency and discourage private financing: Georgia, Michigan, New Mexico, New York, and Texas. We chose five other states because they seemed on first impression to discourage Medicaid dependency and to encourage private financing: California, Connecticut, Minnesota, Nebraska, and Oregon. Let's look at these two groups of states first, then we'll examine them one by one.

First the pro-Medicaid, anti-private pay states. Four of the five, New Mexico excepted, proved to have relatively generous eligibility systems. Four of the five reported zero estate recoveries in 2002. The one exception, New York, was ranked 37th in the country for estate recoveries on a percentage basis, relatively low. Three of the five were in the top half of states for HCBS; New York was #2 and New Mexico, #7. Only Georgia and Michigan were in the second half of states for HCBS.

Given these characteristics, we would expect these states to score relatively low on long-term care insurance and home equity conversion market penetration and relatively high on Medicaid nursing home census. In fact, they do. All five have the lowest possible LTC insurance market penetration: 1%-5%. Three of the five score in the bottom half of states for home equity conversion; New York and New Mexico are the exceptions. And all five score in the top half of states for Medicaid nursing home census with Georgia and New York ranking fourth and sixth respectively.

Next, the anti-Medicaid, pro private-pay states. Four of the five, California excepted, proved to have relatively strict Medicaid eligibility systems. Four of the five were among the top half of states in estate recoveries, including Oregon, ranked #2 and Minnesota, ranked #7. Counterbalancing these factors, however, four of the five were in the top half of the states for HCBS, with Connecticut, Oregon and Minnesota ranking #5, #6, and #9 respectively.

Given these characteristics, we would expect these states to score relatively high on long-term care insurance and home equity conversion market penetration and relatively low on Medicaid nursing home census. In fact, all five states score higher on LTCi market penetration than the pro-Medicaid states, two at 6%-9%, two at 10%-14% and one at 15%+. Similarly, four of the five states score in the top half of states for HEC market penetration, with Connecticut at #6, California at #9, and Oregon at #10. Three of the five states were in the lower half of states for Medicaid nursing home census, including Nebraska which has the lowest Medicaid census in the country at 53.76%. The other two states had roughly average Medicaid censuses, ranking #22 (Connecticut) and #24 (California).

Thus, at least for these 10 states which we chose to test the relationship between the primary variables, the anticipated relationships hold more or less.

In a moment, we'll take a closer look at all the variables for each of these target states and ask: What does this analysis suggest that each state should do to improve its long-term care system? For the answer to this question, see the section of this report titled "State Medicaid Long-Term Care Profiles," which follows immediately after the current section. Then we'll close with a "Conclusion and Recommendations" section that summarizes what needs to be done at both the federal and state levels.

Q: All right, let's say we tighten Medicaid long-term care eligibility—maybe even require reverse mortgages—and we increase estate recoveries, and we publicize all this and we take the inevitable political heat. What difference will it make?

A: Well, to say for sure would require a lot of new empirical research and a much bigger study. That's work that definitely should be done. In the meantime, to whet your appetite, here's what we found based on interviewing Medicaid eligibility staff in Nebraska recently.⁶⁷

"[Nebraska] Medicaid eligibility workers estimate conservatively that 20 percent of long-term care cases transfer assets without penalty which would result in a loss of **\$49 million** across the caseload that might otherwise have been spent privately for care."⁶⁸ A totally unscientific projection to the rest of the country, qualifying as no more than a rough, but very suggestive guess, would place the amount lost at **\$6.4 billion**.

"Huge amounts of wealth are sheltered from long-term care spend-down requirements by federally mandated exemptions such as prepaid burials for Medicaid recipients and their spouses, which [prepaid burials alone] may divert over **\$51 million** from private long-term care spending [in Nebraska]."⁶⁹ The comparable amount nationwide would be **\$6.7 billion**.

"Nebraska Medicaid exempts the first \$5,000 of a deceased Medicaid long-term care recipient's estate from otherwise mandatory 'estate recovery' if a child of any age survives the recipient. At any given time, upwards of **\$31 million** is exempted from estate recovery in this way. By eliminating the exemption, Nebraska could recover an additional **\$10 million** per year, after expenses, from estates."⁷⁰ If every state in the country recovered from estates at the same rate as Oregon (6.9% of total Medicaid nursing home expenditures), total recoveries would be **\$3.2 billion** instead of the paltry \$350 million reported for 2002.

"Medicaid pays for 54.4 percent of all nursing home patient days in Nebraska. The state could save **\$54 million** per year by dropping this percentage to 44.4 percent. Conversely, if the percentage of nursing home days paid by Medicaid continues to increase to 64.4 percent, expenditures will increase by \$54 million per year."⁷¹ The comparable savings or loss at the national level would be **\$7.1 billion**.

These are just a tiny sampling of the kinds of program savings that could be achieved in the short term by targeting Medicaid more effectively to the genuinely needy and requiring others to utilize their otherwise illiquid wealth for long-term care. The really big savings will accrue over the long term as the public is weaned off the entitlement mentality regarding long-term care and comes to see the need to insure against this risk.

Q: Why hasn't the research been done to establish this potential and to define and prescribe the necessary corrective actions? And why in the world aren't the nursing homes, the LTC insurers and the reverse mortgage lenders screaming bloody

murder? If you're right, their markets are severely impeded by Medicaid's long-term care funding monopsony.

A: The answer is simple and, admittedly, somewhat discouraging.⁷² Most **academics** are biased in favor of public financing of long-term care and therefore give little attention to documenting how it chills the market for private financing alternatives. (A rare and promising exception is an unpublished working paper, by Amy Finkelstein of Harvard and Jeffrey Brown of the University of Illinois, that concludes: "Our main finding is that, given the existence of Medicaid, individuals throughout most of the wealth distribution would be unwilling to pay for private insurance coverage" Their paper goes on to suggest that recent federal and state initiatives to increase demand for private long-term care insurance will be of limited effectiveness as long as Medicaid maintains its current structure.)⁷³

The **nursing home industry** has been basically a public utility dependent on Medicaid and Medicare financing for nearly 40 years. Consequently, its public policy advocacy is focused almost entirely on increasing Medicaid and Medicare reimbursement rates rather than on controlling and targeting Medicaid eligibility.

Long-term care insurers are scared of the political sensitivity of this issue. Most of them figure no one will buy their product if the government's giving it away, so they'd better not acknowledge that reality, much less advocate public policy to change it.

Home equity conversion lenders are new to the long-term care issue. It's too soon to say whether they'll actively support responsible changes in Medicaid LTC policy.

Of course, interest groups like **senior advocates**—who mistakenly believe the elderly benefit from the status quo—and **Medicaid planners and trial lawyers**—for whom the status quo is a financial bonanza—fight any effort to target Medicaid long-term care benefits to the needy or to encourage private financing.

Bottom line, legislators have their work cut out for them to overcome political opposition from advocates of government financing, to win over support from private sector interest groups, and to convince the public that it is in everyone's best interest to reform Medicaid. But failure to act and act soon could spell disaster.

There is some good news, however. Most of America's long-term care service delivery and financing problems are self-inflicted by well-intentioned but perversely counterproductive public policy. If we stop doing what we've always done, we'll stop getting the result we've always gotten and the system will right itself. All it takes is the knowledge to understand the problem, the vision to see the solution, and the will to act.

Now, let's focus the microscope and look in detail at some individual states.

State Medicaid Long-Term Care Profiles

Alert: The following section is not intended to stand alone. The individual state profiles must be read after, and in the context of, the main body of the report. Otherwise, many key terms and references may be unclear or impossible to understand.

Five states that, on the margin, encourage Medicaid (plus) and discourage private financing of long-term care (minus):

Georgia State Profile (Medicaid plus, Private minus)

Medicaid Eligibility (Subjective rank from 1, easy to 5, hard):	1
Medicaid Estate Recoveries—Probate (Percent, Rank):	None, Last
HCBS (Expenditures per capita, Rank):	\$212.66, 30
LTCi Market Penetration:	1%-5%
Home Equity Conversion (HECMs per 1000 elderly, Rank):	3.4, 33
Medicaid Census (Percent, Rank):	77.19%, 4
Predictability (Plus +, Minus -, or Mixed ±):	+

Diagnosis: Georgia is a long-term care basket case. The state has an extremely high Medicaid nursing home census which has increased rapidly for years. Generous long-term care eligibility prevails. Staff is aware of a strong elder law bar and widespread Medicaid planning, but the state has conducted no studies to determine the nature or impact of this practice. Georgia still collects no estate recoveries despite the federal mandate.⁷⁴ Long-term care insurance and home equity conversion market penetration are minimal. Georgia aspires toward more home and community-based services but budget constraints and waiting lists have limited fiscal damage from the woodwork factor. The state is unlikely to be able to expand HCBS until it controls LTC eligibility and implements estate recoveries. Gimmicks like "bed taxes" to leverage up federal Medicaid matching funds only delay the day of reckoning in Georgia.

Prognosis: Measures have only recently been taken—driven by the budget crisis—to control eligibility and plan for estate recoveries. Extreme public opposition and political sensitivity pertain toward controls on Medicaid LTC eligibility and estate recoveries. When budget conditions improve, corrective actions being taken currently to tighten eligibility and implement estate recoveries, are vulnerable to repeal, leaving the state extremely susceptible to future budget problems, especially with the aging of the baby boom.

Prescription: Georgia should conduct a study of Medicaid long-term care eligibility; assess why its Medicaid nursing home census is so high (4th highest in the country); examine the techniques and extent of Medicaid planning; implement eligibility controls and a strong estate recovery program drawing on best practices from other states; use some of the savings from tightening Medicaid eligibility and recovering from estates to

fund education campaigns and tax incentives to encourage LTC insurance and home equity conversion; and begin a public relations campaign to educate Georgians that long-term care is a personal responsibility for which they should plan early and save, invest or insure.

Medicaid LTC Eligibility:

Medically needy, but changing to "income cap" in July 2004 due to budget cuts.⁷⁵ New income cap system will be vulnerable to "Miller income diversion trusts."

Subjective "intent to return" means home remains exempt regardless of ability to return.

No transfer assets before income allowed: income first state.

Round down?: Yes. Applicants can give away one dollar less than double the monthly nursing home average of \$3860 each month without incurring any extra penalty beyond the current month.

Prepaid burial funds?: Estimate 80% of recipients have them averaging \$5,000 each.

Strong Medicaid planning, extreme political sensitivity.

Biggest eligibility loophole?: "Biggest problem now is with promissory notes. . . . Over the years that has become a huge loophole. People set up a promissory note with \$100,000 but only \$25 per month payment. The Medicaid planning bar has taken advantage. Maybe 10% or 15% of cases. We will not allow after July 2004." (Interview)⁷⁶

"Like in many other states, we believe that we have a very serious issue with financial advisers and attorneys holding seminars throughout the state. These two entities advertise that they can show people 'how to get Medicaid to pay for their long term care services' without having to purchase long term care insurance or divesting their assets. Of course they try to get the people to purchase annuities or establish trusts with their organizations. These practices are indeed having a great negative impact on the long-term care insurance industry in our state." (Survey)⁷⁷

An internet search for "Medicaid Planning in Georgia" reveals several firms that specialize in the field. Two examples:

<http://www.georgiamedicaidplanning.com/>

Quote: "Helping Your Loved One Get the Nursing Home Care They Deserve While Legally Protecting Your Family's Assets"

http://www.howell-law.com/default.aspx?daURL=/ELMS/elms_index.asp

Quote: "In fact, in our lifetime, Medicaid has become the long term care insurance of the middle class."

Medicaid Estate Recoveries:

"Estate recovery is projected to save the state \$2 million during the fiscal year starting July 1. It's part of a broader effort to reduce the costs of Medicaid in Georgia, which shot up from \$3.3 billion in fiscal 2000 to \$4.4 billion just two years later." (Dave Williams, "State Eyes Estate Recovery to Recover Medicaid Costs," *Gwinnett Daily Post Online Edition*,

<http://www.citizenonline.net/citizen/archive/article2296FF8C112944669616154660B405C2.asp?printerFriendly=true>

"We are going to our Board May 12, 2004 with our estate recovery plan. If approved, we will move forward in August 2004. We've gotten burned with estate recoveries before. We had a plan five years ago, but it blew up politically. There is a lot of resistance in the state. It is a real volatile issue." (Interview)⁷⁸

Home and Community-Based Services: "Georgia is budgeting more home and community-based services each legislative year. Georgia has a waiting list for all home and community-based services programs. We expect the lists to continue to increase. Georgia seniors are reviewing options re: estate planning to become eligible for Medicaid services. This activity is increasing." (Survey)

Long-Term Care Insurance: LTC insurance market penetration in Georgia is between 1% and 5%.⁷⁹

Home Equity Conversion: Georgia has had 3.4 home equity conversion mortgages (HECMs) per 1000 elderly homeowners. The state ranks 33rd in HECM loans.

Medicaid Nursing Home Census:

"Yes the Medicaid resident census has increased. It has increased from 75% in 1996 to 85% in 2003. This has caused significant budget increases. Reimbursement rates to nursing homes have increased also." (Survey)

Bed tax issue: Because state Medicaid programs can leverage up state dollars with federal matching funds, many states use creative financing techniques, such as taxing nursing home beds to generate extra funds that can be turned into additional federal match at the FMAP (Federal Medical Assistance Percentage) rate. The federal government wants to curtail, but often complies with such techniques, which add to its program costs without increasing or improving care. States sometimes charge the bed tax to nursing homes and then divert the proceeds to other purposes, much to the chagrin of the LTC providers. Following are two related news items applying to Georgia:

"Feds OK 'bed tax,' save state from fine. By Andy Miller. *The Atlanta Journal-Constitution*. April 9, 2004 Federal approval has finally been given to the \$7.80 per patient per day nursing home bed tax that the state of Georgia has been collecting,

illegally, since last July. For every dollar spent on Medicaid services, the federal government gives Georgia \$1.67, keeping the state's nursing homes afloat. The CMS, however, plans to audit Georgia's financing strategies to ensure that the state is adhering to federal rules."

"LTC Daily Analysis Briefs Georgia Nursing Homes Sound Alarm on Funding
ATLANTA, GA — 04/23/2004 — (Eli Digital) Georgia nursing homes say a government plan to divert away from the facilities money raised by a bed tax will have a devastating effect on their financial condition. The state legislature and Gov. Sonny Perdue last year crafted a law allowing nursing homes to tax themselves in order to qualify for more matching federal money, the *Macon Telegraph* reports. The plan was for the money to be returned to the facilities as state Medicaid payments. In the upcoming fiscal year, the bed tax and its federal match will still go to nursing homes, but about \$52 million in regular nursing home funds will be redirected to other budget areas, according to the paper. The state's nursing home industry leaders warn that the diversion could lead to layoffs of as many as 1,700 long-term care workers." (Source: LTC Daily Analysis Briefs, April 23, 2004, prepared by www.eliresearch.com for www.snalfnews.com <http://www.snalfnews.com/AnalystNews.cfm?id=4948>)

Michigan State Profile (Medicaid plus, Private minus)

Medicaid Eligibility (Subjective rank from 1, easy to 5, hard):	1
Medicaid Estate Recoveries—Probate (Percent, Rank):	None, Last
HCBS (Expenditures per capita, Rank):	\$198.44, 32
LTCi Market Penetration:	1%-5%
Home Equity Conversion (HECMs per 1000 elderly, Rank):	3.6, 29
Medicaid Census (Percent, Rank):	66.49%, 21
Predictability (Plus +, Minus -, or Mixed ±):	+

Diagnosis: Michigan has generous Medicaid long-term care eligibility, no estate recoveries, and no tax incentive or Partnership program for private long-term care insurance. The state sends a clear message to residents: "Don't worry about long-term care; we have you covered." Alas, it is not true, as Michigan's budget crisis, low LTCi and HEC market penetration, high Medicaid nursing home census, and relatively low HCBS spending show. Any rational person in possession of all the facts would not choose to depend on Michigan's Medicaid program to provide long-term care, yet the state has done little to awaken its public to the risk and the need to take personal responsibility early.

Prognosis: Like most other states, Michigan faces a severe budget challenge. Furthermore, "The picture will not improve in fiscal year 2005. Health care costs are continuing to increase. Medicaid enrollment is also likely to continue to expand unless there is a dramatic turnaround in the state's economy. The state will also lose access to the revenues [from] enhanced federal matching payments which phase out in July 2004."⁸⁰ How has Michigan responded? "Looking to save some \$12 million in the 2004 budget, the state of Michigan on October 1, 2003, stopped paying for routine dental care for 600,000 adults on Medicaid, the state-federal health insurance plan for persons with few assets and low incomes. Among those no longer receiving Medicaid dental care are low-income mothers, nursing home residents, and developmentally disabled and mentally ill people."⁸¹ Cutting critical benefits for people genuinely in need while preserving generous eligibility for affluent seniors and insuring their inheritances for boomer heirs is misguided public policy that will sink Michigan deeper and deeper into the fiscal mire over time.

Prescription: Michigan should review policies in other states to seek ways to tighten its Medicaid LTC eligibility system. The state should immediately implement an aggressive Medicaid estate recovery program building on best practices from successful states like Oregon. Savings accruing from these measures should be used in part to educate and incent the public to purchase LTC insurance and/or to utilize their home equity for LTC through reverse mortgages. Michigan should implement a public relations campaign to tell the public the truth about long-term care, i.e. Medicaid can no longer carry the LTC load for everyone, the program's scarce resources will henceforward be targeted to the most needy, others will be expected to pay their own way, and anyone who preserves resources through asset shelters will repay Medicaid for the cost of their care from their

estates or from the estates of their surviving spouses. Having put the public on notice and having restructured the Medicaid program in this way, Michigan will be better able to provide a range of home and community-based services to a smaller number of genuinely eligible recipients because it will have reduced considerably its Medicaid nursing home census and ameliorated its budget crisis.

