The Long-Term Care Dilemma
What States Are Doing Right – and Wrong

by Steve Moses

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Executive Summary

Less than a decade before America's baby boomers begin to retire and two decades before the Social Security and Medicare trust funds are exhausted, the country's long-term care system is on the brink of financial collapse.

By making Medicaid nursing home benefits routinely available to virtually anyone since 1965, we have created a nursing-home based, welfare-financed long-term care system that fails everyone, especially the poor.

We don't spend too little government money on long-term care. We spend too much in the wrong ways.

A number of states have recognized the crisis and are moving to address some of the problems. Other states are adopting shortsighted policies, or refusing to enforce current laws, and thus are only making the problems worse.

This paper explains the long-term care dilemma facing the country, and includes profiles of 10 states — five of which could be considered "pro-Medicaid" and five "pro-private pay" states — by looking at six variables and ranking them accordingly.

The pro-Medicaid states are those that make it especially easy to qualify for Medicaid and seldom enforce estate recovery rules. For example, four of the five proved to have relatively generous eligibility systems; and four of the five reported zero estate recoveries in 2002.

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.
- All five score in the top half of states for Medicaid nursing home census. Georgia and New York rank fourth and sixth, respectively.
- Three of the five were in the top half of states for home and community based services (HCBS); New York was second and New Mexico was seventh. Only Georgia and Michigan were in the second half of states for HCBS.

As for the pro-private pay states, four of the five proved to have relatively strict Medicaid eligibility systems. And four of the five were among the top half of states in estate recoveries.

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 pro-private pay 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 sixth, California ninth and Oregon tenth.
- 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 — Connecticut at 22nd and California at 24th — had roughly average Medicaid censuses.

In other words, the easier Medicaid is to obtain and the more attractive its long-term care benefits are, the less likely people will be to plan early and pay privately for long-term care and the more likely they will be to become dependent on public assistance.

What we need to do to correct the problem is target scarce public resources to the genuinely needy and create a real long-term care spend-down liability. If we do, most people will voluntarily save, invest or insure to prepare for the risk and cost of long-term care, thus relieving the financial burden on Medicaid. That is the only way to save Medicaid for the poor and improve long-term care for everyone.

Table of Contents

INTRODUCTION

Less than a decade before America's baby boomers begin to retire and two decades before the Social Security and Medicare trust funds are exhausted, the country's long-term care system is on the brink of financial collapse.

- 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.
- The home and community-based services infrastructure is grossly underdeveloped and starved for revenue.
- A severe lack 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 commonplace.
- Quality is questionable at every level of care partly because of counterproductive regulations, which have tied publicly financed providers in knots.
- Tort liability is large, growing and threatens the future viability 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.[1]
- 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.
- Despite efforts by the states and federal government to encourage 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.
- Finally, America's Age Wave has not yet begun to crest. Imagine what these problems will be like in 30 years when the baby boomer generation starts needing long-term care in large numbers.

Most health policy experts recognize that something must be done to stem the public's massive and growing dependence on government-funded long-term care — and that it must be done now.

A number of states have recognized the crisis and are moving to address some of the problems. Other states are adopting shortsighted policies, or refusing to enforce current laws, and thus are only making the problems worse. This paper explains the long-term care dilemma facing the states and what they are doing, or should do, about it.

Identifying the Long-Term Care Problems

The country's long-term care crisis did not emerge overnight, and it won't be solved overnight. But it can be solved. Before elected officials can resolve a problem, however, they need to understand it. The following Q&A format provides some basic definitions and explanations of what long-term care is, how it is funded and why it is facing a crisis.

1. What is Medicaid? 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 afford it. The program is state-administered and federally overseen, and both levels of government share the cost: 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.

2. What is long-term care? Long-term care is the assistance, whether medical, personal 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.

3. How big a part of Medicaid is long-term care? 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, who account for only about one-third of Medicaid's costs.

The remaining 25% of Medicaid recipients are aged, blind or disabled, but they account for two-thirds of the program's costs. The main cost driver for this 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.[2] Medicaid also spends a large and rapidly increasing amount for home and community-based long-term care. Long-term care accounts for one-third to one-half of total Medicaid expenditures in most states.

4. Why does Medicaid play such a big role in financing long-term care? The typical explanation is that long-term care, especially nursing home care, is very expensive. Since few American families can afford such costs for long, conventional wisdom concludes, most people spend down into impoverishment quickly and thus qualify for Medicaid benefits.[3] In fact, the answer is much more complicated. The American public is in denial about the risk of long-term care because Medicaid and Medicare have paid for most expensive extended care services since 1965. When a care crisis occurs and large expenses begin to be incurred, families frequently turn to the public benefit programs and learn that qualifying for Medicaid is easier than they thought and that Medicare, although very limited in its benefits, has no means test to obstruct eligibility. Consequently, few people plan, save, invest or insure for long-term care and most people end up dependent on the public programs.

5. How is long-term care delivered and financed in the United States? 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 care-giving.

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

Home Care. The U.S. 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.[4]

Assisted Living. Assisted living facilities, by contrast, which cost an average of $28,548 per year, are 90% private pay.[5]

Nursing Homes. For nursing homes, which cost Americans $103.2 billion in 2002:

- Medicaid accounted for nearly 50% of reimbursements;
- Private pay covered about 25%;
- Medicare was responsible for about 12%, and private health insurance about 6% (other public sources make up most of the difference).

These numbers are accurate, but misleading. They vastly *understate* the impact of Medicaid and *overstate* the degree of private financing of long-term care.

For example, although Medicaid only pays for about half of nursing home expenditures, it covers two-thirds of all nursing home residents, and affects almost 80% of all patient days.[6] That's true because people on Medicaid have to contribute their personal income toward their cost of care and because Medicaid residents tend to stay longer in nursing homes than private-pay patients. These facts are critical because Medicaid's low reimbursement rates severely impair the nursing home profession's ability to provide quality care for nearly *four-fifths* of all residents.

Furthermore, over half of so-called out-of-pocket payments for nursing home care are really just a "spend-through" of Social Security income. That is to say, what is usually assumed to be a spend-down of life savings *is mostly the income from another government program that Medicaid recipients must contribute toward their cost of care*.[7]

6. But if Medicaid is welfare, why are so many seniors dependent on it for long-term care? Doesn't Medicaid require impoverishment? 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 financial tests that must be passed: one is based on income and the other on assets.

Income eligibility is determined in two ways. Thirty-four states and the District of Columbia have "medically needy" income eligibility systems.[8] In those states, medical expenses — including private nursing home costs, insurance premiums, medical expenses not covered by Medicare, etc. — are deducted from Medicaid applicants' income. If they have too little income to pay for their care, they are eligible for Medicaid — not just for long-term care but also for the full array of Medicaid services.

The remaining states have "income cap" Medicaid eligibility systems.[9] In these states, anyone with income over $1,692 per month (300% of the SSI monthly benefit of $564) is ineligible for long-term care benefits.[10] 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 the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) that allow people to divert income into the trust and become eligible for Medicaid.[11] 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.

Thus, 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.

Bottom line: Income is rarely an obstacle to Medicaid long-term care benefits, as long as medical expenses are high enough. Only the top 10% or 15% of seniors would have too much income to qualify.

7. What about assets? Don't people have to spend themselves into impoverishment before they qualify for Medicaid? 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 the patient will ever be able to return.[12]

Medicaid also exempts:

- One business, including the capital and cash flow, of unlimited value;[13]
- 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";
- Unlimited term life insurance with no effect on eligibility;[14]
- Home furnishings up to $2,000, but they are rarely counted;[15]

- One car of unlimited value, assuming it's used for the benefit of the Medicaid recipient;[16] (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 can be stashed in exempt assets without impeding Medicaid long-term care eligibility.

8. What are "Medicaid planners?" Some millionaires and many upper-middle-class people qualify for Medicaid by consulting legal specialists who use an array of qualification techniques, including the purchase of annuities, irrevocable income-only trusts, life care contracts and many others. Thus, even beyond Medicaid's extremely generous basic eligibility rules as described above, savvy seniors with cunning legal advisors can stretch Medicaid long-term care eligibility much further still.

Medicaid planning has negative consequences beyond overloading the program with recipients who could have paid for their own care. 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 that patients cannot count on getting into a quality nursing home unless they can pay privately for an extended period of time. Once they're in, however, state and federal laws prohibit nursing homes from removing them just because they 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 transfer the financial burden to Medicaid, tax payers and nursing homes. The tragedy is that poor people, whom Medicaid is supposed to help, do not have key money and consequently must occupy the less desirable beds in nursing homes more heavily dependent on Medicaid's low reimbursement rates.

9. How has this excessive dependency on Medicaid affected nursing homes? 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 by $4.1 billion in 2001, with the shortfall averaging $11.55 per Medicaid patient day.[17] With two-thirds of their residents on Medicaid, nursing homes struggle to provide quality care. The consequences for nursing homes have been devastating. Inadequate revenue has spawned bankruptcies, staff shortages and quality problems, which have led to tort liability suits, giant punitive settlements and skyrocketing liability insurance premiums.