Medicaid LTC Eligibility:

Medically needy eligibility system for long-term care. Medical expenses including nursing home care are deducted from income to establish eligibility.

Subjective intent to return protects the home indefinitely.

Query: Could someone with \$40,000 per year of income qualify if their medical expenses were high enough? Answer: "Yes, such a person could qualify, but the patient-pay amount would exceed Medicaid's cost of care, so we would pay nothing, but the recipient would still be eligible and would pay the Medicaid rate—not the private pay rate—to the nursing home. This is not common but it does happen." (Interview)⁸²

"Income first" state; transfer assets before income to establish a higher CSRA is not allowed.

Michigan rounds down monthly asset transfers. Applicants can therefore give away double the average monthly nursing home cost (\$5250) less one dollar or \$10,499 each month without incurring more than the month of the transfer as penalty.

Prepaid irrevocable burial contracts are allowed in any amount. Staff guess that 70% of recipients have them averaging \$4000 to \$5000 each. But they have no hard data to corroborate.

Purchase of annuities with balloon payments has been a heavily advertised Medicaid planning technique in Michigan. The state hopes to tighten up the policy on annuities. Michigan would like to have a state law to control abuse of annuities, but cannot find a legislator to sponsor such legislation because of the political sensitivity.

Medicaid planning is "getting increasingly common. It is becoming a downright annoyance. We need to address Medicaid planning more in our policies. In MI, as around the country, planners are getting pretty creative." (Interview)

Purchase exempt assets? "Yes, that is fairly common. Big screen TVs, trade in a car for a more expensive one. Goes on. No question about it. Understood by caseworkers that its OK if at fair market value." (Interview)

"Wealthy people weeks before they apply will put a property up for sale. If they have an offer, it is not a countable asset at that time. Then if they don't follow through on the sale, we may not know. Could be investigated through fraud." (Interview)

An internet search for "Medicaid Planning in Michigan" reveals many firms that specialize in the field. Two examples:

http://www.florkalaw.com/default.aspx?daURL=/ELMS/elms_index.asp

Quote: "The reason for Medicaid planning is simple... you plan so that if you need it, you will be eligible to receive Medicaid benefits. Medicaid planning is an extremely complex area of the law. One wrong move could trigger an ineligibility penalty of up to five years, so don't try to go it alone. Consult an experienced estate planning attorney. . . . To request a copy of our free report on 'Setting the Stage for Medicaid' please fill out online request form."

http://www.florkalaw.com/default.aspx?daURL=/forms/request_report.asp

<http://fosterzacklowe.lawoffice.com/PracticeAreas/PracticeAreaDescriptions60.asp>

Quote: "Many people assume they must sell their home and spend down all their assets before Medicaid will help with their medical costs. Wrong! Our Elder Law Attorneys can help you through the maze of state and federal rules and regulations to help you or your loved ones qualify for Medicaid benefits to help pay the cost of nursing home care. We can provide valuable information on preserving assets and qualifying for Medicaid on an expedited basis."

Medicaid Estate Recoveries: Michigan has no estate recovery program.

Home and Community-Based Services: Michigan spends only \$198.44 per elderly resident on HCBS and ranks 32nd among the states.

"We have a program called HCBS waiver with probably 10,000 people. It has no cap, but enrollments are held back. There is no freeze either, but limited. Eligibility is based on the limit of 300% of SSI. If medically needy, then not eligible because there is no patient pay amount." (Interview)

Long-Term Care Insurance: Michigan falls in the lowest category of LTCi market penetration at 1% to 5%. The state has no tax incentive for LTCi and no LTC Partnership program. "We don't see much long-term care insurance." (Interview)

Home Equity Conversion: Home equity conversion market penetration is relatively low in Michigan at 3.6 HECMs per 1000 elderly residents ranking the 29th in this category.

Medicaid Nursing Home Census: Michigan's Medicaid nursing home census is relatively high at 66.49% and the state ranks 21st in this category.

New Mexico State Profile (Medicaid plus, Private minus)

Medicaid Eligibility (Subjective rank from 1, easy to 5, hard):	4
Medicaid Estate Recoveries—Probate (Percent, Rank):	None, Last
HCBS (Expenditures per capita, Rank):	\$608.70, 7
LTCi Market Penetration:	1%-5%
Home Equity Conversion (HECMs per 1000 elderly, Rank):	5.8, 17
Medicaid Census (Percent and Rank):	70.49%, 15
Predictability (Plus +, Minus -, or Mixed ±):	+

Diagnosis: Like most states, New Mexico faces a severe budget challenge driven in large part by Medicaid, especially long-term care, costs. Although the state maintains a relatively tight Medicaid long-term care eligibility system, federal rules prevent targeting benefits only to the poor. Middle and upper-middle class people can qualify routinely without spending down significantly due to the use of Miller income trusts for higher income citizens and generous exemptions of homes and other assets. The state has focused heavily on popular HCBS services that attract Medicaid applicants and has largely ignored Medicaid estate recoveries which tend to deter middle-class applicants. New Mexico has a large population of truly needy citizens for whom Medicaid is a critical safety net. The state needs to preserve Medicaid by encouraging its relatively small proportion of well-to-do citizens, who reside mostly in the larger urban areas of Albuquerque and Santa Fe, to purchase private insurance and/or utilize home equity conversion for their long-term care costs before relying on Medicaid.

Prognosis: New Mexico is struggling currently with an over-extended Medicaid program that is heavily invested in HCBS. Unless the state can divert more people toward private long-term care financing and away from Medicaid dependency, Medicaid will continue to consume a larger and larger proportion of a very limited state budget.

Prescription: New Mexico should mobilize to control Medicaid long-term care eligibility more effectively by studying best practices in other states, discouraging the further development of a Medicaid estate planning bar, and educating eligibility workers on the importance of controlling eligibility to preserve Medicaid for the needy. Unless and until the state can divert more people to private financing alternatives, New Mexico should focus less on providing HCBS and more on financing nursing home care adequately for those patients requiring the highest acuity of care. The state should immediately implement and publicize a strong and effective Medicaid estate recovery program and use the substantial nontax revenue likely to accrue to fund a public education campaign on the importance of early planning for long-term care financing.

Medicaid LTC Eligibility:

Income cap eligibility system with Miller income trusts for people whose income exceeds the cap.

Subjective intent to return means the home remains exempt whether or not the recipient is able medically to return home. Staff estimated 60% to 70% in Santa Fe own homes. In other parts of New Mexico, home ownership and home values are much lower.

Community Spouse Resource Allowance is half the joint assets not to exceed \$92,760 but no less than \$31,290, which is more generous than the federal minimum of \$18,552 as of 2004.

"Income first" state. No transfer of assets before income is allowed to increase the Community Spouse Resource Allowance in order to generate more income for the community spouse.

Purchase of exempt assets: When applicants have excess assets, eligibility workers tell them how much they have to spend down. Workers are not supposed to recommend exempt assets on which to spend down. After spenddown, the worker asks what excess assets were spent on. If for care or for exempt assets or services, e.g. re-roofing a house, eligibility is approved.

Half-a-loaf strategy: New Mexico rounds down asset transfers so that applicants can give away double the average monthly cost of a nursing home (\$3899 is the amount used to compute transfer of assets penalties) less one dollar each month (hence two times \$3899 minus \$1 or \$7797) without incurring more than the current month as an ineligibility penalty: "I've gotten a couple of letters lately that attorneys have given to clients that say 'gift yourself \$8,000 this month and every month thereafter gift \$2,000. There is some kind of tricky stuff going on; people giving advice on how to qualify.'" (Interview)⁸³

We found no evidence of widespread Medicaid estate planning in New Mexico, although respondents indicated there is some going on and it is increasing. The Senior Citizens' Law Office, Inc. in Albuquerque published a guidebook on Medicaid eligibility and planning titled "Medicaid, Life Planning and Elder Law Essentials" summarizing the proceedings of a conference held January 17, 2003. The book contains material on Medicaid eligibility rules for nursing home and community-based care, transfer of assets and gifting, Medicaid and SSI trusts, including Miller income trusts, etc. In most states, legal aid offices focus their assistance on low-income people but routinely refer more affluent families to private Medicaid planning attorneys.

Medicaid Estate Recoveries: New Mexico reported zero probate recoveries to the federal government in 2002. State staff indicate they recovered \$28,200 for state fiscal year 2004 with .5 FTEs (full time equivalent staff). New Mexico has not implemented the expanded definition of "estate" authorized by OBRA '93. Bottom line, the state of New Mexico has such a limited estate recovery effort that it hardly bears considering. Staff indicated, however, that a more aggressive effort is planned.

"We have the [MER] statute on our books because it is a federal requirement. We only act if a deceased recipient's attorney contacts us. We have no formal program for these collections nor can we give an amount of recoveries. Recently, we've had a policy

change to be more aggressive but we have not developed systems and procedures yet. If a home is valued at less than half the value of an average home in a county at the time of the recipient's death, it would qualify for a hardship waiver."

Home and Community-Based Services: New Mexico heavily emphasizes HCBS through Medicaid waivers and its "personal care option" program. The state spends \$608.70 per elderly resident on HCBS, ranking it 7th highest in the country. "Initially we had a big push for HCBS in New Mexico, but our funding for those programs is limited and we have waiting lists. The personal care option is not as extensive as the waiver (limited to chore services) but it is designed to help keep someone at home." (Interview)

A recent trade journal article stated: "A report from New Mexico . . . noted that a 'personal care option' program the state anticipated would cost about \$10 million actually cost \$200 million and was the state's fastest growing Medicaid component. 'The "personal care option" approach is very likely to see an explosion of costs,' noted Matt Salo, the director of NGA's [National Governors Association] Health and Human Services Committee, 'because they don't have the controls of more targeted waivers.'"⁸⁴

Long-Term Care Insurance: New Mexico does have a tax incentive to encourage the purchase of private long-term care insurance. The New Mexico Taxation and Revenue Department confirmed that "such premiums would qualify for the NM state medical care expense deduction . . ."⁸⁵ The state does not have a Long-Term Care Partnership program.

Home Equity Conversion: New Mexico's home equity conversion market penetration is 5.8 HECMs per 1000 elderly residents, ranking the state 17th in the country.

Medicaid Nursing Home Census: New Mexico's Medicaid nursing home census is 70.49%, 15th highest in the United States.

New York State Profile (Medicaid plus, Private minus)

Medicaid Eligibility (Subjective Rank from 1, easy to 5, hard):	1
Medicaid Estate Recoveries—Probate (Percent, Rank):	.27%, 37
HCBS (Expenditures per capita, Rank):	\$1,224.63, 2
LTCi Market Penetration:	1%-5%
Home Equity Conversion (HECMs per 1000 elderly, Rank):	6.2, 16
Medicaid Census (Percent, Rank):	73.81%, 6
Predictability (Plus +, Minus -, or Mixed ±):	± (2 of 3)

Diagnosis: New York State has the single most generous Medicaid long-term care program in the country. Eligibility rules are generous to begin with and very elastic when stretched by the state's numerous Medicaid planning experts. Estate recoveries are low as compared to total Medicaid nursing home and HCBS spending. New York spends nearly double on personal care and HCBS compared to neighboring Connecticut (\$692.67), which makes government-financed long-term care inordinately attractive to New York and other nearby consumers. Consequently, Medicaid is the primary payor of long-term care in New York; private-pay for long-term care is low and declining; entitlement mentality is very strong; senior advocates and the Medicaid planning bar are powerful political forces; and long-term care insurance market penetration is disappointing.

Prognosis: New York is a long-term care disaster waiting to happen. The state budget is already stressed. The federal government is starting to balk at New York's creative financing schemes previously used to leverage up matching funds. Long-term care providers complain about inadequate Medicaid reimbursements. New Yorkers are asleep about the risk and cost of long-term care because it is considered a free good. If something is not done soon to change the center of gravity in New York's long-term care system from public to private financing, the fragile service delivery and financing structure is likely to implode soon after the baby boom begins to retire, if not before.

Prescription: The State of New York should conduct a top-to-bottom review of Medicaid long-term care eligibility, coverage, services, and estate recoveries. The county-administered system in New York creates problems and complications that need to be monitored more closely, documented thoroughly, and corrected where possible. The state should put an end to the "Spousal Refusal" eligibility dodge by pursuing its subrogated right to litigate on its and the Medicaid recipient's behalf in all such cases. New York should study and document the practice of Medicaid estate planning, develop hard-dollar estimates of the cost to state and federal taxpayers (who each pay half the cost of Medicaid), and close eligibility "loopholes" that can be controlled at the state level. New York should renew efforts begun by Governor Pataki to seek federal waivers to help the state control its Medicaid long-term care eligibility hemorrhage. The state should mount a public relations campaign to educate the public that long-term care is a personal responsibility for which public financing will become less and less available as time goes on.

Late Development: State Assemblyman Steven Englebright (D, East Setauket) has introduced four bills to increase the tax credit for LTC insurance, encourage reverse mortgages, and implement a long-term care education campaign. These are positive proposals, but in the absence of controls on Medicaid eligibility which Assemblyman Englebright opposes, none of them will have the desired effect for reasons explained in this report.

Medicaid LTC Eligibility:

Medically needy: Medical expenses are deducted from income before determining Medicaid eligibility.

Subjective "intent to return" means the home remains exempt regardless of ability to return.

Community Spouse Resource Allowance (CSRA) is more generous than required by federal law: half of joint assets not to exceed \$92,760 (2004) but no less than \$74,820.

No transfer of assets before income: income first state.

Round down?: No. New York applies a partial month penalty for transfers that exceed the average monthly nursing home rate, which varies from \$5,842 for central New York (Syracuse) to \$9,296 on Long Island.

Prepaid burial fund? New York passed legislation a few years ago which allows a pre-need burial agreement or trust of any amount; anything left over goes to the state.

Spousal refusal: New York allows community spouses to refuse with impunity to support Medicaid spouses. This technique is also known as "just say no." It is based on a loose interpretation of Social Security law. No other state besides Florida allows spousal refusal, despite national advocacy by New York state elder law attorneys to expand the practice.

Strong Medicaid planning bar; very influential politically.

When asked about common Medicaid planning techniques such as "purchase exempt assets," "half a loaf," trusts, annuities, life estates, etc., state staff pled ignorance regarding their frequency and amount because "counties determine LTC eligibility in New York."

Governor Pataki's legislative proposals this year to tighten LTC eligibility were not enacted due to strong opposition from advocacy groups. He sought to apply transfer of assets (TOA) restrictions to home care services, and to pursue a federal waiver extending the TOA look-back period to 60 months for all resources, to start the eligibility penalty period at the time an individual applies and would otherwise be eligible, and to require that an undue hardship must also exist before "spousal refusal" is allowed.

"Of the New York AARP members surveyed on long-term care issues: — 75 percent oppose increasing the look-back period and implementing a harsher penalty period for nursing home and home care — 71 percent oppose applying the look back period to home care — 81 percent oppose the elimination of the spousal refusal provision — 72 percent support extending spousal impoverishment protections to home care — 47 percent who do not have long-term care insurance have not purchased it because it is too expensive — 93 percent voted regularly for Governor and State Legislators over the past ten years."⁸⁶

An internet search for "Medicaid Planning in New York" reveals several firms that specialize in the field. Two examples:

http://lklp.lawinfo.com/elder_law.php?content=medicaid

Quote: "How we can help. We will: *Inform you of the Medicaid rules *Advise you how to protect your assets * Implement appropriate documents, such as the Durable Power of Attorney, Trusts and Wills * * Prepare and submit your Medicaid application * Represent you before the local Medicaid agency."

<http://www.russoelderlaw.com/>

A search for "Medicaid planning" on this website revealed 80 articles and documents. The principal is a former president of the National Academy of Elder Law Attorneys (NAELA), the national professional association of Medicaid planning attorneys. Quote: "Medicaid is the primary payer of Long Term Care. There are strict Medicaid eligibility rules. These rules are complex and contain exceptions which allow you to protect assets and income." (<http://www.russoelderlaw.com/html/medicaidplanning.shtml>)

Medicaid Estate Recoveries:

Staff report that New York has no way of knowing how much the state collects in estate recoveries nor how many FTEs are dedicated to the effort because counties conduct the recoveries and do not report the amounts they collect or their level of effort.

Nevertheless, staff believe that the actual amount recovered is higher than the amount the state is required to report to CMS as "probate recoveries" and that recoveries could be higher still with more staff dedicated to the effort. Staff report "some political opposition" to estate recoveries.

New York has not implemented the expanded definition of estate to include assets that pass in joint tenancy with right of survivorship, etc. as authorized by OBRA '93.

Home and Community-Based Services: "Personal care services programs are available seven days a week, 24 hours a day, provided a physician approves. Each patient is self-directing or has a self-directing agent. Personal care eligibility does not require need for nursing-home level of care. Waivered services do require nursing-home level of care. No transfer of assets penalty for home care. For home care, we use the medically-needy

income level so recipients have to spend down to that level. We have some individuals with high spenddown in the community because they are getting home care services. They must pay providers what they owe, but at the Medicaid rate rather than the private pay rate." (Interview)⁸⁷

New York has the second most generous Medicaid home and community-based services in the country and extremely lenient eligibility for such services. The state spends \$1,224.63 per capita on HCBS services, the second highest in the country. New York exceeds the state in third place (New Hampshire at \$962.09 per capita) by 27%.