Aon Risk Consultants recently reported that nursing home litigation has exploded 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 $2,290; but in Florida, with its high elderly population, per-bed liability costs have reached $8,170. Aon concludes: "The cost crisis has caused many nursing homes to either cut back on insurance coverage or to drop it altogether . . . . 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."[18]

10. What can be done about this problem? Eighty-one percent of seniors own their homes. Seventy-three percent of elderly homeowners own their homes free and clear.[19] Nearly $2 trillion worth of home equity is held by seniors that could go to offset the cost of long-term care — enough money to solve the long-term care financing crisis now and in the future.[20] The key is expanding home equity conversion.

Home equity conversion 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. For example, when interest rates plummeted, many seniors turned to reverse annuity mortgages as a way to replace lost income.

Recently, the Centers for Medicare and Medicaid Services and the National Council on the Aging (NCOA) have encouraged the use of home equity to pay for long-term care.

In addition, reverse annuity mortgages have long been an option to help older people afford the insurance.[21] Indeed, it was noted 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."[22]

11. So should we make Medicaid long-term care available to people only after they consume their home equity with a reverse mortgage? When Congress authorized transfer-of-assets penalties, liens and estate recoveries in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), it did so with the intent "to assure that all of the resources available to an institutionalized individual, *including equity in a home,* 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."[23] [Emphasis added] 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.[24]

The goal of TEFRA was to turn 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 for Medicaid, place liens on their 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) and the "look back" period was extended to three years, five for transfers to trusts in 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 back the cost of their care 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.

12. If Medicaid estate recoveries are mandated by federal law, why haven't the states succeeded in recovering more of the money they spend on long-term care? Although state Medicaid programs have been required since OBRA '93 to recover benefits 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 0.75%.[25]

Even states like Oregon that pursue estate recoveries aggressively are hamstrung by restrictions in federal law that protect large amounts of money from recovery.[26] Nevertheless, Oregon recovered $13.7 million from estates in 2002, which is 6.9% of what the state spent on Medicaid nursing home benefits that year.[27] If every state were as successful as Oregon, estate recoveries would total $3.2 billion.[28]

13. So, why don't we just compel the states to enforce the federal statutory authorities that are already in place? 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 to circumvent the rules and take advantage of Medicaid.

14. Well then, what's the answer? One solution is for federal law to 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 approach would prevent Medicaid from being "inheritance insurance" for baby boomer heirs as it is now, and it would wake up the boomers 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 their long-term care needs. 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.

With fewer people dependent on Medicaid, that program would be able to do a better job for its proper clientele: the poor. 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.

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 higher level of care. That fact will breathe financial oxygen into the home and community-based services infrastructure and, over time, eliminate the system's institutional bias.

15. Can states extend the transfer-of-assets look-back period to a decade and require home equity spend-down with a reverse annuity mortgage? Not under current federal law, but there are several ways to fix that problem. For example:

- Congress could 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.[29] If they're willing to forgo 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.[30]

- 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.

16. What is the most important thing states can do? 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 better afford to provide the most attractive home and community-based services (HCBS) and pay adequately for them.

How Did We Get to Where We Are Today?

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 it could raise the walls of new facilities. The public filled these new beds immediately, even when a nursing-home level of care was unneeded. 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 that promoted 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 the still-growing differential between low Medicaid reimbursement rates and higher private-pay charges, i.e. "cost shifting" from Medicaid to private payers.

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. Industry executives claim that Medicaid demands "Ritz Carlton care for Motel 6 rates" while imposing a "regulatory Jihad."[1] 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.[2]

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. 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."[3] Similar comments are still common in the professional literature.

Medicaid census grew and private pay census declined.[4] 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 specialty law practice known as 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.[5] Liens on homes were authorized.[6] And when none of these measures stanched the eligibility hemorrhage, Congress and President Clinton finally made it a crime to transfer assets in order to qualify for Medicaid.[7] 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.[8] 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.[9]

Good intentions led to unintended consequences. Thus, by funding nursing home care through Medicaid with the hope of helping people in need, government created the long-term care system's institutional bias, impeded the market for privately financed home and community-based care, obviated the need for private long-term care insurance and home equity conversion, saddled the country with a runaway welfare program easily abused by prosperous people, and set the stage for a catastrophically dysfunctional and costly long-term care system that cannot hope to survive the coming age wave of baby boomers.

[1] Quotes from Stephen A. Moses, "The LTC Triathlon: Long-Term Care's Race for Survival," Center for Long-Term Care Financing, Seattle, Washington, 2000, http://www.centerltc.com/pubs/triathlon.pdf.

[2] 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).

[3] 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.

[4] "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.

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

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

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

[8] In the Balanced Budget Act of 1997 (BBA '97).

[9] 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 .

State Medicaid Long-Term Care Profiles

What follows are profiles of how 10 different states address the problems facing long-term care. Like people and their athletic abilities — some are good at one or two sports, some are good at most sports, and some are not good at any sports — there are states that do well in some areas but not others. Every state has room for improvement; but some states have no place to go but up.

This study looks at six related key variables that 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.

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.[31] 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 will be.[32]

(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 (CMS), to measure this variable.[33]

Dependent Variables:

(4) Long-term care insurance market penetration. We use LTCI market penetration as reported by America's Health Insurance Plans (AHIP). These data were formerly published by the Health Insurance Association of America, which is now part of AHIP.[34]

(5) Home equity conversion market penetration. We use a compilation from various sources of data to estimate HEC market penetration.[35]

(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) database.[36]

Relationship between the Variables

As the profile will show, no state is perfect. Every state has some characteristics that tend in opposite directions. Nevertheless, 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.

Conversely, if a state Medicaid program enforces stricter long-term care eligibility, offers 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 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. 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.

For this study, we took a close look at 10 state Medicaid programs. We chose five states — Georgia, Michigan, New Mexico, New York and Texas — because they appeared to encourage Medicaid dependency and discourage private financing. We chose five other states — California, Connecticut, Minnesota, Nebraska and Oregon — because they seemed to discourage Medicaid dependency and to encourage private financing.

Summary of the Findings

Four of the five "pro-Medicaid" states, New Mexico excepted, proved to have relatively generous eligibility systems. And four of the five reported zero estate recoveries in 2002. New York, which is ranked a relatively low 37th in the country for estate recoveries on a percentage basis, is the one exception. Three of the five were in the top half of states for HCBS; New York was second and New Mexico was seventh. 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.

Now for 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 — including second-ranked Oregon and seventh-ranked Minnesota — were among the top half of states in estate recoveries. Counterbalancing these factors, however, four of the five were in the top half of the states for HCBS, with Connecticut, Oregon and Minnesota ranking fifth, sixth and ninth, 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 sixth, California ninth and Oregon tenth.

- 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 — Connecticut at 22nd California at 24th — had roughly average Medicaid censuses.

Thus, at least for these 10 states the anticipated relationships generally hold true.

GEORGIA

State Snapshot		
Medicaid Eligibility	*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 1,000 elderly, Rank:*	**3.4, 33**
Medicaid Census	*Percent, Rank:*	**77.19%, 4**

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 is just now beginning to implement an estate recovery program — one of the last states to do so. 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," 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. 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:
Driven by the budget crisis, Georgia has only recently taken measures to control eligibility and plan for estate recoveries. The state has met with extreme public opposition and political sensitivity. When budget conditions improve, the corrective actions are vulnerable to repeal, leaving the state extremely susceptible to future budge problems, especially with the aging of the baby boomers.

PRESCRIPTION:
Georgia should conduct a study of Medicaid long-term care eligibility; assess why its Medicaid nursing home census is the fourth highest in the country; examine the techniques and extent of Medicaid planning; implement eligibility controls; ensure that its new estate recovery program draws on best practices from other states; use some of the savings from reforms 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 changed to "income cap" in July 2004 due to budget cuts.[37] New system vulnerable to Miller Income Trusts.
- Subjective "intent to return" means home remains exempt regardless of ability to return.
- "Income first" state; transfer of assets before income to establish a higher Community Spouse Resource Allowance is not allowed.
- Round down?: Yes. Applicants can give away one dollar less than double the monthly nursing home average of $3,860 each month without incurring any extra penalty beyond the current month.

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

- Biggest eligibility loophole?: Promissory notes. "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)[38]

Impact of Medicaid Planning: "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)

Examples of ads:
Pyke & Associates, P.C
http://www.georgiamedicaidplanning.com/
Ad excerpt: "Helping Your Loved One Get the Nursing Home Care They Deserve While Legally Protecting Your Family's Assets."

Larry Howell, Attorney at Law
http://www.howell-law.com/default.aspx?daURL=/ELMS/elms_index.asp
Ad excerpt: "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 $5 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*)

"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)

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: Market penetration in Georgia is between 1% and 5%.[39]

Home Equity Conversion: Georgia has had 3.4 home equity conversion mortgages (HECMs) per 1,000 elderly homeowners. The state ranks 33rd in HECM loans.