Long-Term Care Insurance: "We have 200,000 long-term care insurance policies in effect throughout New York state, including partnership policies." (Interview)

New York has a model "Long-Term Care Insurance Partnership Program" to encourage the purchase of private LTCi by guaranteeing Medicaid eligibility if the private insurance runs out. New York allows a state income tax credit for 10% of the premium paid for qualifying long term care insurance premiums.

Despite these public policy incentives, New York's long-term care insurance market penetration is only 1% to 5%.

Home Equity Conversion: New York's relatively high market penetration of home equity conversion mortgages (6.2 HECMs per 1000 elderly homeowners) is higher than expected based only on the state's generous Medicaid long-term care benefits. But, LTC is only one factor influencing the use of home equity, and a relatively minor one (especially when publicly financed LTC is so readily available) compared to the need to replace income due to plunging interest rates on seniors' savings.

Medicaid Nursing Home Census: New York's Medicaid nursing home census (73.81%) is the sixth highest in the country. This is to be expected given the state's generous Medicaid LTC eligibility rules, its lack of transfer of assets (TOA) restrictions for Medicaid home care (which can be utilized for three years while any TOA penalty for nursing home eligibility runs its course), and the nominal Medicaid estate recovery liability New York residents face.

Texas State Profile (Medicaid plus, Private minus)

Medicaid Eligibility (Subjective Rank from 1, easy to 5, hard):	2
Medicaid Estate Recoveries—Probate (Percent, Rank):	None, Last
HCBS (Expenditures per capita, Rank):	358.58, 20
LTCi Market Penetration:	1%-5%
Home Equity Conversion (HECMs per 1000 elderly, Rank):	2.1, 41
Medicaid Census (Percent, Rank):	69.07%, 17
Predictability (Plus +, Minus -, or Mixed ±):	+

Diagnosis: Texas is another example of a state doing almost everything wrong in long-term care. Although Medicaid LTC eligibility is not quite as generous as it might be, a combination of Miller trusts and wide open loopholes for asset sheltering or divestiture (described below) make the program available to practically anyone regardless of income or asset levels. With no estate recoveries, Texas sends the message that long-term care is a free good. By promoting but not adequately financing home and community-based care, the state misleads the public to believe that Medicaid LTC is more desirable than it actually is. Consequently, Texas' LTC insurance and HEC market penetration are low, its Medicaid nursing home census is high, and funding is a bigger and bigger problem as time goes on.

Prognosis: The foregoing recipe for long-term care failure in Texas is a prescription for disaster in the future as boomers age, retire, and decline physically and mentally. State nursing homes are already struggling. Short-term half measures like a bed tax to leverage up federal funds are under consideration, but CMS discourages such practices and bed taxes further penalize private payers, driving them more than ever toward Medicaid. Unless changes are made to discourage Medicaid dependency and encourage private financing, Texas should expect further declines in nursing home quality, HCBS availability, and market penetration for LTCi and HEC. Medicaid nursing home census and costs will likely continue to increase.

Prescription: Texas should educate the public that Medicaid is strained financially and can no longer remain the primary payor of long-term care for the middle- and upper-middle class. The state should implement a media campaign to encourage personal responsibility for long-term care and to deny Medicaid planners the moral high ground by documenting the damage they do. Texas should implement an aggressive lien and estate recovery program immediately to make perfectly clear that seniors' biggest asset and heirs' biggest source of inheritance will no longer be protected from long-term care expenses by a public welfare program. The state should tighten eligibility by changing from the "asset first" to the "income first" rule, by implementing partial month's penalties for asset transfers, and by systematically studying what other states have done to eliminate other eligibility loopholes. Then implement similar controls. Texas should use the savings from these incremental improvements to fund further public education, tax incentives for LTC insurance and home equity conversion, and to improve reimbursement to long-term care providers.

Medicaid LTC Eligibility:

Income cap eligibility system but with Miller income trusts, AKA "Qualified Income Trusts," for higher income recipients, although staff estimate only 1% of nursing home and waiver recipients have these trusts currently.

Subjective "intent to return" means home remains exempt regardless of ability to return.

"Transfer assets before income," AKA "resource first," allows married institutionalized recipients to transfer large amounts of money above the Community Spouse Resource Allowance to the well spouse in the community. "With interest rates so low, if the community spouse has low personal income, the family can protect several hundred thousand—maybe as much as a million dollars with Certificates of Deposit paying only 1%. I don't know what savings would be but anecdotally there could be significant savings by delaying eligibility for some folks." (Interview)⁸⁸ There is strong opposition from the Medicaid planning bar to any change in the "income first" rule.

Aggressive monthly transfers just under the monthly penalty threshold and inter-spousal transfers after which the community spouse transfers the asset. "Anecdotal reports indicate these techniques are common." (Survey)⁸⁹ "We have seen aggressive gifting by the estate planning community. We use the average nursing home cost \$2,908 dollars per month. They can give away just slightly under double that amount without additional penalty. We round down any fractions so they can give away almost double every month. We don't have the ADP ability to have a partial month charge." (Interview)

"Annuities are not as big a problem. Still can turn into an income stream, but not a way to transfer assets to an heir. The CMS determination that annuity should be considered a resource makes it more clear that we're in compliance with current CMS policy on annuities. Not a giant problem like before." (Interview)

Strong Medicaid planning; Medicaid planning seminars are common; attorneys call eligibility workers for information on exclusions and exemptions; strong political opposition to tightening eligibility or implementing liens and/or estate recoveries.

"1200 estate planning attorneys in the state. Probably a lot of stuff can go on." (Interview)

"Medicaid estate planning complicates the eligibility determination process resulting in workload impacts on staff and the need to work closely with the Office of General Counsel on legal issues beyond the expertise of policy staff." (Survey)

"Every technique used elsewhere is used in Texas to some degree. One of our policy experts now works for Wright Abshire [Medicaid planning firm]. He has a better grasp of policy than I do. Pretty good racket." (Interview)

Excerpts from Houston Medicaid planning law firm "Wright Abshire." For more, see <http://www.wrightabshire.com/> and "LTC Bullet: The Medicaid Seduction," Wednesday, April 14, 2004 at <http://www.centerltc.com/bullets/archives2004/497.htm>.

"Hundreds of families have sought the services of the attorneys of Wright Abshire over the years, and millions of dollars have been preserved for people just like you. . . . Even if a client's assets are substantial, the firm will in almost every case be able to successfully achieve a satisfactory plan for the client to preserve assets. . . . Likewise, if the Medicaid applicant has excess income, the firm will in most cases be able to assist the client in the creation of a Miller trust to solve this eligibility obstacle. . . . They want to assist you to obtain the benefits congress intended for you to obtain without becoming impoverished in the process."⁹⁰

Medicaid Estate Recoveries: Texas is one of three states that have still not implemented estate recoveries as mandated by OBRA '93. Highly controversial; much opposition from the elder law bar and senior advocates. State legislature authorized estate recoveries last year. Work groups and public forums are ongoing with publication of proposed rules expected soon. (Interview)

Home and Community-Based Services: Texas has given lip service to expanding HCBS, but practically speaking little is available: "In general, there are more folks wanting to be in waivers than are in waivers. 30,000 people are in the waiver with a waiting list of 40,000. Number of nursing home residents has not gone down significantly: still in the 65,000 to 70,000 range. We have a pretty large attendant care program in the range of 100,000, Texas is unusual for Medicaid." (Interview)

Long-Term Care Insurance: Low LTCi market penetration. No tax incentive. No Partnership program. "I don't think LTC insurance is very big or many people have it. It was offered to state employees, but only one person I know of bought it." (Interview)

Home Equity Conversion: Only 2.1 HECMs per 1000 elderly; Texas ranks 41st nationally.

Medicaid Nursing Home Census: 69.07% of nursing home residents are Medicaid eligible; Texas ranks 17th highest in the country in Medicaid census.

Five states that, on the margin, encourage Private-Pay (plus) and discourage Medicaid financing of long-term care (minus):

**California State Profile
(Private plus, Medicaid minus)⁹¹**

Medi-Cal Eligibility (Subjective rank from 1, easy to 5, hard):	1
Medi-Cal Estate Recoveries—Probate (Percent, Rank):	.93%, 16
HCBS (Expenditures per capita, Rank):	\$399.04, 16
LTCi Market Penetration:	6%-9%
Home Equity Conversion (HECMs per 1000 elderly, Rank):	9.0, 9
Medi-Cal Census (Percent, Rank):	66.12%, 24
Predictability (Plus +, Minus -, or Mixed ±):	±

Diagnosis: California, which we originally expected to rank very high on long-term care policy because of its strong estate recoveries and heavy emphasis on private long-term care insurance, actually ranks low. The state falls somewhere between schizophrenic (extremely generous Medi-Cal eligibility combined with stringent estate recovery) and suicidal (given that virtually anyone can qualify for Medi-Cal long-term care, often including HCBS, without spending down significantly and, with simple planning, can avoid estate recovery). Like New York, California's Medi-Cal eligibility system is state-supervised, but county-administered and, as in New York, central office eligibility policy staff in California have no knowledge nor means of measuring the extent to which Medi-Cal planning techniques are being used to qualify affluent seniors for the program. Given California's gigantic, and much publicized, budget shortfalls, it is hard to understand why the state allows its Medi-Cal long-term care eligibility to hemorrhage, expands Medi-Cal-financed HCBS which makes the program ever more popular, and fails to fill estate recovery slots that bring in 20 times in nontax revenue what they cost. In spite of serious efforts to encourage private long-term care insurance through tax incentives and the LTC Partnership program, there is little wonder why Medi-Cal predominates and private insurance lags in California's long-term care system.

Prognosis: California is on a path toward long-term care disaster having sent a powerful message to the state's citizens that long-term care is not a risk they need to plan to meet personally. Nevertheless, the state has a good foundation of strong estate recoveries and long-term care insurance promotion on which to build for Medi-Cal reform. With Medi-Cal LTC eligibility exceedingly generous, however, and with home equity conversion and private insurance unnecessary to pay for long-term care and estate recoveries easy to avoid with advance planning, nothing is likely to change until the state takes decisive action to measure and correct these problems.

Prescription: California should conduct a comprehensive study of Medi-Cal long-term care eligibility and Medi-Cal estate planning to find and close the "loopholes" that abound, some of which are summarized below. The state should immediately implement OBRA '93 transfer of assets rules, closely monitor the huge Medi-Cal estate planning bar, publish notifications throughout California warning of new LTC eligibility restrictions

and strong Medi-Cal planning enforcement. California should end its focus on providing HCBS until it gets control of Medi-Cal long-term care eligibility. The state should fill the Medi-Cal estate recovery unit's authorized but currently empty slots and implement the measures which the outgoing director believes could double annual recoveries to \$100 million per year. California should advise state citizens that long-term care is a personal responsibility, that the state is clamping down on the use of Medi-Cal as "inheritance insurance," and that everyone should expect to pay his or her own way for long-term until assets, including home equity, are consumed either up front through a reverse mortgage or *ex post facto* through estate recoveries.

Medicaid LTC Eligibility:

Medically needy eligibility system which allows deduction of medical expenses, including the cost of nursing home care, from applicant's income before determination of income eligibility.

Subjective expression of intent to return allows recipient to retain home regardless of ability to return.

Instead of using the federal guideline of half the joint assets not to exceed the Community Spouse Resource Allowance (CSRA, \$92,760 for 2004), the community spouse is allowed to retain the full \$92,760 regardless of total, joint assets.

Instead of using the Minimum Monthly Maintenance Needs Allowance (MMMNA, \$1515 per month until the annual inflation increase becomes effective July 1, 2004) plus housing costs, California allows the maximum \$2319 regardless of applicants' housing costs.

When the Medi-Cal spouse is married, couples frequently request a hearing to increase the Community Spouse Resource Allowance in order to generate enough income to bring the community spouse up to the Minimum Monthly Maintenance Needs Allowance (up to \$2319 for 2004). "What happens is they go to an administrative hearing and they get the CSRA increased. For example, if they have \$200,000, the case is denied, then goes to a hearing, and they get the CSRA increased. Most of the time, the community spouse does not have the \$2319 income we allow, so they can move the extra assets over, apply the going Certificate of Deposit rate [as low as 1% recently, with the lowest possible rate most beneficial to the applicants], and so they can have hundreds of thousands of dollars [and still qualify]." (Interview)⁹²

California is a "resource first" state (as opposed to using the stricter "income first" rule) which allows transfer of extra assets over and above the CSRA to bring the community spouse up to the MMMNA, which the state sets at the maximum of \$2319.

Annuity abuse is common: "Annuities are exempt for purposes of determining countable property, the theory being that we'll get the income to defray Medi-Cal expenses. What attorneys are doing is transferring the income stream from the annuity to someone else.

Because of limiting language in the Social Security act about the name-on-the-check rule, we're limited in what we can do. To the extent the vender of an annuity is willing to change the person receiving the income, we can no longer count the income stream either." (Interview)

California allows unlimited asset transfers without penalty as long as they are done in a certain way. The state has not implemented OBRA '93 transfer of assets (TOA) rules that prohibit this practice. "We only penalize single transactions. Thus, applicants could gift \$4400 (the average monthly nursing home cost which is the amount used to figure the TOA penalty) to 10 people on the same day and there would be no penalty because it was 10 separate transfers." (Interview) California does have draft regulations to implement OBRA '93 TOA rules in the future." (Interview)

Purchase of exempt assets. This practice is commonplace by Medi-Cal planners in California. Because California has not implemented OBRA '93 which prohibited the practice, people can shelter assets by purchasing an expensive exempt home and then transfer it to someone else without penalty on the reasoning that it is exempt, so not a transfer to qualify. "The only time we have a penalty is when something is transferred to make themselves eligible." (Interview)

"Pyramid divestment," which was prohibited by OBRA '93, is still legal in California. This is the practice of giving away declining amounts of assets each month so that penalty periods run simultaneously, thus reducing the total eligibility penalty. For example, instead of giving away \$200,000 all at once resulting in a 45 month penalty ($\$200,000/\$4400 = 45$), the family might give away \$60,000 one month resulting in an 13 month penalty, \$50,000 the next month resulting in a 11 month penalty running simultaneously, \$40,000 the following month resulting in a nine month simultaneous penalty and so on until the whole \$200,000 is gone with only a 13 month penalty.

Irrevocable burial trust funds are exempt in any amount in California as elsewhere. Staff do not perceive that this exemption is being abused in that annuities and asset transfers are so easy to use.

An internet search for "Medi-Cal Planning in California" reveals innumerable firms that specialize in the field. Two examples:

<http://www.ashensenioreresources.com/index.cfm/entitlements.htm>

Quote: "Ashen Senior Resources [of Carmel, California] has a 100% success rate in getting clients qualified for Medi-Cal. Our clients have NEVER been denied for their Medi-Cal entitlements. The truth is that almost everyone can qualify for nursing home Medi-Cal benefits, but it's all in knowing how." (Emphasis in the original.)

http://www.falkandcornell.com/default.aspx?daURL=/ELMS/elms_index.asp

Quote from Falk, Cornell & Associates, LLP of Palo Alto California: "Many people cannot afford to pay \$3,000-\$5,000 per month or more for the cost of a nursing home . . . Fortunately, the Medicaid Program is there to help. In fact, in our lifetime, Medicaid has

become the long term care insurance of the middle class. But, the eligibility to receive Medicaid benefits requires that you pass certain tests on the amount of income and assets that you have. The reason for Medicaid planning is simple... you plan so that if you need it, you will be eligible to receive Medicaid benefits."

Following are excerpts from Evan Halper, "Public Pays for Wealthy Seniors' Care," *Los Angeles Times*, May 2, 2004, which is archived at:

<http://pqasb.pqarchiver.com/latimes/results.html?QryTxt=halper> :

"For older Californians distressed by the thought of nursing home bills devouring their savings, the words of a Los Angeles attorney may seem astonishing: 'We can qualify even a millionaire for Medi-Cal benefits.' But as troubled as they may be by such an offer, officials at California's healthcare program for the poor admit it's possible. At a tremendous cost to taxpayers, aging Americans in California and across the nation are transforming themselves, at least on paper, from affluent seniors to needy individuals eligible for state health benefits. . . . Clients can pour all of their money into an expensive new house and still qualify. If they tell the state that their intention is to return to that home, the state can't take it. The house can then be transferred to relatives while the patient is in a nursing home, and the state can't go after it once the patient dies. . . . 'We have tried to tighten all the loopholes we are aware of that can be tightened under federal law,' said Stan Rosenstein, who oversees the Medi-Cal program. 'There are some loopholes in the federal law that we can't touch.' . . . Most elder-law experts . . . say that if recipients fill out the paperwork properly before entering the system, they can keep the state from ever having a claim on their property. . . ." For longer excerpts from this and other similar articles, see "LTC Bullet: Medicaid Planning and Estate Recovery Issues Are Heating Up," Wednesday, May 12, 2004 in the LTC Bullet archives at <http://www.centerltc.com/> .

"A Placer County [California] attorney who advises seniors throughout the state on how to qualify for state health care benefits is under investigation on suspicion of defrauding the state's Medi-Cal program of \$50 million, according to a search warrant affidavit unsealed in Sacramento Superior Court." To read the whole story, go to http://www.sacbee.com/content/community_news/placer/story/8571151p-9499485c.html

Medicaid Estate Recoveries: California has a very aggressive and successful estate recovery program. The state reported over \$39 million in "probate recoveries" to the federal government in 2002 and estimates total estate recoveries of \$49 million for state fiscal year 2004 (July 2003 to June 2004.) MER staff estimate a 20 to one ratio of recoveries to the cost of collection meaning the state spends a nickel to collect each dollar. Nevertheless, although the MER unit is authorized a staff of 40, it has only been able to hire 30 because of a hiring freeze which does not exempt revenue-producing divisions. California, which previously had a recovery threshold of \$500, currently does not recover from estates of less than \$2500 because of these staff shortages. Inadequate staffing also prevents the MER unit from pursuing recoveries from the estates of most surviving spouses of Medi-Cal recipients. A 1989 GAO study estimated California could increase estate recoveries 70% by pursuing spousal recoveries.⁹³ California has implemented the expanded definition of "estate," as authorized by OBRA '93.