Medicaid Nursing Home Census: "Yes, the Medicaid resident census 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: 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 — 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." (Andy Miller, *Atlanta Journal-Constitution*. April 9, 2004)

"LTC Daily Analysis Briefs: Georgia Nursing Homes Sound Alarm on Funding — 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." (LTC Daily Analysis Briefs, April 23, 2004)

MICHIGAN

State Snapshot		
Medicaid Eligibility	*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 1,000 elderly, Rank:*	**3.6, 29**
Medicaid Census	*Percent, Rank:*	**66.49%, 21**

DIAGNOSIS:
Michigan has generous 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. Yet the state has done little to awaken its public to the risk and the need to take personal responsibility early.

Query: Could someone with $40,000 per year of income qualify if 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)

PROGNOSIS:
Like most other states, Michigan faces a severe budget challenge. "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."[40]

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. Among those no longer receiving Medicaid dental care are low-income mothers, nursing home residents and developmentally disabled and mentally ill people."[41] Cutting critical benefits for people genuinely in need while preserving generous eligibility for affluent seniors is misguided public policy.

PRESCRIPTION:
Michigan should review policies in other states to seek ways to tighten its Medicaid LTC eligibility system; immediately implement an aggressive Medicaid estate recovery program building on best practices from successful states like Oregon; use part of the savings accruing from these measures to educate and encourage the public to purchase LTC insurance and/or to utilize their home equity for LTC through reverse mortgages; and implement a public relations campaign to tell the public the truth about long-term care: 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.

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.

- "Income first" state; transfer of assets before income to establish a higher Community Spouse Resource Allowance is not allowed.

- Michigan rounds down monthly asset transfers. Applicants can therefore give away double the average monthly nursing home cost ($5,250) 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 estimates that 70% of recipients have them, averaging $4,000 to $5,000 each.

- 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 it's OK if at fair market value." (Interview)

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

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.

Examples of ads:
Strategic Legal Services, P.C
http://www.florkalaw.com/default.aspx?daURL=/ELMS/elms_index.asp
Ad excerpt: "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."

Foster Zack & Lowe, P.C
http://fosterzacklowe.lawoffice.com/PracticeAreas/PracticeAreaDescriptions60.asp
Ad excerpt: "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: Market penetration is relatively low in Michigan at 3.6 HECMs per 1,000 elderly residents, ranking 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 Snapshot		
Medicaid Eligibility	*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 1,000 elderly, Rank:*	**5.8, 17**
Medicaid Census	*Percent, Rank:*	**70.49%, 15**

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 overextended 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 study best practices in other states, discourage the further development of a Medicaid estate planning bar and educate eligibility workers on the importance of controlling eligibility. 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 level 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 home remains exempt regardless of ability to return to it. Staff estimates 60% to 70% of Medicaid recipients in Santa Fe own their 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; transfer of assets before income to establish a higher Community Spouse Resource Allowance is not allowed.

- 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 spend-down, the worker asks what excess assets were spent on — care or 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 ($3,899 is the amount used to compute transfer-of-assets penalties, less one dollar each month — hence two times $3,899 minus $1, or $7,797) 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)

Impact of Medicaid Planning: 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 members indicate they recovered $28,200 for state fiscal year 2004 with 0.5 FTEs (full time equivalent staff). New Mexico has not implemented the expanded definition of "estate" authorized by OBRA '93.

Bottom line: 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 seventh 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 the National Governors Association Health and Human Services Committee, 'because they don't have the controls of more targeted waivers.'"[42]

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 . . . ."[43] 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 1,000 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 Snapshot		
Medicaid Eligibility	*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 1,000 elderly, Rank:*	**6.2, 16**
Medicaid Census	*Percent, Rank:*	**73.81%, 6**

Diagnosis:
New York has the single most generous Medicaid long-term care program in the country. Eligibility rules, generous to begin with, are stretched by the state's numerous Medicaid planning experts. Estate recoveries are low 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. Consequently, Medicaid is the primary payer 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.

Governor Pataki's 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. Unfortunately, New York's AARP strongly opposes most reasonable reforms.[44]

If something is not done soon to change the emphasis of 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 boomers begin to retire.

Prescription:
New York should conduct a top-to-bottom review of Medicaid long-term care eligibility, coverage, services and estate recoveries. The county-administered system 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.

Medicaid LTC Eligibility:

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

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

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

- "Income first" state; transfer of assets before income to establish a higher Community Spouse Resource Allowance is not allowed.

- 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 that 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.

Impact of Medicaid Planning: 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."