Recipients' \$2,000 personal accounts with nursing homes and banks are not required to be sent to the MER unit automatically upon the recipient's death and are often taken first by families and must then be recovered from the estate. The state does not have a timely process of notification upon the death of recipients, but rather waits for a data match with Vital Records. Local eligibility workers in the counties are deemed to be too busy with other duties to make this notification.

The MER unit's retiring director said: "I believe if we had all the systems and people we need including legal support and the ability to track surviving spouses instead of the bailing wire and band aid system we have now, doubling estate recoveries would be a certainty. How much we could recover over that is anybody's guess. I think we could collect \$100,000,000, if we reduced the recovery ratio to 15 to 1, but that is conjecture. California experiences 80,000 plus Medi-Cal deaths over age 55 every year, but we open only 4000 cases. Our average claim collected is \$15,000 to \$20,000 [which is very high]." (Interview)

Home and Community-Based Services: California spent \$399.04 per elderly resident for Medi-Cal HCBS, ranking the state #16 nationally. This relatively generous provisions of more desirable services (as compared to nursing facility care) probably increases demand for Medi-Cal and lowers demand for private LTC insurance without affecting demand for home equity conversion in that homes are exempt.

Long-Term Care Insurance: California has a tax incentive to encourage the purchase of long-term care insurance and a very strong and relatively successful LTC Partnership program.⁹⁴ Yet, the state's LTCi market penetration is only 6% to 9%. California's extremely generous Medi-Cal long-term care eligibility rules probably discourage early planning and insurance against this risk. The state's strong estate recovery program is doubtlessly a partial counterbalance, but weakened by the fact that most people do not learn about estate recovery until they become eligible for Medi-Cal.

Home Equity Conversion: California has a high HECM market penetration rate with 9.0 home equity conversion mortgages for every 1000 elderly citizens. Given the fact that California exempts recipients' homes and allows transfers of the homes after eligibility is determined, it is unlikely that long-term care costs are driving the use of home equity conversion in the state. Rather, it would appear that high home values combined with plummeting interest rates led California seniors to tap their home equity to maintain monthly income and customary life style.

Medicaid Nursing Home Census: California's Medi-Cal nursing home census is 66.12%, ranking the state 24th in the country, and almost equaling the national average of 66.27%.

Connecticut State Profile (Private plus, Medicaid minus)

Medicaid Eligibility (Subjective rank from 1, easy to 5, hard):	4
Medicaid Estate Recoveries—Probate (Percent, Rank):	.79%, 23
HCBS (Expenditures per capita, Rank):	\$692.67, 5
LTCi Market Penetration:	6%-9%
Home Equity Conversion (HECMs per 1000 elderly, Rank):	9.3, 6
Medicaid Census (Percent, Rank):	66.48%, 22
Predictability (Plus +, Minus -, or Mixed ±):	+

Diagnosis: Connecticut's long-term care service delivery and financing system is a mixed bag. Because it is a "209b" state, Connecticut can maintain stricter Medicaid eligibility rules than most states, and it does. Furthermore, the "1115" demonstration waiver Connecticut has requested indicates a desire to tighten eligibility even further. Connecticut's Medicaid estate recovery program is strong and more effective than most although it ranks only in the middle among states in percentage recoveries, probably because total Medicaid LTC expenditures are so high in the state. Nevertheless, Medicaid estate planning is very strong in Connecticut and an "entitlement mentality" prevails in public opinion. Very high state spending for home and community-based services under Medicaid sends a strong message that program eligibility is very highly desirable. Putting these counterbalancing factors together, it is not surprising that Connecticut has only moderate LTCi market penetration and a Medicaid nursing home census only slightly less than the national average. The state's high home equity conversion market penetration probably reflects the high property values in the state as well as Connecticut's relatively stringent Medicaid LTC eligibility and estate recovery.

Prognosis: State officials in Connecticut have seen the handwriting on the wall. Medicaid cannot go on supplying long-term care, especially in HCBS settings, to middle and upper middle class people and still provide a high-quality safety net for the needy. The state has responsibly studied the problem and taken limited action to correct it, but much more attention to the issue will be necessary to reverse the public's expectation, and Medicaid planners' promises, that long-term care can be had at public expense without spending down one's own savings.

Prescription: As we've explained elsewhere and repeatedly in this report, states' hands are tied by restrictive federal rules when it comes to targeting Medicaid LTC benefits to the genuinely needy and reducing artificial impoverishment through Medicaid estate planning. Connecticut has already done much of what it is able to do under federal law toward this end. Something unique is being considered in Connecticut, however, as the following news report suggests: 'Connecticut officials are exploring a controversial approach to Medicaid that's designed to rein in spending on the program. An unsigned memo from the administration of Gov. John Rowland (R) to the Centers for Medicare & Medicaid Services proposes testing a system under which the federal government would give the state a lump-sum block grant to cover its share of Medicaid costs, the *Hartford*

Courant reports. The state in turn would get more control over which services to cover.¹⁹⁵

Perhaps through a program of this kind, Connecticut could expand the transfer of assets lookback period, require consumption of illiquid real property assets by means of a reverse mortgage, substantially reduce the cost of Medicaid, and thus improve the program's ability to provide a wide range of high quality LTC services to the genuinely needy. Such a program would likely increase market penetration of LTCi insurance and HEC while reducing Medicaid nursing home census thus increasing state tax revenue while reducing LTC costs. Failing the achievement of these authorities under a block grant approach, Connecticut should continue to pursue the same objectives to the extent possible under existing federal statutory and waiver authorities.

Medicaid LTC Eligibility:

Medically needy: Medical expenses deducted from income.

Partial month transfer of assets penalty. Unlike many other states that round down monthly transfers and hence allow transfers up to double their average nursing home rate less one dollar each month, Connecticut prorates the penalty period to reflect the actual amount transferred. The state's average nursing home cost is high at \$7417 which is the amount that can be transferred in a month without incurring any additional penalty, as compared to \$14,833 if Connecticut rounded down.

Connecticut changed from a "resource first" to an "income first" state in July 2003, thus making its Medicaid LTC eligibility stricter by eliminating the ability of applicants to push the CSRA higher by transferring assets instead of income to bring the community spouse up to the MMMNA.

The Connecticut Department of Social Services has also linked annuities to trusts for purposes of determining transfer of assets penalties and spelled out what "exceptional circumstances" and "financial duress" mean in order "to make eligibility harder to obtain." (Survey)⁹⁶

Home is exempt for six months with a physician's statement (renewable upon review every six months) specifying that recipient is expected to return home. Connecticut can legally impose this restriction because it is a "209b" state. "209b" is a special provision in the Medicaid law that allowed states with stricter eligibility rules to retain them when the program was implemented.

Connecticut has studied the problem of Medicaid estate planning (twice in the 1990s) and acted by requesting an "1115" demonstration waiver to tighten eligibility and discourage artificial impoverishment techniques. The waiver request (available at http://www.dss.state.ct.us/pubs/TOA_proposal.pdf) seeks to discourage transfer of assets and to eliminate the half-a-loaf strategy by extending the lookback period for real property transfers from 36 months to 60 months and by starting the penalty for transfer of

assets from the date an applicant would otherwise have become eligible instead of from the date of the transfer. The state estimates a savings of nearly \$88 million for the five-year duration of this demonstration.

This waiver request is highly controversial and remains under consideration by CMS. "We've encountered strong opposition to such changes. There is strong sentiment that the elderly should be able to pass on assets. At same time, we are talking about cutting dental benefits for the most needy. The poorest of the poor get hit; those that can afford it come out unscathed." (Interview)⁹⁷

Medicaid has a strong Medicaid planning bar. Staff "see advertisements claiming they can teach people how to prevent states and nursing homes from 'gobbling up their assets.'" Lawyers call asking staff about exclusions and exemptions.

"Half-a-loaf" is the most common strategy used. Staff estimate asset sheltering or divestiture are involved in one-third of all cases.

Life estates? "We've seen many of them. Standard operating procedure is to quitclaim the property and retain a life estate. The life estate is an inaccessible asset. The quitclaim is done outside the three-year lookback or it is done so the penalty will run out before eligibility. Commonplace, although not necessarily done for Medicaid, but rather often for tax and estate planning." (Interview)

An internet search for "Medicaid Planning in Connecticut" reveals numerous firms that specialize in the field. Some examples:

<http://www.linnealevine.com/HomePage.shtml>

Quote: "The Law Offices of Linnea J. Levine [Stamford, Connecticut] assists [sic] families with the daunting task of planning for Medicaid coverage. Income and asset amounts play a critical role in the ability to qualify for benefits. If an individual's income exceeds a certain amount, alternative planning devices must be implemented in order to qualify for Medicaid. Many legal remedies and solutions are available to overcome the stringent guidelines required for Medicaid eligibility. Our lawyers evaluate and assess each situation in an effort to simplify the application process and preserve assets for the individual's family."

<http://www.connecticutestateplanningelderlaw.com/index.html>

Quote: "If my family member is already in a [nursing] home or the hospital, is it too late to do anything? No. Planning can be done to preserve assets for almost all clients even if they are already in a long term care facility."

<http://www.elderlawalliance.com/Default.asp> (website of the Elder Law Alliance, which includes a Connecticut member)

Quote: "The key to Medicaid planning is to act quickly. Failure to act eventually costs a considerable amount of money. If a nursing home cost in a particular state is \$5,000 per month, then that is the cost of additional months of nursing home care that the family

must pay. Since the Medicaid penalties for transfers begin at the date of the transfer, it is possible to protect significant assets by planning early. In those cases where planning was not done and the person is already in a nursing home assets can also be protected, but the earlier the planning is done, the more money is saved."

Medicaid Estate Recoveries: Connecticut has a very active and effective estate recovery program. The state estimates Medicaid estate recoveries for state fiscal year 2003 to exceed \$10 million. Fourteen staff administer the program at a cost of approximately \$700,000 per year, or seven cents for every dollar recovered, a 14 to one recovery ratio. The threshold to recover is \$100 or cost effectiveness.

The state will recover hard assets, such as automobiles, jewelry, silverware, etc., and auction them unless the family labels such assets as "personal effects."

"Value rich, cash poor estates are fairly common here. Real estate is very valuable in Connecticut. If the family wants to keep and live in the deceased recipient's house, we have a statute that allows the Commissioner to take back a mortgage in satisfaction of the claim. It may include interest payments or not. We have had that option for years and we have some old mortgages." (Interview)

The state of Connecticut is a preferred creditor and is next in line after estate administration costs and expenses of the last illness and funeral. No spousal recoveries unless community spouse predeceases the Medicaid spouse.

Nursing homes routinely send patient accounts to the estate recovery unit when a recipient dies, but these checks cannot be cashed until the state is appointed by the probate court.

Connecticut has expanded the definition of "estate" partially to include annuities, but not to include assets that pass in joint tenancy with right of survivorship, as authorized by OBRA '93.

"Legislators are very reluctant to say we should have the state get money instead of the adult kids. There is a breaking point coming. Truly poor people get screwed currently; those with money, benefit. But there is no will to expand restrictions." (Interview)

Obstacles to recovery? "Biggest problem is that people assume Title XIX is paid by tax money so why should they have to pay it back? Something is fundamentally skewed when poor people can't get basic services, but loopholes in federal code allow a very active, sophisticated elder law bar to preserve maximum use of money for recipients' family members." (Interview)

Upside potential? State staff estimate that Medicaid estate recoveries could increase from \$10 million to \$12 or \$13 million per year if they had the ability to pursue joint property, right of survivorship, and special needs trusts more aggressively.

Home and Community-Based Services: Connecticut spends \$692.67 per elderly resident on Medicaid home and community-based ranking the state 5th in the country. "Yes, this is a strong program. There is no cap on the number of enrollees. It seems to be the most desirable alternative to nursing home care." (Survey) "Our home care program has been increasing 10% a year; we don't have a waiting list; awareness is fairly strong and increasing."

Long-Term Care Insurance: Long-term care insurance market penetration in Connecticut is moderate at 6%-9% despite the state's strong LTC Partnership program. State staff speculated as to the reason: "Due to loopholes, LTC insurance is a hard sell. Why purchase it when they can avail themselves of Medicaid through estate planning mechanisms?" (Survey)

Home Equity Conversion: HEC market penetration in Connecticut is high at 9.3 HECMs per 1000 elderly recipients ranking the state 6th in the nation.

Medicaid Nursing Home Census: Connecticut's Medicaid nursing home census is slightly above average at 66.48% with the state ranking 22nd in the country.

Minnesota State Profile (Private plus, Medicaid minus)

Medicaid Eligibility (Subjective rank from 1, easy to 5, hard):	3
Medicaid Estate Recoveries—Probate (Percent, Rank):	1.71%, 7
HCBS (Expenditures per capita, Rank):	\$563.33, 9
LTCi Market Penetration:	10%-14%
Home Equity Conversion (HECMs per 1000 elderly, Rank):	6.6, 14
Medicaid Census (Percent, Rank):	59.01%, 43
Predictability (Plus +, Minus -, or Mixed ±):	+

Diagnosis: Minnesota is better positioned to move Medicaid and long-term care financing policy in the right direction than any of the other states reviewed in this study. The Minnesota Department of Human Services appointed a Long Term Care Task Force to review this issue. It produced an excellent report in January 2001: <http://www.dhs.state.mn.us/Agingint/Ltctaskforce/report.htm - intro> . Although their report emphasized expanding HCBS, it did so in the context of encouraging personal responsibility for long-term care, especially private LTCi. Minnesota has requested a demonstration waiver to implement very aggressive measures to discourage Medicaid planning as described below. The state's strong policies have already translated into high LTCi and HEC market penetration and low Medicaid nursing home census.

Prognosis: The future is bleak for every state in long-term care financing because of outdated federal rules that prevent creative experimentation with more sensible policy. But Minnesota is better positioned than most states to adapt.

Prescription: Minnesota should stay on its current track with regard to controlling Medicaid LTC eligibility and encouraging estate recoveries. In fact, the state should redouble such efforts. Minnesota is a leader in this area and should consider mobilizing support from other states to bring pressure on CMS to approve its demonstration waiver. Minnesota should join other states to advocate for more freedom for state Medicaid programs to experiment—even without waivers—with initiatives to target Medicaid LTC benefits to the needy and encourage private financing alternatives like LTCi and HEC.

Medicaid LTC Eligibility:

Medically needy LTC eligibility system which allows deduction of medical expenses, including private nursing home care, from income before eligibility is determined.

Minimum CSRA is \$26,109, which is somewhat above the federal minimum of \$18,552 for 2004.

"Income first" state; transfer of assets to raise the community spouse to the MMMNA is not allowed.

Minnesota enforces a partial month transfer of assets rule. Transfers that exceed the average nursing home cost of \$3848 by more than \$200 incur a partial month's penalty. Unlike many other states, Minnesota does not round down to the next lowest month.

Home exemption: For people residing in a LTC facility, the homestead is excluded for the first six calendar months of LTCF residence, for as long as it is the residence of a qualifying relative or for as long as the LTC resident intends to return home and can reasonably be expected to return home. Minnesota can legally impose this 6-month restriction because it is a "209b" state. "209b" is a special provision in the Medicaid law that allowed states with stricter eligibility rules to retain them when the program was implemented.

Half-a-loaf and transfer assets outside the look back period? "A lot of the elder law attorneys recommend half-a-loaf. For those who do go to Medicaid planners, it is common to do that. Our waiver is intended to attack that strategy. . . . I also think it is fairly common to transfer assets outside the lookback period, especially with real estate. They do it way in advance. Sometimes they set up family trusts too. We catch up with a lot of those because not done five years back. Families that go to attorneys often plan way in advance. Hard for us to track." (Interview)⁹⁸

Annuities? "We have some state regulations to tackle annuities in addition to the federal regulations. We don't recognize private annuities, only commercial ones. Life expectancy has to reflect any terminal illness diagnosis. We are allowed to use a shorter life expectancy than normal life tables. This must be verified by a physician. We have a ruling from CMS that annuities can be marketable. If purchased to reduce marital assets, we still count it as asset." (Interview)

Life estates? "Very common. Seems like I'm looking at them all the time, but probably less than 50%. Quite a few still own homes, especially couples. Close to 65% to 70% of people are single or widowed. Of the single people, many no longer have homesteads but may still have a life estate." (Interview)

Although Minnesota has not conducted a formal study of Medicaid estate planning or liens and estate recoveries, the state has moved aggressively through legislative action to address the use of annuities, burial contracts and transfers of income and assets. (Survey) For details, see <http://www.dhs.state.mn.us/FMO/LegalMgt/Bulletins/pdf/2002/02-21-08.pdf>.

Minnesota has also sought a path-breaking "1115" demonstration waiver from CMS to allow the state to extend the lookback period for asset transfers to 72 months, to begin the penalty period when the applicant would otherwise be eligible instead of at the date of the transfer, and to apply other stricter limitations on the "Transfer of Excluded Assets," "Complete Ineligibility for Medical Assistance," "Penalty Period Divisor," "Permissible Homestead Transfers to Relatives," "Medical Assistance Recipient Transfers to Spouses," and "Transfers to Trusts." For details, see <http://www.dhs.state.mn.us/HealthCare/waivers/Asset-Transfers-Waiver-2003.pdf>.