Examples of ads:
Littman Krooks, LLP
http://lkllp.lawinfo.com/elder_law.php?content=medicaid
Ad excerpt:
"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."

Medicaid Estate Recoveries: Staff report that New York has no way of knowing how much the state collects in estate recoveries but believe that the actual amount recovered is higher than the amount the state is required to report to CMS as "probate 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." (Interview)

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, 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 1,000 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 Snapshot		
Medicaid Eligibility	*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 1,000 elderly, Rank:*	**2.1, 41**
Medicaid Census	*Percent, Rank:*	**69.07%, 17**

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 growing problem.

PROGNOSIS:
The state is facing a 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 payer of long-term care for the middle- and upper-middle-class; 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; and 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 improve reimbursement to long-term care providers.

MEDICAID LTC ELIGIBILITY:

- Income cap eligibility system, with the addition of Miller Income Trusts, also known as "Qualified Income Trusts," for higher income recipients, although staff estimate only 1% of nursing home and waiver recipients currently have these trusts.

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

- "Transfer assets before income," also known as "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)

- Aggressive monthly transfers just under the monthly penalty threshold and inter-spousal transfers after which the community spouse transfers the asset are common. "We have seen aggressive gifting by the estate planning community. We use the average nursing home cost, $2,908 per month. They can give away just slightly under double that amount without additional penalty." (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)

Impact of 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. "1,200 estate planning attorneys in the state." (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]." (Interview)

Examples of ads:
Wright Abshire Attorneys
http://www.wrightabshire.com/
Ad excerpt: "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."[45]

Medicaid Estate Recoveries: Texas is one of three states that have still not implemented estate recoveries as mandated by OBRA '93. State Legislature authorized estate recoveries last year, but they are opposed by the elder law bar and senior advocates. 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: "Thirty thousand 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 1,000 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.

CALIFORNIA[46]

State Snapshot		
Medicaid Eligibility	*1 easy, to 5 hard:*	**1**
Medicaid 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 1,000 elderly, Rank:*	**9.0, 9**
Medicaid Census	*Percent, Rank:*	**66.12%, 24**

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 or means of measuring the extent to which Medi-Cal planning techniques are being used to qualify affluent seniors for the program. 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. The state should immediately implement OBRA '93 transfer-of-assets rules, closely monitor the huge Medi-Cal estate planning bar, and publish notifications throughout California warning of new LTC eligibility restrictions and strong Medi-Cal planning enforcement. It also should end its focus on providing HCBS until it gets control of Medi-Cal long-term care eligibility; 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 care 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 that allows deduction of medical expenses, including the cost of nursing home care, from applicant's income before determination of income eligibility.

- Subjective "intent to return" means home remains exempt 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.

- Instead of using the Minimum Monthly Maintenance Needs Allowance ($1,515 per month until the annual inflation increase becomes effective July 1, 2004) plus housing costs, California allows the maximum $2,319 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 (MMMNA). "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 $2,319 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)

- 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.

- 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 $4,400 (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 a 13-month penalty, $50,000 the next month, resulting in an 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.

Impact of Medicaid Planning:

Examples of ads:

Ashen Senior Resources

http://www.ashenseniorresources.com/index.cfm/entitlements.htm

Ad excerpt: "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.)

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.'. . . 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."

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-1 ratio of recoveries to the cost of collection, meaning the state spends a nickel to collect each dollar. Nevertheless, inadequate staffing 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.[47] California has implemented the expanded definition of "estate," as authorized by OBRA '93. Nursing homes and banks are not required to automatically send Medicaid recipients' $2,000 personal accounts to the MER unit upon the recipient's death. They 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 think we could collect $100 million 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 4,000 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 16th nationally.

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.[48] 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 doubtless 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 1,000 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 Snapshot		
Medicaid Eligibility	*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 1,000 elderly, Rank:*	**9.3, 6**
Medicaid Census	*Percent, Rank:*	**66.48%, 22**

DIAGNOSIS:
Connecticut's long-term care service delivery and financing system is a mixed bag. Because it is a "209b" state — a special provision in the Medicaid law that allowed states with stricter eligibility rules to retain them when the program was implemented — 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 of 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 throughout 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. 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 and 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."[49]

Perhaps through a program of this kind, Connecticut could expand the transfer-of-assets look-back 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 LTC 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 $7,417, 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 Community Spouse Resource Allowance higher by transferring assets instead of income to bring the community spouse up to the Minimum Monthly Maintenance Needs Allowance.

- 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)

- Home is exempt for six months with a physician's statement (renewable upon review every six months) specifying that the recipient is expected to return home. Connecticut can legally impose this restriction because it is a "209b" state.

- 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 look-back 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 the 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)

- "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 look-back 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)

Impact of Medicaid Planning: The state 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.

Examples of ads:
Law Offices of Linnea J. Levine, P.C
http://www.linnealevine.com/HomePage.shtml
Ad excerpt: "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."

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-1 recovery ratio. The threshold to recover is $100 or cost effectiveness.

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

- 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 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 million 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 services, ranking the state fifth in the country. "Our home care program has been increasing 10% a year; we don't have a waiting list; awareness is fairly strong and increasing." (Survey)

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 1,000 elderly recipients ranking the state sixth 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 Snapshot		
Medicaid Eligibility	*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 1,000 elderly, Rank:*	**6.6, 14**
Medicaid Census	*Percent, Rank:*	**59.01%, 43**

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, which is available at http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs_id_005812.hcsp. Although the 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 Community Spouse Resource Allowance 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 $3,848 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 an LTC facility, the homestead is excluded for the first six calendar months of LTC facility 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 six-month restric-

tion because it is a "209b" state — 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. . . . Our waiver is intended to attack that strategy. . . . I also think it is fairly common to transfer assets outside the look-back 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 not done five years back." (Interview)

- 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. . . . 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)

- 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/main/groups/aging/documents/pub/dhs_id_005812.hcsp

Minnesota has also sought a path-breaking 1115 demonstration waiver from CMS to allow the state to extend the look-back 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/main/groups/healthcare/documents/pub/dhs_id_008288.pdf

Impact of Medicaid Planning: 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." (Survey)

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.

- The counties do pursue recoveries from the estates of surviving spouses of Medicaid recipients.

- Minnesota has adopted the expanded definition of "estate" to include annuities and joint tenancy with right of survivorship, as authorized by OBRA '93.

Home and Community-Based Services: Minnesota spends $563.33 per elderly resident on Medicaid home and community-based care, ranking ninth 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: 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 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."[50]

Home Equity Conversion: HEC market penetration is also high in Minnesota with 6.6 HECMs per 1,000 elderly residents, ranking the state 14th in the country. Counseling about reverse mortgages is available through the Department of Human Services Web site.

Medicaid Nursing Home Census: As one would expect given Minnesota's responsible Medicaid and long-term care financing policy, the 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.

NEBRASKA[51]

State Snapshot		
Medicaid Eligibility	*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 1,000 elderly, Rank:*	**2.2, 39**
Medicaid Census	*Percent, Rank:*	**53.76%, 50**

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 60s or early 70s.

Nebraska's worrisome aging demographics compel serious consideration of ways to control Medicaid long-term care expenses. Nebraska must cope with nearly one and a half times as many "old-old" (over age 85) residents *per capita* in the future as compared to the rest of the country.[52] The share of persons age 85 and older, the age group most likely to need long-term care, will rise from 1.5% to 1.9% between 2000 and 2020 in the United States. The comparable increase in Nebraska is from 2.0% to 2.7%.[53]

PROGNOSIS:
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, as Oregon does, 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; and stop the slide into "entitlement mentality" by passing the "Heartland Manifesto."[54]

According to state staff, reducing the percentage of nursing facility days paid by Nebraska Medicaid to 44.4% from the current 54.4% 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 rate of recovery similar to Oregon's, the state would generate approximately $12 million per year in nontax 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% 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% 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.

- "Income first" state; transfer of assets before income to establish a higher Community Spouse Resource Allowance is not allowed.

- 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.

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.[55]

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 rate of recovery similar to Oregon's (see the Oregon state profile in this report), the state would generate approximately $12 million per year in nontax revenue at a cost of only $590,000 per year, netting approximately $10 million per year more than the state currently recovers.

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 deinstitutionalized most of the lowest acuity nursing home patients.

Another concern raised by the 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). 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%. Other states in the Heartland have similarly high rates of long-term care insurance and concomitantly high private-pay nursing home censuses.[56] This is important because people who pay privately for nursing home care often pay one and a half times the Medicaid reimbursement rate.[57]

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

Home Equity Conversion: More Nebraska seniors own their homes on average (80.8%) than is true for the country as a whole (79.4%). The state ranks 22nd 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.[58]

Medicaid Nursing Home Census: Nebraska had the lowest Medicaid nursing home census in the United States as of 2002. Medicaid covered only 52.8% of nursing home residents in Nebraska, as compared to an average of 66.7% for the country as a whole.[59] This is important because higher dependency on relatively low Medicaid reimbursements for nursing home care can exacerbate financial, staffing and quality problems.