Minnesota has a "strong Medicaid estate planning bar. Annual seminars devoted to the topic are held, and presentations are made at a number of related legal education classes. Outright gifting of real and personal property, along with planning of ineligibility periods, is used most often. Life estates are a common vehicle for transferring real property. The purchase of annuities and establishing trusts are also common. New vehicles, such as the family limited partnership and business trusts have also been seen. Although these practices are fairly common it is not possible to estimate the percentage of nursing home cases that involve sheltering. Those who are more affluent will work with an attorney or other financial planner to shelter as many assets as possible. Those with less assets may only establish a life estate interest in real property in an attempt to transfer their real property to others." (Survey)⁹⁹

Medicaid Estate Recoveries: Minnesota estimates \$12.4 million for MER (which are collected by the counties) and \$4.2 million for lien recoveries (which are collected by the state) for state fiscal year 2003. The state reported \$18.7 million in probate recoveries to CMS for 2002, which is 1.7% of total Medicaid LTC expenditures and ranks Minnesota 7th in the country for estate recoveries.

The state has no record of the cost of recovery because estate recoveries are done at the county level. The counties retain half of the nonfederal portion of these recoveries.

Minnesota sets no minimum threshold for recoveries but pursues recovery only if cost-effective.

Minnesota does not use auctions to dispose of hard assets but rather requires liquidation of estates.

Heirs are allowed to pay back estate recovery liability over time without interest under certain circumstances. "We'll do whatever we can to help people." (Interview)

The counties do pursue recoveries from the estates of surviving spouses of Medicaid recipients. "Historically, those are large recoveries too. Maybe because of Medicaid planning." (Interview)

Minnesota has adopted the expanded definition of "estate" to include annuities and joint tenancy with right of survivorship, as authorized by OBRA '93. "And we're hip deep in litigation over it." (Interview)

Obstacles to recovery: "The ultimate issue is whether people use their resources to pay for their own care or not, because this is supposed to be a system to provide care for people who can't pay for their own care. One of the biggest headaches we have is the use of trusts and annuities to become eligible for Medicaid and evade MER. It's a way to raid the public treasury." (Interview)

Home and Community-Based Services: Minnesota spends \$563.33 per elderly resident on Medicaid home and community-based care, ranking 9th in the country. "Minnesota has offered HCBS alternatives for the elderly in the Medicaid program since 1982. Minnesota currently has a number of MA [Medical Assistance, i.e. Medicaid] waivers which pay for home and community-based services for persons who are elderly or have disabilities. . . . Minnesota also assists people with their home and community-based expenses through the Alternative Care Program. This program is funded with state dollars and is intended for people who are at a nursing home level of care, age 65 or older and are not eligible for MA." (Survey)

Long-Term Care Insurance: LTCi market penetration in Minnesota is predictably high at 10% to 14% given the state's serious efforts to control Medicaid LTC eligibility, collect from estates, and encourage personal planning and insurance for the LTC risk. Insurance counseling, including counseling about LTC insurance and reverse mortgages, is available through the Department of Human Services (DHS) Website at <http://www.dhs.state.mn.us/Agingint/Services/ship.htm>. DHS offers LTC insurance to its employees. Minnesota has no Long-Term Care Partnership program. The state does provide a tax incentive for long-term care insurance: "A credit is allowed for long term care insurance premiums during the taxable year equal to the lesser of : (1) 25% of premiums paid to the extent not deducted in determining federal taxable income; or (2) \$100."¹⁰⁰

Home Equity Conversion: HEC market penetration is also high in Minnesota with 6.6 HECMs per 1000 elderly residents, ranking the state 14th in the country. Counseling about reverse mortgages is available through the Department of Human Services (DHS) Website at <http://www.dhs.state.mn.us/Agingint/Services/ship.htm>.

Medicaid Nursing Home Census: As one would expect given Minnesota's responsible Medicaid and long-term care financing policy, state's Medicaid nursing home census is very low at 59.01%, ranking Minnesota 43rd on this measure in the country. Nevertheless, the state is sensitive to pressures in the opposite direction: "Medicaid resident census has increased in the past 10 years. We do not have specific statistics readily available for the prior 10 years, however it has increased several percentage point during that time period. This is attributable to both eligibility bracket creep and Medicaid estate planning. Medicaid budget expenditures with regard to Long Term Care have been steadily rising due to a variety of factors." (Survey)

Nebraska State Profile¹⁰¹ **(Private plus, Medicaid minus)**

Medicaid Eligibility (Subjective rank from 1, easy to 5, hard):	4
Medicaid Estate Recoveries—Probate (Percent, Rank):	.21, 41
HCBS (Expenditures per capita, Rank):	\$250.37, 26
LTCi Market Penetration:	15%+
Home Equity Conversion (HECMs per 1000 elderly, Rank):	2.2, 39
Medicaid Census (Percent and Rank):	53.76%, 50
Predictability (Plus +, Minus -, or Mixed ±):	± (2 of 3)

Diagnosis: Traditional heartland values of self-reliance and personal responsibility combined with a relatively strict Medicaid long-term care eligibility system have produced in Nebraska one of the highest long-term care insurance market penetrations and one of the lowest Medicaid nursing home censuses in the country. Home equity conversion market penetration is low in Nebraska but that appears to be caused less by Medicaid planning than by an estate planning convention that older Nebraskans routinely pass their property (including homes, farms and businesses) to their progeny relatively early, in their late 60's or early 70's.

Nebraska's worrisome aging demographics compel serious consideration of ways to control Medicaid long-term care expenses. Nebraska must cope with nearly half again as many "old-old" (over age 85) residents *per capita* in the future as compared to the rest of the country.¹⁰² The share of persons age 85 and older, the age group most likely to need long-term care, will rise from 1.5 percent to 1.9 percent between 2000 and 2020 in the United States. The comparable increase in Nebraska is from 2.0 percent to 2.7 percent.¹⁰³

Prognosis: Many respondents interviewed for the Center for Long-Term Care Financing's "Heartland Model" study worried that a much stronger "entitlement mentality" is taking hold in Nebraska. Concerns about escalating Medicaid expenditures, especially for long-term care, have impelled state legislators and policymakers to seriously consider measures to control eligibility and increase estate recoveries. The good news for Nebraska is that the state has a much more solid foundation on which to build compared to Medicaid long-term care programs in most other states.

Prescription: To tap the potential resources itemized below, Nebraska will need to pass laws, operationalize programs, and possibly seek waivers and/or changes to federal law. Specifically: Encourage LTCi and HEC with education and tax incentives. Enhance estate recoveries by studying successful programs and increasing staff. Make sure eligibility workers and the public know Medicaid is welfare and enforce the rules consistently. Conduct a valid random sample of LTC cases to estimate leakage from asset transfers of all kinds. Seek an "1115" waiver like Connecticut, Minnesota, and Massachusetts. Fight financial abuse of the elderly like Oregon by appointing conservators to recover stolen money and represent clients' and the state's interests. Revisit Nebraska's 1997 LTC Plan and implement the other half of its recommendations

that have not yet been pursued. Stop the slide into "entitlement mentality" by passing the "Heartland Manifesto."¹⁰⁴

According to state staff, reducing the percentage of nursing facility days paid by Nebraska Medicaid to 44.4 percent from the current 54.4 percent would subtract **\$54 million** from the cost of the program. If Nebraska were to recover an equivalent proportion of its long-term care expenditures from the estates of deceased recipients at a similar rate of recovery compared to Oregon, the state would generate approximately **\$12 million** per year in non-tax revenue at a cost of only \$590,000 per year. With approximately 7,800 Medicaid recipients in nursing facilities and 2,000 in assisted living facilities at any given time, as much as **\$31 million** is exempted from estate recovery by Nebraska's exceptionally high \$5,000 recovery threshold. Assuming only 80 percent of Nebraska's 9,800 Medicaid recipients residing in nursing homes or assisted living facilities have set aside an average of \$6,500 for their burials, we can estimate conservatively that **\$51 million** has been diverted from private long-term care financing to a Medicaid expenditure in this way. When asked to give a "conservative" estimate of the percentage of cases in which a property transfer occurs, eligibility workers responded that 20 percent of their long-term care cases averaging \$25,000 "on the low end" would be their "best guess." Hypothetically projecting this estimate statewide would suggest that up to **\$49 million** may have avoided the transfer of assets penalty given Nebraska's current long-term care caseload.

Medicaid LTC Eligibility: Nebraska utilizes a "medically needy" eligibility determination system in which the costs of medical expenses, including nursing home care, are deducted from an applicant's income before income eligibility is determined. This system is marginally more generous than the "income cap" systems used in 15 other states, but Nebraska is stricter than most other states in other aspects of its Medicaid LTC eligibility system. For example, the state allows applicants who own homes or businesses only six months to sell their property unless they can show proof they will be able to return home. Sale proceeds are required to be spent down before eligibility is allowed.

Nebraska is an "income first" state and does not allow "transfer of assets before income" to increase the Community Spouse Resource Allowance.

Although Medicaid estate planning (i.e., artificial self-impoverishment to qualify for Medicaid long-term care benefits) is not nearly as prevalent in Nebraska as in many other states, there is evidence that the practice is increasing, based on comments from interviewees.

Large amounts of wealth are passed from older to younger generations in Nebraska for reasons other than (or in addition to) qualifying for Medicaid. Such transfers of homes, businesses, farms and ranches—done in the normal course of estate planning—have the (perhaps) unintentional but nevertheless devastating effect of drastically reducing the assets of future long-term care patients that might otherwise have been spent down privately prior to qualification for Medicaid long-term care benefits.¹⁰⁵ The faster people

spend down to Medicaid asset levels, the sooner they become dependents of the state and the greater the cost of the program.

Medicaid Estate Recoveries: Nebraska has a Medicaid estate recovery program, but its recoveries are severely constrained by low staffing, limited organizational authority, and restrictions in state law. One full time equivalent (FTE) Health and Human Services System staff member, supported part time by 1.5 FTE attorneys, generates an average of \$1.2 million per year in Medicaid estate recoveries for Nebraska. State law protects the first \$5,000 of any estate from recovery if the deceased Medicaid recipient is survived by a child of any age. If Nebraska were to recover an equivalent proportion of its long-term care expenditures from the estates of deceased recipients at a similar rate of recovery as Oregon (see the Oregon state profile in this report), the state would generate approximately \$12 million per year in non-tax revenue at a cost of only \$590,000 per year, netting approximately \$10 million per year more than the state currently recovers.

The germane public policy question is whether the purpose of Medicaid is to protect inheritances for heirs or to provide a safety net for access to long-term care for the needy. Such a politically sensitive question is easy to ignore when state revenues are plentiful. When hard choices have to be made, however, about whether to raise taxes or cut services and about who will bear the financial brunt, re-examining the fundamental purpose of Medicaid becomes necessary and more feasible politically.

Home and Community-Based Services: Nebraska has made great strides in the last few years toward deinstitutionalizing Medicaid long-term care recipients and providing them alternative care in the community. State staff report that average monthly nursing facility recipients dropped from 8,743 in 1996 to 7,872 in 2003. In the same period, Nebraska's home and community-based waiver (home care and assisted living) slots increased from 600 to 4,200.

Although Nebraska's Medicaid program has creatively increased cost-effective home and community-based alternatives to expensive nursing home institutionalization, the state has already de-institutionalized most of the lowest acuity nursing home patients. Further relocation of Medicaid recipients into the community will be ever more difficult because those remaining in nursing facilities are the most frail or infirm.

Another concern raised by the State Medicaid Director is the "woodwork factor," i.e. the tendency for added home care or assisted living slots to be quickly filled by persons in the community who were previously managing somehow without state support.

Ironically, the more attractive Nebraska makes Medicaid long-term care services by providing services in the home and community, the less likely Nebraskans will be to plan, save, invest or insure to be able to pay for their own long-term care and the more likely they will be to plan for Medicaid eligibility. Thus, controlling eligibility for Medicaid long-term care benefits is critical to the goal of improving the program's services without increasing costs.

Long-Term Care Insurance: Nebraska has one of the highest market penetrations for private long-term care insurance in the country—over 15 percent. Other states in the Heartland have similarly high rates of long-term care insurance and concomitantly high private-pay nursing home censuses.¹⁰⁶ This is important because people who pay privately for nursing home care often pay half again as much as the Medicaid reimbursement rate.¹⁰⁷ Nevertheless, the State of Nebraska made a long-term care insurance policy available to state employees in 1997, but terminated the program in January 2004 for lack of demand.

Nebraska has no tax incentive for the purchase of long-term care insurance and no LTCi Partnership program.

Home Equity Conversion: More Nebraskan seniors own their homes on average (80.8 percent) than is true for the country as a whole (79.4 percent). The state ranks 22 in the nation for home ownership by the elderly. This is important because home value represents the single biggest asset most seniors possess. Home equity can ensure access to quality long-term care in the private marketplace for seniors who might not otherwise be able to afford care or private insurance.¹⁰⁸

Medicaid Nursing Home Census: Nebraska had the lowest Medicaid nursing home census in the United States as of 2002. Medicaid covered only 52.8 percent of nursing home residents in Nebraska, as compared to an average of 66.7 percent for the country as a whole.¹⁰⁹ This is important because higher dependency on relatively low Medicaid reimbursements for nursing home care can exacerbate financial, staffing and quality problems.

Oregon State Profile **(Private plus, Medicaid minus)**

Medicaid Eligibility (Subjective rank from 1, easy to 5, hard):	3
Medicaid Estate Recoveries—Probate (Percent, Rank):	5.87%, 2
HCBS (Expenditures per capita, Rank):	\$636.97, 6
LTCi Market Penetration:	6%-9%
Home Equity Conversion (HECMs per 1000 elderly, Rank):	7.4, 10
Medicaid Census (Percent, Rank):	61.12%, 41
Predictability (Plus +, Minus -, or Mixed ±):	+

Diagnosis: Oregon's long-term care system is not perfect, but the state is doing several things right that most other states get wrong. Medicaid long-term care eligibility in Oregon cannot be called strict, but it is considerably tighter than in many states, utilizing income cap eligibility instead of a Medically needy system and disallowing "resource first" transfers. Oregon has one of the most advanced and successful Medicaid estate recovery programs in the country, recovering nearly 6% of total Medicaid LTC expenditures from the estates of deceased recipients. The state has focused for over 20 years on expanding HCBS and deinstitutionalizing nursing facility residents. Nevertheless, Oregon's LTCi and HEC market penetration are high at 10%-14% and 7.4 HECMs per 1000 elderly, respectively, and the state's nursing home census is relatively low at 61.12%. Arguably, Oregon has been able to focus on HCBS without creating too large a "woodwork" factor because the state maintains relatively tight controls on eligibility and enforces strong estate recoveries, which make Medicaid less available and attractive to the middle class. Upper middle class people who consult Oregon's large stable of Medicaid planners are still able to qualify with considerable ease.

Prognosis: Although Oregon faces the same kinds of fiscal constraints that bedevil other states and it must cope with special challenges related to support of many small adult family homes and HCBS, the state is better positioned than most to adjust to future demographic pressures.

Prescription: Oregon should build on its relatively solid LTC foundation. The state should systematically study how other states have controlled Medicaid LTC eligibility and implement additional measures to ensure scarce Medicaid resources go only to the truly needy. Oregon should join Minnesota, Massachusetts, and Connecticut in requesting an "1115" waiver from CMS to extend the transfer of assets (TOA) look back period, to start the TOA penalty at the date of Medicaid application instead of at the date of the transfer, and to implement other eligibility controls. The state should allow the Medicaid estate recovery program to hire four additional staff in order to achieve the extra \$8 million staff estimate could be recovered. Oregon should capitalize on its exemplary Medicaid estate recovery program by educating the public that Medicaid is means-tested public assistance, that spenddown is required, that exempt assets retained are subject to estate recovery, that no one with significant wealth should expect to receive Medicaid long-term care benefits without repayment, and that anyone healthy and affluent enough should purchase private LTC insurance. The state should encourage the

use of home equity to pay for long-term care and work with CMS to find a way, either by waiver or by a change in federal law, to mandate consumption of home equity through a reverse mortgage as a condition of Medicaid LTC eligibility.

Medicaid LTC Eligibility:

Income cap eligibility system with Miller income trusts used by 6% of HCBS and nursing home recipients.

"Income first;" no transfer assets before income.

Oregon does not use a partial month transfer of assets penalty so applicants can give away double the average cost of a nursing home (\$4300) or \$8600 less one dollar without incurring more than the current month as an eligibility penalty.

Subjective "intent to return" means home remains exempt regardless of ability to return.

Oregon has a strong Medicaid planning and elder law bar. Examples of Medicaid planning techniques: purchase a single premium annuity with the community spouse as the annuitant which allows immediate eligibility and avoids private-pay spenddown; for couples who can afford the legal fees, get a spousal support order that increases the MMMNA [Minimum Monthly Maintenance Needs Allowance] so that a higher CSRA [Community Spouse Resource Allowance] is needed to generate the income needed by the community spouse to meet living expenses; court-ordered division of resources sought by elder law attorneys who request a district court judge to grant all of the marital assets to the community spouse routinely allowed up to an unwritten limit of double the CSRA. Staff estimate 5% of recipients use asset divestiture or sheltering.

"There is a strong Medicaid estate planning bar in Oregon. With the spousal impoverishment changes [MCCA '88], the Oregon state bar established an elder law section that deals specifically with Medicaid and estate planning. Seminars are provided for clients explaining options and attorneys do call the Department to seek information on exclusions and exemptions. Oregon has never conducted a study to determine how serious an issue Medicaid planning might be." (Survey)¹¹⁰

Medicaid Estate Recoveries: Oregon ranks #2 in estate recoveries nationally and returns nearly 6% of its total nursing home and HCBS Medicaid costs to state coffers each year.

Estate recovery staff estimate they collected \$16 million during the 2002-2003 state fiscal year employing 21 FTES (full time equivalent staff) giving a cost benefit ratio of \$14 collected for every dollar invested in estate recovery.¹¹¹

MER Unit management: "If we dropped to a 10 to one return, with a few additional staff, we could bring Medicaid recoveries up by half to \$24,000,000. We have only pursued the low hanging fruit so far. 25 people could bring in \$24 million. Four more people to

get \$8 million more. . . . But it is hard to get authorization to hire. The problem is politics." (Interview)¹¹²

Oregon MER staff say "It's a wonder there is anything to recover" given loopholes in eligibility that permit asset shelters and divestiture. They believe stronger eligibility controls and enforcement would reduce Medicaid expenditures and increase estate recoveries.

Oregon estate recovery "best practices:"

Oregon attempts recovery in all cases (at least a bank letter, otherwise a cost benefit criterion) and uses no minimum threshold amount. Its \$2500 per case average recovery is much lower than most states. For example, Nebraska does not pursue estates of less than \$5,000.

Oregon does not use TEFRA liens but is a priority creditor and places toward the top in the hierarchy of who gets paid first in probate. For example, "We get paid before Visa and Sears Roebuck." (Interview)

Oregon pursues recoveries from spouses who are predeceased by a Medicaid recipient spouse and from former recipients who die after leaving Medicaid. One full time probate specialist pursues such cases profitably. Few other states pursue spousal or post-eligibility recoveries.

Oregon's judicial information network (OJIN) sends a monthly report of every probate filed in the State of Oregon to the MER unit.

Personal representatives of deceased Medicaid recipients are required by law to send to the MER unit a notice of death with a copy of the death certificate on all probates, big or small.

Oregon MER can file a "request of notice" with county recorders on any client who has real property so that the county will notify the MER unit of any transaction such as a sale or encumbrance of the property that could reduce its value for estate recovery.

Oregon implemented the expanded definition of estate authorized by OBRA '93 in July 1995. "That increased recoveries significantly because it allowed us to go after life estates, annuities, and survivorship interests. We still don't recover from community spouse annuities, however."

Oregon, unlike most state programs, will "carry paper," such as trust deeds or notes. This is done so families that wish to preserve an asset like a family home are not forced to sell it to satisfy probate but rather can pay back the debt owing the state over time.

"Open ended mortgages" are a special program that allows otherwise nonexempt relatives, such as a disabled sibling or partner, to continue to live in a decedent recipient's

home without having to pay anything and interest free until that person dies. Only then does Oregon recover. This "allows us to be warm and fuzzy but still get our money. It avoids ill will in the community when we accept payment over time." (Interview)

"Some states use a collection agency model. That's the wrong way. We are more like a law office. We're always negotiating, working deals. We provide flexibility. We get angry people, but if we let them know we are willing to work with them, that they can keep the home in the family, and that if they have expenses, we'll try to give them credit, they become more willing to cooperate." (Interview)

Training eligibility staff on estate recoveries is important: "A lot of case workers don't like MER. We have workers say in their narrative 'told client how to avoid estate recovery.' Even the workers who want to do the job right, don't have the resources they need. We have only two eligibility policy specialists for the whole state. . . . Field eligibility units sometimes complain about having to do the notification of recipient deaths, but our recoveries are paying their salaries. A critical element of our program is that we do regular ongoing training of eligibility and case managers in the field units." (Interview)

Proactive advocacy on behalf of abused Medicaid recipients: "If we get a client who has been taken advantage of by adult children, we'll appoint an attorney as a conservator to recover the stolen goods. This is helpful to the case managers." (Interview)

"Foreign recoveries" are recoveries from former recipients who have moved to other states or countries. These can be done cost effectively. "We found a condo in Paris, France and recovered with the help of a French attorney." (Interview)

How are recipients' nursing home or personal accounts (\$2,000) handled? "Nursing homes and other facilities including any service provider who has a personal incidental fund for a client is required by law to send that resource to estate administration upon the recipient's death." (Interview)

Home and Community-Based Services: "Oregon has moved toward HCBS. Since the first HCBS waiver in 1981, Oregon has maximized the placement of individuals in community (rather than nursing facility [NF]) settings. Today, over 81% of senior and physically disabled individuals receive Long-term care services under the Medicaid waiver in a community setting. Only 19% remain in the NF setting." (Survey)¹¹³

Long-Term Care Insurance: Market penetration is 6% to 9%, the second lowest of four levels reported by America's Health Insurance Plans (AHIP).

For policies issued after January 1, 2000, Oregon allows a credit for amounts paid or incurred for long term care insurance by a taxpayer on behalf of the taxpayer, the taxpayer's dependents and parents and for amounts paid or incurred by an employer on behalf of employees. The credit is equal to the lesser of 15% of premiums paid during the tax year or \$500.¹¹⁴

LTCi Partnership state? No.

Home Equity Conversion: Oregon has had 7.4 HECMs per 1000 elderly residents. It ranks #10 in home equity conversion by this measure.

Medicaid Nursing Home Census: Staff estimate that Medicaid census has increased from 60% to 65% in the past 10 years but they do not attribute the increase to Medicaid planning. (Survey)

Conclusions and Recommendations

The United States is the richest country in the world. We have more than enough wealth to ensure access to quality long-term care for all American citizens. Yet our long-term care service delivery and financing system is seriously dysfunctional. It is already on the verge of collapse, a decade before our aging demographic crisis begins in earnest.

Most academics and policy makers dive directly into proposing solutions to the long-term care problem without first analyzing its causes and derivation. Thus, we hear proposals repeatedly made that have no hope of success.

- Shall we add long-term care to Medicare? That would be like adding deck chairs to the Titanic after the incident with the iceberg.
- Shall we ease up on Medicaid eligibility rules and expand welfare to include even more middle and upper-middle class people? That oxymoronic idea would sink the state and federal ships of state quicker than ever.
- Shall we expand government-financed long-term care by incrementally adding home and community-based services to Medicare and Medicaid? Every step in that direction hits a brick wall of fiscal reality.
- Shall we jawbone the public to take personal responsibility for long-term care by saving and insuring against the risk? Everything else we're doing in public policy today contradicts such encouragement and numbs the public to LTC risk.

If proposals like these would work, they'd be in effect and successful by now. But they don't work and they won't work. To figure out why, we have to know what caused our long-term care problems in the first place. That's what this report explained.

Bottom line: we don't spend too little government money on long-term care. We spend too much in the wrong ways. By making Medicaid nursing home benefits routinely available to virtually anyone since 1965, we created a nursing-home based, welfare financed long-term care system that fails everyone, especially the poor. Any proposal to pour more money into such a system to fix it is tantamount to "extinguishing" a fire by dousing it with gasoline.

The correct solution is exactly the opposite. Target scarce public resources to the genuinely needy, create a real long-term care spenddown liability, and most people will voluntarily save, invest or insure to prepare for the risk and cost of long-term care. That is the only way to save Medicaid for the poor and improve long-term care for everyone.

It is the only way to bring critically needed new revenue into the service delivery system. But such a course is politically difficult, some say suicidal. Nonsense. The day is quickly approaching when it will be political suicide NOT to deal responsibly with long-

term care and Medicaid policy. When economic times are good and tax revenues are rolling in, it may be politically expedient to ignore these problems and expand public programs. That's what states did in the 1990s. But times have changed. Budgets are tight. Politicians and public administrators are forced to make tough funding decisions. When the alternative is cutting dental benefits for poor children or axing medications for schizophrenics, the option of requiring affluent seniors to pay for their own long-term care loses much of its political sensitivity.

Furthermore, if you think we've got problems now, just wait a few years until baby boomers start taking money out of Social Security and Medicare instead of contributing 62% of all payroll taxes toward those programs as they do today. The current economic and fiscal crisis, out of which the country is beginning to emerge, should be a clarion call to legislators and policy makers: "Don't make the same mistakes again!" Save Medicaid before it's too late. If you wait until the next economic down cycle, the boomers will be retired and their echo-boomer offspring will be too overburdened supporting Social Security and Medicare. Act now!

But how?

They say the first step to fight an addiction is to recognize you have one, so . . .

- Appropriate the money to study the issues discussed in this report. Find out what other states have done already.
- Document the extent to which Medicaid chills the market for private long-term care financing alternatives.
- Estimate the savings that could accrue to Medicaid by tightening Medicaid eligibility rules and expanding Medicaid estate recoveries.
- Call in your long-term care policy makers and administrators, show them the facts, and get them to admit they've been "Medicaid-holics."

Step two is to mobilize . . .

- Convene all the interest groups concerned about long-term care, e.g. senior advocates, providers, insurers, legislators, program administrators.
- Consolidate support for a plan to improve Medicaid for the needy while diverting others to home equity conversion and private insurance.
- Join with other states to bring pressure on Congress to change the laws and on the Centers for Medicare and Medicaid Services to grant waivers that permit states to target scarce public benefits more effectively.

Step three is to implement . . .

- When and if authorized by federal law or a waiver, make home equity conversion a condition of Medicaid long-term care eligibility.
- In the meantime, do everything possible under existing federal statutes to close the most egregious Medicaid eligibility loopholes, such as those related to annuities, trusts, asset transfers, and life care contracts.
- Implement a strong estate recovery program to generate nontax revenue while making Medicaid a loan, not a grant, for the middle class as intended by federal law.
- Educate the public that long-term care is no longer an entitlement to be ignored but a personal responsibility for which to plan.
- Use the savings in Medicaid that will accrue from the measures above to fund tax incentives for LTC insurance and home equity conversion.

Although these recommendations will not be easy to implement, they will—if implemented—address the underlying problem successfully as never before.

Respondents and Interviewees

Barbara Barnes, Medical Assistance Specialist, Bureau of Medicaid Eligibility Operations and Family Health Plus, New York State Department of Health

Kathanette Barnes, Georgia Department of Community Health (survey respondent)

Cec Brady, Deputy Medicaid Administrator, Nebraska Health and Human Services System (Nebraska study respondent)

Fran Ellington, Director of Recipient and Third Party Services, Georgia Department of Community Health

Roy Fredericks, Manager, Estate Administration Unit, Oregon Department of Human Services

Judy Funke, Income Maintenance Program Consultant for Health Care, Minnesota Department of Human Services (survey and interview respondent)

Liz Hruska, Program Analyst, Legislative Fiscal Office, Nebraska Health and Human Services System (Nebraska study respondent)

Alan Klein, Chief, California Estate Recovery Unit, California Department of Health Services, Third Party Liability Branch

Robin Johnson, Health Program Administrator, Bureau of Third Party Liability, New York State Department of Health

George Kahlandt, Administrator, Public Assistance Unit, Nebraska Health and Human Services System (Nebraska study respondent)

Joey Kellenaers, Management Analyst, New Mexico Department of Health and Human Services

Robert Laederich, Policy Analyst, California Department of Health Services, Medi-Cal Eligibility Branch

Dana McNeil, Program Specialist in Estate Recovery and TPL, Nebraska Health and Human Services System (Nebraska study respondent)

Jeff Miller, Medical Policy Analyst, Oregon Department of Human Services

Richard H. Mills, Assistant Manager, Estate Administration Unit, Oregon Department of Human Services

The Realist's Guide to Medicaid and Long-Term Care

Carol Payne, Management Analyst Supervisor, Third Party Liability Unit, New Mexico Department of Health and Human Services

Dave Rappolee, Medi-Cal Income Eligibility Specialist, California Department of Health Services

Dan Ridge, Policy Analyst, Michigan Department of Community Health

Joe Rubenstein, Staff Attorney, Special Recovery Unit, Minnesota State Department of Human Services

Joanne Schiedler, Medical Policy Analyst, Oregon Department of Human Services, Seniors and People with Disabilities Division (survey respondent)

Joyce Schneider, Medicaid Eligibility Program Specialist, Nebraska Health and Human Services System (Nebraska study respondent)

Bob Seiffert, Medicaid Administrator, Nebraska Health and Human Services System (Nebraska study respondent)

Kathleen Sherry, Health Program Administrator, Bureau of Long-Term Care, New York State Department of Health

Marc Shok, Public Assistance Consultant, Connecticut Department of Social Services, (survey and interview respondent)

Jan Taylor, Minnesota State Department of Human Services

Mary Anne Tribble, Medical Services Admin., Michigan Department of Community Health

Margaret O. Willard, Medical Assistance Specialist, Bureau of Long-Term Care, New York State Department of Health

Abbie Wotkyns, Estate Administrator, Connecticut Department of Administrative Services

Randy Wyatt, Medicaid Eligibility Unit Manager, Texas Department of Human Services (survey and interview respondent)

Marsha Zenderman, Assistant General Counsel, New Mexico Department of Health and Human Services

End Notes

¹ "Ariadne gave Theseus a ball of string to mark his trail through the Labyrinth, and Theseus managed to kill the Minotaur in the Labyrinth and lead out all of the Athenian hostages."

<http://www.e-classics.com/theseus.htm>

² Joel C. Dobris, "Medicaid Asset Planning by the Elderly: A Policy View of Expectations, Entitlement and Inheritance," *Real Property, Probate and Trust Journal*, Vol. 24, No. 1, Spring 1989, p. 12.

³ "Wanted: One Armed Economist: 'Give me a one-armed economist!' demanded President Harry S. Truman. President Truman was the first president to appoint a council of economic advisers. Unlike some later presidents, he actually liked to listen to his policy advisers. However, he preferred a clear recommendation, not a long discussion of the advantages and disadvantages of a particular course of action. He quickly grew tired of economists who gave a good recommendation, and then began, 'On the other hand ...'" <http://www.csuchico.edu/econ/old/links/econhumor.html>

⁴ See: <http://www.cms.hhs.gov/statistics/nhe/historical/t7.asp> ; "Table 7: Nursing Home Care Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1980-2002" and C. McKeen Cowles, *2002 Nursing Home Statistical Yearbook*, Cowles Research Group, Montgomery Village, MD, 2003, p. 64.

⁵ "The 2003 daily rate for a private room in a nursing home increased by \$13.42, which brings the national average to \$181.24 [\$66,153 per year]. This is an increase of 8% since 2002. Semiprivate room rates increased by \$15.70 to \$158.26 [\$57,765 per year]. This is an increase of 11% since 2002. The hourly rate in 2002 for a Home Health Aide was \$17.60. The 2003 hourly rate increased to \$18.12 or a 2.9% increase." ("The MetLife Market Survey of Nursing Home & Home Care Costs," MetLife Mature Market Institute, August 2003, <http://www.metlife.com/WPSAssets/22802718901060258447V1F2003 NH HC Market survey.pdf>.)

⁶ The classic citation for this length-of-stay estimate, which has been corroborated by more recent studies, is the following: "We project that almost one third of all persons who reached 65 years of age in 1990 will spend at least three months in a nursing home during their lifetimes; 24 percent, at least a year; and 9 percent, at least five years." (Peter Kemper and Christopher M. Murtaugh, "Lifetime Use of Nursing Home Care," *New England Journal of Medicine*, Vol. 324, No. 9, February 28, 1991, p. 597.) It should be noted, however, that changes in service delivery modalities from primarily nursing home care to primarily home- and community-based care are likely to indicate shorter institutional stays and longer periods for formal care in the community when newer data become available.

⁷ Long-term care insurance agents, frustrated by the public's seeming indifference toward their statistics about the high risk and cost of long-term care, quip that "denial is not a river in Egypt."

⁸ See: <http://www.cms.hhs.gov/statistics/nhe/historical/t9.asp> ; "Table 9: Personal Health Care Expenditures, by Type of Expenditure and Source of Funds: Calendar Years 1995-2002."

⁹ "The 2003 survey revealed that the national average monthly base rate for an individual residing in an assisted living facility is \$2,379 or \$28,548 yearly." ("The MetLife Market Survey of Assisted Living Costs," MetLife Mature Market Institute, October 2003, <http://www.metlife.com/WPSAssets/16670870001065792597V1F2003 Assisted Living Survey.pdf>.)

¹⁰ See: <http://www.cms.hhs.gov/statistics/nhe/historical/t7.asp> ; "Table 7: Nursing Home Care Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1980-2002."

¹¹ For more details and bibliographic citations for these facts, see "LTC Bullet: So What If the Government Pays for Most LTC, 2002 Data Update," Wednesday, January 21, 2004, Center for Long-Term Care Financing, <http://www.centerltc.com/bullets/archives2004/481.htm> .

¹² "The percentage of nursing home costs paid by government (mostly Medicaid and Medicare) has been going up for the past 14 years (from 49.6% in 1988 to 64.0% in 2002, up 14.4% of the total) while out-of-pocket costs have been declining (from 38.5% in 1988 to 25.1% in 2002, down 13.4% of the total). Source: <http://cms.hhs.gov/statistics/nhe/historical/t7.asp> ." ("LTC Bullet: So What If the Government Pays for Most LTC, 2002 Data Update," Wednesday, January 21, 2004, Center for Long-Term Care Financing, <http://www.centerltc.com/bullets/archives2004/481.htm>)

¹³ Roemer's Law, "a built bed is a filled bed," was applied to nursing homes as well as hospitals. "Milton I. Roemer first posited Roemer's law around 1960. In 1993, he reiterated this observation in *National Health*

Systems of the World, Volume Two (Oxford University Press): "The optimal supply of hospital beds needed by each country, for planning purposes, has been a subject of study and debate everywhere. If there is an assured payment system, it seems that almost any additional hospital beds provided will tend to be used, up to a ceiling not yet determined." (Source: *Dartmouth Atlas of Health Care 1999*, http://www.dartmouthatlas.com/99USlinks/chap_3_roemer.php)

¹⁴ "A new analysis of the nation's Medicaid program by the accounting firm BDO Seidman reveals states are under funding seniors' nursing home care by at least \$4.1 billion annually, and the report warns, the under funding will 'continue to increase every year because rate increases have not kept pace with nursing home cost inflation.'" (Press release of the American Health Care Association on February 4, 2004, <http://www.ahca.org/news/nr040204.htm>) To access the full study, "A Report on Shortfalls in Medicaid Funding for Nursing Home Care," December 2003, go to <http://www.ahca.org/brief/seidmanstudy0312.pdf>

¹⁵ "The CEO of a long-term care company complained that the government and the public '**expect Ritz-Carlton care for Motel 6 rates.**'" (p. 17, emphasis in the original)

"**'It's been an unprecedented regulatory jihad,'** said the Executive Director of a state nursing home association." (p. 11, emphasis in the original)

Stephen A. Moses, "The LTC Triathlon: Long-Term Care's Race for Survival," Center for Long-Term Care Financing, Seattle, Washington, 2000.