OREGON

State Snapshot		
Medicaid Eligibility	*1 easy, to 5 hard:*	**3**
Medicaid Estate Recoveries — Probate	*Percent, Rank:*	**5.87%, 2**
HCBS	*Expenditures per capita, Rank:*	**$637.97, 6**
LTCI Market Penetration		**6%-9%**
Home Equity Conversion	*HECMs per 1,000 elderly, Rank:*	**7.4, 10**
Medicaid Census	*Percent, Rank:*	**61.12%, 41**

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.

Oregon's LTCI and HEC market penetration are high at 10%-14% and 7.4 HECMs per 1,000 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 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 and 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 that 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 spend-down 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" state; transfer of assets before income to establish a higher Community Spouse Resource Allowance is not allowed.

- Oregon does not use a partial month transfer-of-assets penalty, so applicants can give away double the average cost of a nursing home ($4,300), or $8,600 less one dollar, without incurring more than one month's eligibility penalty.

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

Impact of Medicaid Planning: 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 spend-down; for couples who can afford the legal fees, get a spousal support order that increases the Minimum Monthly Maintenance Needs Allowance so that a higher 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 [Medicare Catastrophic Coverage Act of 1988], 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)

Medicaid Estate Recoveries: Oregon ranks second 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.[60]

- MER Unit management: "If we dropped to a 10-to-1 return, with a few additional staff, we could bring Medicaid recoveries up by half to $24 million. We have only pursued the low hanging fruit so far. Twenty-five 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)

  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 attempts recovery in all cases (at least a bank letter, otherwise a cost benefit criterion) and uses no minimum threshold amount. Its $2,500 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 [Tax Equity and Fiscal Responsibility Act of 1982], 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)

- 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 homes 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)

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.[61]

Home Equity Conversion: Oregon has had 7.4 HECMs per 1,000 elderly residents. It ranks tenth 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.

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.

Bottom line: We don't spend too little government money on long-term care. We spend too much in the wrong ways.

While it is understandable that seniors want to protect their assets in order to pass on something to their families and friends, the best way to do that is to take financial responsibility and protect their assets by purchasing long-term care insurance, not become dependent on the Medicaid system.

What we need to do is target scarce public resources to the genuinely needy and create a real long-term care spend-down liability. If we do, 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 the alternatives are 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.

What can states do?

- 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."
- 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.
- 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.

Although these recommendations will not be easy to implement, they will 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

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)

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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

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

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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Endnotes

[1] "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)

[2] 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.

[3] "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.)

[4] 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." Other sources, such as the Veterans program, paid the remaining amounts.

[5] "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/166708700010657925 97V1F2003 Assisted Living Survey.pdf.)

[6] 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."

[7] 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.

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

[9] Ibid.

[10] 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.

[11] The Omnibus Budget Reconciliation Act of 1993.

[12] 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.

[13] 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)

[14] 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]."

[15] 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)

[16] 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."

[17] 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

[18] 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.

[19] 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.

[20] "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)

[21] "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.)

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

[23] 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.

[24] 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.

[25] "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 Centers for Medicare and Medicaid Services has of total state and national Medicaid estate recoveries.

[26] 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.

[27] Oregon reported $13.7 million in "probate recoveries" to CMS for Federal Fiscal Year 2002 (FFY-02). State staff believes 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%.

[28] 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.

[29] "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.)

[30] "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/.)

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

[32] 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.

[33] "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.

[34] 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.

[35] 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.

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

[37] This change was recently postponed for three months by the governor.

[38] In all the profiles, (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. (Interview) refers to the fact that we received this quote in a personal or telephone interview for the current study.

[39] 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."

[40] 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.

[41] 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

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

[43] 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).

[44] "N.Y.: Governor and Senate Medicaid Proposals Opposed by AARP Members," U.S. Newswire (press release) — Washington, D.C., April 13, 2004, http://releases.usnewswire.com/GetRelease.asp?id=110-04132004.

[45] 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).

[46] Medicaid is known as Medi-Cal in California.

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

[48] "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.

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

[50] Source: STATE TAX INCENTIVES FOR LONG TERM CARE INSURANCE, updated June 2003, http://www.ltcas.com/downloads/StateTaxIncentives2003.pdf.

[51] 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.

[52] Ibid.

[53] 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.

[54] "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.)

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

[56] 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.

[57] 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% of the private pay rate.

[58] Ibid.

[59] 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.

[60] 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.

[61] State Tax Incentives for Long Term Care Insurance, updated 06/2003, http://www.ltcas.com/downloads/StateTaxIncentives2003.pdf.