¹⁶ "From 1980 to 1997, federal law directly linked Medicaid nursing home rates with minimum federal and state quality of care standards. As part of the Omnibus Reconciliation Act of 1980, the 'Boren amendment' required that Medicaid nursing home rates be 'reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards' (Section 1902(a)(13) of the Social Security Act). State Medicaid officials overwhelmingly came to oppose the amendment as impossible to operationalize, believing that they were forced by the courts to spend too much on nursing homes at the expense of other services. . . . The federal Balanced Budget Act of 1997 repealed the Boren amendment, giving states far greater freedom in setting nursing home payment rates. The nursing home industry warned that Medicaid reimbursement levels already are too low, and that further reductions would adversely affect quality of care." (Joshua M. Wiener and David G. Stevenson, "Repeal of the Boren Amendment: Implications for Quality of Care in Nursing Homes," Number A-30 in Series, "New Federalism: Issues and Options for States," Urban Institute, December 1, 1998, <http://www.urban.org/url.cfm?ID=308020> .)

¹⁷ "Nearly 60 percent of certified nurse assistants (CNAs) are assaulted by a patient at least once a week, and few know how to decrease patients' agitation and aggressiveness, according to a recently published study in the *Journal of the American Medical Directors Association*." (Kathleen Vickery, "Assaults on CNAs Found to Be Commonplace," *Provider*, Vol. 30, No. 6, June 2004, p. 19.)

"LTC Daily Analysis Briefs Nursing Assistants Face High Risk of Injuries. WASHINGTON, DC — 04/02/2004 — (Eli Digital) Nursing assistants, orderlies and attendants in nursing homes and other health care facilities face the highest risk of workplace injury, along with truck drivers. That's the finding of a new report on lost-time work-related injuries released by the U.S. Bureau of Labor Statistics.

Musculoskeletal disorders accounted for 34 percent of the injuries that resulted in lost workdays in 2002. The service industry reported the highest number of MSDs, while the specific occupation with the highest number was the nurse aides, orderlies and attendants category. Ninety-one percent of the 79,000 injured nursing assistants and related workers were women, and they predominantly suffered sprains and strains to their trunk — particularly their back — while moving or lifting patients. For more details on the report's findings, click here." <http://www.bls.gov/news.release/osh2.toc.htm> (Source: *LTC Daily Analysis Briefs*, April 2, 2004, prepared by www.eliresearch.com for www.snalfnews.com.)

¹⁸ Christine E. Bishop, "Competition in the Market for Nursing Home Care," *Journal of Health Politics, Policy and Law*, Vol. 13, No. 2, Summer 1988, p. 352.

¹⁹ "LTC Daily Analysis Briefs. Study: Low Medicaid Rates Hurt Nursing Home Residents. LAKE SUCCESS, NY — 09/30/2003 — (Eli Digital) In news that probably won't come as a shock to many long-term care providers, a study has found that government fiscal and regulatory policies get in the way of good nursing home care. MyZiva.net, a company that provides information for nursing home consumers and providers, analyzed data from the Centers for Medicare & Medicaid Services. It concluded that current staffing and Medicaid payment policies are hurting facilities' ability to provide high quality care. 'The government has imposed a series of policies, which lack a cohesive structure and will do more to impede

care than ensure the well-being of residents,' says MyZiva founder and CEO Robert Abrams, who presented his findings at the recent National Association of Subacute and Post Acute Care conference. The report — titled 'Government Dilemma: How The Government's Own Data Exposes a Direct Correlation Between Inadequate Medicaid Reimbursement, Low Staffing Levels, Excessive Regulation and the Harm Caused to Nursing Home Residents' — is available for free in PDF format by clicking here."

<http://www.myziva.net/about/pressrel/myzivanetreport.pdf> (Source: LTC Daily Analysis Briefs, September 30, 2003, prepared by <http://www.eliresearch.com/> for <http://www.snalfnews.com/> <http://www.snalfnews.com/AnalystNews.cfm?id=3182>)

²⁰ "Medicaid census" and "private-pay census" are terms of art that refer to the percentage of residents in a nursing home who are covered by Medicaid (even if they pay out of pocket for most of the bill) or non-Medicaid patients who are entirely private-pay, usually at a much higher billing rate than Medicaid.

²¹ In the Medicare Catastrophic Coverage Act of 1988 (MCCA '88) and the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) respectively.

²² In the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82).

²³ In the Health Insurance Portability and Accountability Act of 1996 (HIPAA '96).

²⁴ In the Balanced Budget Act of 1997 (BBA '97).

²⁵ "The cost of malpractice insurance for nursing homes has jumped an average 51%, according to a study funded by a long-term-care trade group to be released today. The situation is particularly severe in several states with large populations of seniors, including Texas, Arkansas and Florida." (Andrea Petersen, "Nursing Homes Face Insurance Crunch: Wave of Consumer Lawsuits Pushes Cost of Malpractice Policies Higher; Some Doctors Stop Seeing Seniors, *The Wall Street Journal*, June 3, 2004, Page D1) For the full report, see Theresa W. Bourdon and Sharon C. Dubin, "Long Term Care General Liability and Professional Liability, 2004 Actuarial Analysis," Aon Risk Consultants, Inc., June 2004, http://www.ahca.org/brief/aon_ltcanalysis2004.pdf.

²⁶ Joel C. Dobris, "Medicaid Asset Planning by the Elderly: A Policy View of Expectations, Entitlement and Inheritance," *Real Property, Probate and Trust Journal*, Vol. 24, No. 1, Spring 1989, p. 12.

²⁷ See "SI 01715.020 List of State Medicaid Programs for the Aged, Blind and Disabled" at <http://policy.ssa.gov/poms.nsf/lnx/0501715020>.

²⁸ Ibid.

²⁹ SSI stands for Supplemental Security Income, the federal welfare program for the aged, blind and disabled. SSI's monthly benefit increases with inflation every year.

³⁰ The Omnibus Budget Reconciliation Act of 1993.

³¹ Treatment of the home according to the Social Security Administration's Program Operations Manual System (POMS): <http://policy.ssa.gov/poms.nsf/lnx/0501130100> : "An individual's home, REGARDLESS OF VALUE [emphasis added], is an excluded resource. . . . An individual's home is property in which he or she has an ownership interest and that serves as his or her principal place of residence. It can include:

* the shelter in which he or she lives;

* THE LAND ON WHICH THE SHELTER IS LOCATED [emphasis added]; and

* related buildings on such land. . . . An individual's principal place of residence is the dwelling the individual considers his or her established or principal home and to which, if absent, he or she INTENDS TO RETURN [emphasis added]. It can be real or personal property, fixed or mobile, and located on land or water. . . . The home exclusion applies not only to the plot of land on which the home is located, but to any land that adjoins it." A small number of "209b" states can require sale of the home if no exempt relative resides in it and the Medicaid spouse is medically unable to return.

³² Treatment of business property according to the Social Security Administration's Program Operations Manual System (POMS): <http://policy.ssa.gov/poms.nsf/lnx/0501130501>: "Essential Property Excluded Regardless of Value or Rate of Return . . . Property essential to self-support used in a trade or business is excluded from resources regardless of value or rate of return effective May 1, 1990."

How is this rule used by Medicaid planners to protect assets? Here is an example: "A new amendment to the Social Security Act allows an exemption for the family business, farm or ranch from countable assets for Medicaid eligibility. The advocate should take maximum advantage of this exemption to achieve immediate or very rapid eligibility for clients in need of Medicaid assistance. A considerable amount of resources can be excluded including the value of land and buildings, equipment, livestock, inventory, vehicles, and liquid resources used in the business. The attorney should also counsel his clients on the best method of transferring the business, farm or ranch to avoid the imposition of liens and recovery from the

estate for amounts spent for Medicaid." (Robert E. Hales and Rebecca L. Shandrick, "Advanced Planning for the Family Business," 1992 *Symposium Manual*, National Academy of Elder Law Attorneys, Tucson, Arizona, 1992, p. 15)

³³ Treatment of burial space according to the Social Security Administration's Program Operations Manual System (POMS): <http://policy.ssa.gov/poms.nsf/lnx/0501130400> : "A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value. . . . Spaces held by deemors for the burial of an eligible individual, his/her spouse and/or any member of the eligible individual's immediate family (including the deemor) are excludable. . . . A burial space is a(n):

- * burial plot;
- * gravesite;
- * crypt;
- * mausoleum;
- * casket;
- * urn;
- * niche; or
- * other repository customarily and traditionally used for the deceased's bodily remains.

The term also includes necessary and reasonable improvements or additions to such spaces, including but not limited to:

- * vaults;
- * headstones, markers, or plaques;
- * burial containers (e.g., for caskets); and
- * arrangements for the opening and closing of the gravesite.

For example, a contract for care and maintenance of the gravesite, sometimes referred to as endowment or perpetual care, can be excluded as a burial space."

³⁴ Treatment of life or burial insurance according to the Social Security Administration's Program Operations Manual System (POMS): <http://policy.ssa.gov/poms.nsf/lnx/0501130300> : "3. FV [face value] of Burial and Certain Term Insurance Not Counted

In determining whether the total FV of the life insurance policies an individual owns on a given insured is \$1,500 or less, the FV of the following are not taken into account:

- * burial insurance policies; and
- * term insurance policies that do not generate a CSV [cash surrender value]."

³⁵ Treatment of household goods and personal effects according to the Social Security Administration's Program Operations Manual System (POMS): Household Goods and Personal Effects:

<http://policy.ssa.gov/poms.nsf/lnx/0501130430> : "1. Items Excluded Regardless Of Value

a. One wedding ring and one engagement ring per individual are excluded regardless of value. . . .

2. Exclusion Of Up To \$2,000 Equity Of Other Items

A general exclusion of up to \$2,000 applies to the total equity value of household goods and personal effects other than those excluded regardless of value. Any portion of the total equity in excess of \$2,000 is not excluded under this provision. . . . Absent evidence to the contrary, accept the allegation. Assume that the total equity value of all household goods and personal effects is \$2,000 or less. No further development is required."

How is this exclusion used to protect assets? Here is an example: "If the person is married, household goods, a car and personal effects are protected without regard to their value!.... For example, oriental rugs or paintings that appreciate in value may be worthwhile investments that add beauty and hide assets at the same time." (Armond D. Budish, *Avoiding the Medicaid Trap: How to Beat the Catastrophic Costs of Nursing-Home Care*, Henry Holt, New York, 1989, p. 39)

³⁶ Treatment of an automobile according to the Social Security Administration's Program Operations Manual System (POMS): <http://policy.ssa.gov/poms.nsf/lnx/0501130200> : "Exclusion Regardless of Value: One automobile is excluded regardless of value if, for the individual or a member of the individual's household, it is:

- * necessary for employment;
- * necessary for the treatment of a specific or regular medical problem;
- * modified for operation by, or the transportation of, a handicapped person; or

* necessary, because of climate, terrain, distance or similar factors, for the performance of essential daily activities."

³⁷ BDO Seidman, LLP, "A Report on Shortfalls in Medicaid Funding for Nursing Home Care," December 2003, <http://www.ahca.org/brief/seidmanstudy0312.pdf>. See also Robert Abrams, "How the Government's Own Data Exposes A Direct Correlation Between Inadequate Medicaid Reimbursement, Low Staffing Levels, Excessive Regulation and the Harm Caused to Nursing Home Residents," MyZiva.net, September 19, 2003, <http://www.myziva.net/about/pressrel/myzivanetreport.pdf>

³⁸ Summary of the Aon report in the "AHCA / NCAL Gazette," Thursday, June 3, 2004. For the full report, see Theresa W. Bourdon and Sharon C. Dubin, "Long Term Care General Liability and Professional Liability, 2004 Actuarial Analysis," Aon Risk Consultants, Inc., June 2004, http://www.ahca.org/brief/aon_ltcanalysis2004.pdf.

³⁹ United States Census Bureau, American Housing Survey for the United States: 2001, Table 7-1. Introductory Characteristics—Occupied Units With Elderly Householder, <http://www.census.gov/hhes/www/housing/ahs/ahs01/tab71.html>.

⁴⁰ "Recent studies show that older Americans, including those who have serious health problems and need long-term care, want to live at home rather than in an institution. Most elders (81% of those age 62 and older) own their homes and 74% of those own them free and clear. With \$1.9 trillion tied up in home equity, this financial resource has the potential to dramatically increase the ability of seniors to pay for long-term care at home. Reverse mortgages can free up needed cash while enabling seniors to continue to own their home." (Press Release of the National Council on the Aging, "Use Your Home to Stay at Home(tm) Program Study Shows That Reverse Mortgages Can Help Many with Long-Term Care Expenses," April 15, 2004, <http://206.112.84.147/content.cfm?sectionID=61&detail=576>)

⁴¹ "The rationale behind the LTC insurance-reverse mortgage link is that it allows seniors to tap into the value in their homes while protecting their retirement income and other assets from the potentially catastrophic costs of long-term care. To the extent that people purchase LTC insurance, thus reducing the number of people who 'spend down' to Medicaid, this proposal could help relieve the strain on state and federal budgets." (Alexis Ahlstrom, Anne Tumlinson, Jeanne Lambrew, "Primer: Linking Reverse Mortgages and Long-Term Care Insurance," March 18, 2004, The George Washington University, Washington, DC, p. 4. Read this paper in full at <http://www.brookings.org/dybdocroot/views/papers/orszag/20040317.pdf>. Read an overview at <http://www.brookings.org/views/papers/orszag/20040317.htm>.)

⁴² Aldo A. Benejam, "Home Equity Conversions as Alternatives to Health Care Financing," *Medicine and Law*, Vol. 6, No. 4, May 1987, p. 340.

⁴³ United States Code, Congressional and Administrative News, 97th Congress—Second Session—1982, Legislative History (Public Laws 97-146 to 97-248) Volume 2, St. Paul, Minnesota, West Publishing Company, p. 814.

⁴⁴ For an explanation of how reverse mortgages work and why families can outlive the equity in their homes and still continue receiving the proceeds of a RAM, see "What is a Reverse Mortgage?" at <http://www.reversemortgage.org/Revmtg.htm>. For much more information on home equity conversion, consult the website of the National Reverse Mortgage Lenders Association at <http://www.reversemortgage.org/index.html>.

⁴⁵ "FY 2002 CMS 64 Medicaid Expenditures - Collections." This table, supplied by Hunter McKay of the United States Department of Health and Human Services, is believed to be the best estimate the Center for Medicare and Medicaid Services has of total state and national Medicaid estate recoveries.

⁴⁶ See SEC. 1917 [42 U.S.C. 1396p] of the Social Security Act, "Liens, Adjustments and Recoveries, and Transfers of Assets," at http://www.ssa.gov/OP_Home/ssact/title19/1917.htm.

⁴⁷ Oregon reported \$13.7 million in "probate recoveries" to CMS for Federal Fiscal Year 2002 (FFY-02). State staff believe that total Medicaid estate recoveries for the same period were actually closer to \$16 million. Oregon spent \$198 million on Medicaid nursing home care in FFY-02. So, probate recoveries in Oregon were 6.9% of nursing home costs and estate recoveries, as estimated by state staff, were 8.1%.

⁴⁸ This estimate is based on applying Oregon's probate recovery rate of 6.9% to the national total Medicaid nursing home expenditures for FFY-02 of \$46.5 billion. Using the 8.1% estate recovery rate estimated by Oregon staff gives a total national estate recovery potential of \$3.8 billion.

⁴⁹ General Accounting Office, "Medicaid: Recoveries from Nursing Home Residents' Estates Could Offset Program Costs," GAO/HRD-89-56, March 1989, p. 4.

⁵⁰ Stephen A. Moses, "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, Seattle, Washington, 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>.

⁵¹ "Recently, Secretary Tommy Thompson of the Federal Department of Health and Human Services, offered states a lifeline. He proposed to increase federal Medicaid matching funds to the states by \$3.25 billion in 2004 and \$12.7 billion over the next seven years. Furthermore, he wants to give states 'carte blanche' to administer their Medicaid programs as they see fit for the one-third of program recipients—representing two-thirds of total expenditures—who fall into 'optional' coverage groups. The idea is to give states the freedom to administer this portion of their Medicaid programs more efficiently and cost-effectively so they don't have to slash eligibility groups, services or reimbursements indiscriminately just to comply with restrictive federal rules." ("LTC Bullet: Medicaid Reform Proposal Might Save Medicaid LTC and Unleash LTCI," Thursday, February 27, 2003, Center for Long-Term Care Financing, <http://www.centerltc.com/bullets/archives2003/421.htm>.)

⁵² "Section 1115 of the Social Security Act provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration project(s) which, in the judgment of the Secretary, are likely to assist in promoting the objectives of the Medicaid statute." (For more on "1115 demonstration waivers, see the CMS website at <http://www.cms.hhs.gov/medicaid/1115/>.)

⁵³ The Omnibus Budget Reconciliation Act of 1981 (OBRA '81)

⁵⁴ "Within long-term care, [Medicaid] spending on home and community-based care services has grown from \$1.2 billion in 1990 to \$16.4 billion in 2002 increasing at an average rate of 25 percent per year. With spending on institutional services growing at a much more moderate pace, spending on institutions dropped from 87 percent of the total Medicaid long-term care budget in 1990 to 70 percent in 2002." (Ellen O'Brien and Risa Elias, "Medicaid and Long-Term Care," Kaiser Commission on Medicaid and the Uninsured, May 2004, p.9, <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=36296>

⁵⁵ "The New Freedom Initiative was announced by President Bush on February 1, 2001, followed up by Executive Order 13217 on June 18, 2001. The initiative is a nationwide effort to remove barriers to community living for people of all ages with disabilities and long-term illnesses. It represents an important step in working to ensure that all Americans have the opportunity to learn and develop skills, engage in productive work, choose where to live and participate in community life." (<http://www.cms.hhs.gov/newfreedom/>.)

⁵⁶ "In July 1999, the Supreme Court issued the *Olmstead v. L. C.* decision. The Court's decision in that case clearly challenges Federal, state, and local governments to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective community-based services. The *Olmstead* decision interpreted Title II of the Americans with Disabilities Act (ADA) and its implementing regulation, requiring States to administer their services, programs, and activities 'in the most integrated setting appropriate to the needs of qualified individuals with disabilities.' Medicaid can be an important resource to assist States in meeting these goals. However, the scope of the ADA and the *Olmstead* decision are not limited to Medicaid beneficiaries or to services financed by the Medicaid program. The ADA and the *Olmstead* decision apply to all qualified individuals with disabilities regardless of age." (<http://www.cms.hhs.gov/olmstead/default.asp>) For the Supreme Court's *Olmstead* decision itself, see <http://supct.law.cornell.edu/supct/html/98-536.ZS.html>.

⁵⁷ "As of 2001, 49 states and the District of Columbia had established some type of HCBS waiver program. (Arizona provides home and community-based services under a separate demonstration program, as discussed later.)" (The Congress of the United States, Congressional Budget Office, "Financing Long-Term Care for the Elderly," April 2004, <ftp://ftp.cbo.gov/54xx/doc5400/04-26-LongTermCare.pdf>, p. 37, footnotes omitted)

⁵⁸ "In general, Medicaid's spending per patient for HCBS programs is much lower than its spending for nursing home care: Medicaid's average costs per HCBS recipient were \$3,135 in 2000, compared with about \$20,220 for the average nursing home resident. But those savings may be illusory because of the so-called woodwork effect and because of cost shifting. . . . As evaluators of HCBS programs discovered, the increased availability of home-based care brought new patients 'out of the woodwork'—patients who were eligible for care in a nursing home but who would not have entered one in the absence of the HCBS program. Of course, the increased spending implied by such an effect is not necessarily inappropriate or unwelcome, since the people who benefit are eligible for the new program and presumably were meant to receive its services. But the woodwork effect boosts the number of recipients beyond what it would have

been if only nursing home care had been available. As a result, it increases Medicaid's costs for providing long-term care, even though home and community-based services cost less per patient than institutional care does. To encourage states to more aggressively move institutionalized Medicaid beneficiaries back into the community, the President, in his 2005 budget, has proposed that the federal government pay all HCBS costs for those beneficiaries for the first year after they leave the facility. (The Congress of the United States, Congressional Budget Office, "Financing Long-Term Care for the Elderly," April 2004, <http://ftp.cbo.gov/54xx/doc5400/04-26-LongTermCare.pdf>, pps. 37-38, footnotes omitted)

⁵⁹ "Although community-based LTC programs proved beneficial to both clients and informal caregivers in the LTC demonstrations, they did not prove budget neutral or cost effective." (Kenneth G. Manton, "The Dynamics of Population Aging: Demography and Policy Analysis," *The Milbank Quarterly*, Vol. 69, No. 2, 1991, p. 322.)

⁶⁰ "Given a choice between nursing home care and nothing, many elderly will choose nothing. But when the choice is expanded to include home care, many will choose home care. Thus, the costs associated with large increases in home care more than offset small reductions in nursing home use." (Joshua M. Wiener and Katherine M. Harris, "Myths & Realities: Why Most of What Everybody Knows about Long-Term Care Is Wrong," *The Brookings Review*, Fall 1990, p. 32)

⁶¹ MR/DD stands for "mentally retarded/developmentally disabled." These expenditures are excluded because this analysis focuses on spending for the elderly.

⁶² Medicaid Long Term Care Expenditures in FY 2002 based on "CMS 64" data as compiled by Brian Burwell of The MEDSTAT Group, Inc., *et al.*, and distributed in a May 13, 2003 memorandum.

⁶³ "FY 2002 CMS 64 Medicaid Expenditures - Collections." This table, supplied by Hunter McKay of the United States Department of Health and Human Services, is believed to be the best estimate the Center for Medicare and Medicaid Services has of total state and national Medicaid estate recoveries.

⁶⁴ Susan Coronel, "Long-Term Care Insurance in 2002," America's Health Insurance Plans, Washington, DC, June 2004, Figure 9: State-by-State Long-Term Care Insurance Market Penetration.

⁶⁵ Our estimate of total home equity conversion mortgages is an incomplete hodgepodge compiled from several different sources we believe to include all HECMs issued through January 2004, excluding the years 2000 to 2002 for which we could not obtain data. At best, this data gives a glimmer of comparability between states.

⁶⁶ Payor mix and nursing home census data current to Spring 2004 and based on the OSCAR data base were provided in personal correspondence by C. McKen Cowles, author of the *2002 Nursing Home Statistical Yearbook*, Cowles Research Group, Montgomery Village, MD, 2003.

⁶⁷ Stephen A. Moses, "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, Seattle, Washington, 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>.

⁶⁸ *Ibid.*, p. iv.

⁶⁹ *Ibid.*, p. iv.

⁷⁰ *Ibid.*, p. iv.

⁷¹ *Ibid.*, p. iii.

⁷² For a fuller explanation of why the long-term care status quo persists and interest groups fail to fight for change, see the following articles by Stephen A. Moses: "Long-Term Care Lemmings," *Broker World*, Vol. 23, No. 5, May 2003, http://www.centerltc.com/pubs/Articles/LTC_Lemmings.pdf; "The Elephant, The Blind Men, and LTC," *National Underwriter LTC E-Wire*, Vol. 2, No. 3, February 2003, http://www.nationalunderwriter.com/LTC/articles/2003_02_elephant.asp; and "Denial is Not a River in Egypt: A Perspective on Public Funding of Long-Term Care," *Health Insurance Underwriter*, Vol. 50, No. 11, December 2002, pps. 36-40; <http://www.centerltc.com/pubs/Articles/denial.htm>.

⁷³ Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," unpublished working paper, University of Illinois at Urban-Champaign, May 2004.

⁷⁴ Georgia is reportedly in the process of implementing an estate recovery program, but intends to exempt the first \$25,000 of every estate from recovery. Based on experience in other states, such as Oregon which has high estate recoveries overall but an average recovery of only \$2,500, this policy is likely to limit severely or eliminate altogether the program's cost effectiveness in Georgia.

⁷⁵ This change was recently postponed for three months.

⁷⁶ (Interview) refers to the fact that we received this quote in a personal or telephone interview for the current study. (Survey) refers to the fact we received a quote from a survey conducted during an earlier study: "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, December 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>. Responses from that survey may be reviewed at http://www.centerltc.org/survey_responses.pdf.

⁷⁷ (Survey) refers to the fact we received a quote from a survey conducted during an earlier study: "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, December 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>. Responses from that survey may be reviewed at http://www.centerltc.org/survey_responses.pdf. (Interview) refers to the fact that we received this quote in a personal or telephone interview for the current study.

⁷⁸ See Endnote #74.

⁷⁹ Susan Coronel, "Long-Term Care Insurance in 2002," America's Health Insurance Plans, Washington, DC., June 2004. "Using long-term care insurance sales data by state . . . AHIP estimated state market penetration rates. These estimates were calculated by dividing the number of policies sold in each state by the reported number of people age 50 or over living in that state."

⁸⁰ John Holahan, "State Responses to Budget Crises in 2004: Michigan," The Urban Institute, February 2004. An overview paper and other state reports can be found at www.urban.org. A combined volume of both the overview and state reports can be found on www.kff.org.

⁸¹ Tim Takacs, "Cuts in Medicaid Dental Care Services Threaten Good Health," Elder Law Fax, March 29, 2004, <http://www.tn-elderlaw.com/prior/040329.html>

⁸² (Interview) refers to the fact that we received this quote in a personal or telephone interview for the current study. (Survey) refers to the fact we received a quote from a survey conducted during an earlier study: "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, December 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>. Responses from that survey may be reviewed at http://www.centerltc.org/survey_responses.pdf.

⁸³ (Interview) refers to the fact that we received this quote in a personal or telephone interview for the current study. (Survey) refers to the fact we received a quote from a survey conducted during an earlier study: "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, December 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>. Responses from that survey may be reviewed at http://www.centerltc.org/survey_responses.pdf.

⁸⁴ Richard L. Peck, "Will Congress Take the Year Off," *Nursing Homes/Long-Term Care Management*, Vol. 53, No. 5, May 2004, p. 26.

⁸⁵ Source: LTC E-Alert #4-007—LTCI Tax Deductibility Lite, Thursday, February 5, 2004, http://www.centerltc.com/members/e-alerts/ltc_ea4-007.htm (if unable to access this URL, contact the Center for Long-Term Care Financing at info@centerltc.org or 206-283-7036, mention this report and request a temporary user name and password to the Center's donor-only zone).

⁸⁶ "NY: Governor and Senate Medicaid Proposals Opposed by AARP Members," U.S. Newswire (press release) - Washington, DC, April 13, 2004, <http://releases.usnewswire.com/GetRelease.asp?id=110-04132004>.

⁸⁷ (Interview) refers to the fact that we received this quote in a personal or telephone interview for the current study. (Survey) refers to the fact we received a quote from a survey conducted during an earlier study: "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, December 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>. Responses from that survey may be reviewed at http://www.centerltc.org/survey_responses.pdf.

⁸⁸ (Interview) refers to the fact that we received this quote in a personal or telephone interview for the current study. (Survey) refers to the fact we received a quote from a survey conducted during an earlier study: "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, December 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>. Responses from that survey may be reviewed at http://www.centerltc.org/survey_responses.pdf.

⁸⁹ (Survey) refers to the fact we received a quote from a survey conducted during an earlier study: "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, December 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>. Responses from that survey may be reviewed at http://www.centerltc.org/survey_responses.pdf. (Interview) refers to the fact that we received this quote in a personal or telephone interview for the current study.

⁹⁰ Source: Advertising compact disc published by Wright Abshire titled "Q: How Can We Afford Nursing Home Care Without Losing Our Life Savings? Medicaid Planning is the Answer." Both of the principals in the firm responsible for this material are Certified Elder Law Attorneys and members of the National Academy of Elder Law Attorneys (NAELA).

⁹¹ Medicaid is known as Medi-Cal in California.

⁹² (Interview) refers to the fact that we received this quote in a personal or telephone interview for the current study. (Survey) refers to the fact we received a quote from a survey conducted during an earlier study: "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, December 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>. Responses from that survey may be reviewed at http://www.centerltc.org/survey_responses.pdf.

⁹³ General Accounting Office, "Medicaid: Recoveries from Nursing Home Residents' Estates Could Offset Program Costs," GAO/HRD-89-56, March 1989, p. 4.

⁹⁴ "A deduction is allowed beginning in tax years on or after 1/1/97. The maximum amount deductible is based on a sliding scale, which is increased each year to account for inflation. Also, beginning in tax year 2003, residents who need long term care services for at least 180 days can qualify for a \$500 tax credit as long as their adjusted gross income does not exceed \$100,000." Source: State Tax Incentives for Long Term Care Insurance, Updated 06/2003, <http://www.ltcas.com/downloads/StateTaxIncentives2003.pdf>

⁹⁵ Source: *LTC Daily Analysis Briefs*, May 5, 2004, prepared by www.eliresearch.com for www.snalfnews.com.

⁹⁶ (Survey) refers to the fact we received a quote from a survey conducted during an earlier study: "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, December 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>. Responses from that survey may be reviewed at http://www.centerltc.org/survey_responses.pdf. (Interview) refers to the fact that we received this quote in a personal or telephone interview for the current study.

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⁹⁸ (Interview) refers to the fact that we received this quote in a personal or telephone interview for the current study. (Survey) refers to the fact we received a quote from a survey conducted during an earlier study: "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, December 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>. Responses from that survey may be reviewed at http://www.centerltc.org/survey_responses.pdf.

⁹⁹ (Survey) refers to the fact we received a quote from a survey conducted during an earlier study: "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, December 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>. Responses from that survey may be reviewed at http://www.centerltc.org/survey_responses.pdf. (Interview) refers to the fact that we received this quote in a personal or telephone interview for the current study.

¹⁰⁰ Source: STATE TAX INCENTIVES FOR LONG TERM CARE INSURANCE, Updated 06/2003, <http://www.ltcas.com/downloads/StateTaxIncentives2003.pdf>.

¹⁰¹ This Nebraska State Profile is based on interviews conducted in October 2003 for a study funded by the Nebraska state legislature. The report of this study was titled "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska." It was published by the Center for Long-Term Care Financing on December 1, 2003. For a copy, go to <http://www.centerltc.com/pubs/Nebraska.pdf>.

¹⁰² *Ibid.*

¹⁰³ Alzheimer's Disease is the single biggest medical cause requiring expensive long-term care. Nearly half of all people over age 85 nationally already have Alzheimer's. "One of the most notable recent developments in Nebraska's vital statistics has been the entry of Alzheimer's Disease into the top ten causes of death, which occurred for the first time in 1995. The number of Nebraska deaths attributed to Alzheimer's Disease increased again in 2002, to 462, making it again the state's sixth leading cause of death. However, among women 75 and older, Alzheimer's Disease was the state's fourth leading cause of death in 2002." Source: <http://www.hhs.state.ne.us/ced/death02.pdf>.

¹⁰⁴ "The Heartland Manifesto: [Nebraska] has very limited dollars available for public assistance. The state's first responsibility is to take care of the truly poor and disadvantaged. The middle class and well-to-

do should pay privately for long-term care to the extent they are able without suffering financial devastation. Prosperous people who rely on public assistance for long-term care should reimburse the taxpayers before giving away their wealth to heirs. Seniors and their heirs who wish to avoid such recovery from the estate should plan ahead, purchase private long-term care insurance, and pay privately for the care of their choice when the time comes." ("The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, December 2003,

<http://www.centerltc.com/pubs/Nebraska.pdf>, p. 31.)

¹⁰⁵ Interviewees opined that such transfers are done primarily to avoid probate and/or inheritance taxes.

¹⁰⁶ Susan A. Coronel, *Long-Term Care Insurance in 2000-2001*, Health Insurance Association of America, Washington, DC, 2003, p. 22. "HIAA found that Arizona, Colorado, Illinois, Indiana, Iowa, Kansas, Maine, Minnesota, Missouri, Montana, NEBRASKA, North Dakota, South Dakota and Washington had the highest market penetration rates." (p. 22, emphasis added). For state nursing home censuses, see C. McKeen Cowles, *Nursing Home Statistical Yearbook, 2002*, Cowles Research Group, Montgomery Village, Maryland, 2003, p. 64.

¹⁰⁷ Steven R. Gregory and Mary Jo Gibson, *Across the States, 2002 Profiles of Long-Term Care, Nebraska*, AARP Public Policy Institute, Washington, DC, 2002, http://research.aarp.org/health/d17794_2002_ats_ne.pdf. According to AARP, the national average Medicaid reimbursement per day for nursing facility care in 1998 was \$96 as compared to the national average private pay rate per day, 2001 of \$150. For comparable years, the Medicaid rate is usually reported as approximately 70 percent of the private pay rate.

¹⁰⁸ *Ibid.*

¹⁰⁹ The slightly higher Medicaid nursing home census cited above for Nebraska is based on 2004 data. C. McKeen Cowles, *Nursing Home Statistical Yearbook, 2002*, Cowles Research Group, Montgomery Village, Maryland, 2003, p. 64.

¹¹⁰ (Survey) refers to the fact we received a quote from a survey conducted during an earlier study: "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, December 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>. Responses from that survey may be reviewed at http://www.centerltc.org/survey_responses.pdf. (Interview) refers to the fact that we received this quote in a personal or telephone interview for the current study.

¹¹¹ This \$16 million figure is higher than the amount reported to the federal government for federal fiscal year 2002 probate recoveries. We used the lower figure in computing Oregon's estate recovery rank to be consistent with other states.

¹¹² (Interview) refers to the fact that we received this quote in a personal or telephone interview for the current study. (Survey) refers to the fact we received a quote from a survey conducted during an earlier study: "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, December 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>. Responses from that survey may be reviewed at http://www.centerltc.org/survey_responses.pdf.

¹¹³ (Survey) refers to the fact we received a quote from a survey conducted during an earlier study: "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, December 2003, <http://www.centerltc.com/pubs/Nebraska.pdf>. Responses from that survey may be reviewed at http://www.centerltc.org/survey_responses.pdf. (Interview) refers to the fact that we received this quote in a personal or telephone interview for the current study.

¹¹⁴ State Tax Incentives for Long Term Care Insurance, updated 06/2003, <http://www.ltcas.com/downloads/StateTaxIncentives2003.pdf>