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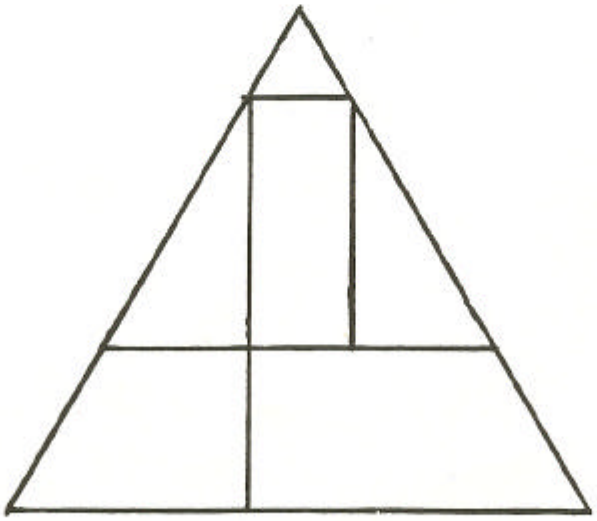
# The Medicaid Estate Recoveries Study

## Volume I: Estate Recoveries In The Medicaid Program



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### Volume I

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## Preface

This is Volume I of a four volume report. The report describes a project conducted by the Health Care Financing Administration's Region Ten Office in Seattle. The State Medicaid programs of Idaho and Oregon provided invaluable support and assistance to the project team. Comments or questions may be addressed to :

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Volume I explains how middle income people qualify for long-term care public assistance payments from the Medicaid program. It concludes that Medicaid could recover non-tax revenues of one-half billion dollars more than current collections by encouraging states to recover benefits correctly paid from the estates of deceased Medicaid recipients. Volume I also suggests that non-tax revenues far in excess of one-half billion dollars are readily attainable by changing the laws to require efficient estate recoveries as a condition of Federal financial participation.

Volume II is the data book for Volume I. It contains quotations and excerpts from the popular media and the professional legal literature on the subject of welfare resource avoidance, i.e. how to qualify for and maximize public assistance payments from the Medicaid program. It also contains source material on the financial status of the elderly, the long-term care funding crisis, and elder abuse. Volume II provides tabular data from a phone survey conducted for this project on the use of liens and estate recoveries by state Medicaid programs nationally. Finally, Exhibit II-7 of Volume II is a first attempt to conceptualize an estate recoveries "franchise package" which any state Medicaid program might adapt for use.

Volume III is the project report on field research conducted in the State of Idaho. The purpose of this research was to determine if, and to what extent, Idaho could recover Medicaid resources by replicating Oregon's model estate recovery program. Using two different methodological approaches, the Idaho project confirmed the availability of a large recoverable resource in Idaho. Volume III concludes that Idaho could recover up to $1,000,000 a year by implementing an estate recoveries program comparable to Oregon's model.

Volume IV is the data book for Volume III. It contains the Idaho project plan, case by case analysis of project findings, and a recurrent themes analysis to help the reader find actual examples of each theoretical point made in the other volumes.

We hope this report will lead to a re-examination of the rights and responsibilities of Medicaid eligibility.

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# Estate Recoveries in the Medicaid Program

## I. Introduction

The original intent of the Medicaid program was to insure access to mainstream health care for the poor. From the beginning, the program contained an institutional long-term care element. The cost of long-term care under Medicaid grew disproportionately in response to the "graying of America" and the perceived economic decline of the elderly during the inflationary 1970's. Today, Medicaid pays for just under half of all nursing home costs in the United States.[1] Private patients pay for most of the other half.[2] Health insurance policies rarely cover nursing home costs and Medicare coverage is very limited.[3] "Thus, almost by default, Medicaid has become the major 'insurance' program for

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[1]Health Care Financing Administration (HCFA), Grants and Contracts Report, Short Term Evaluation of Medicaid: Selected Issues, October 1984, Contract No. HHS-100-82-0038, p. 121.

[2]Scanlon, William J. and Judith Feder, "The Long-Term Care Marketplace: An Overview," Health Care Financial Management, January 1984, p. 25.

[3]Medicare Part A hospital insurance will pay for up to 100 days of skilled nursing facility (SNF) care. The SNF care must (1) follow a stay of at least three days in a hospital, (2) be related to the condition treated in the hospital, and (3) begin usually within 30 days of dehospitalization. A doctor must certify, and the patient must receive, daily skilled care. If these conditions are met, Medicare will pay the first 20 days of skilled care in full but the patient must contribute $44.50 per day for the 21st to 100th days. According to HCFA, op cit., p. 128: "The majority of nursing home admissions are short-stayers (with an average length of stay of 1.8 months), but on any given day, long-stayers (with an average length of stay of 2.5 years) constitute over 90% of all nursing home residents. These long-stayers, who are more likely to be Medicaid recipients, thus consume the vast majority of resident bed days (General Accounting Office, 1983)." Hence, Medicare's contribution to nursing home costs is small and Medicaid's is large.

nursing home care, not only for elderly persons of low income, but for middle-income persons who cannot afford the high cost of nursing homes for very long."[4]

This paper will discuss these middle income Medicaid recipients. Who are they? What are their options, besides Medicaid, to pay for long term care? How do they qualify for public assistance? Do they have sufficient assets in their estates to repay the welfare benefits they receive? Are they required to do so? How much non-tax revenue could improved estate recoveries generate for Medicaid? And finally, what can we do to develop this funding source? The answers are in the Conclusion. The paper adduces the evidence.

## II. The Elderly and Long-Term Care Costs

In 1900, life expectancy at birth was 46 years for men and 48 years for women; only one person in 25 was over 65 years of age.[5] By 1980, life expectancy had increased to 70 and 78 years,[6] respectively, and one person in eight was over 65.[7] The fastest rate of growth in life expectancy has been among the oldest and most vulnerable of the elderly. The number of people 85 years of age and older is increasing at a rate of 4.03 percent per year as compared to 2.68 percent

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[4]HCFA, op. cit., p. 122, emphasis added.

[5]Council of Economic Advisers (CEA), The Annual Report of the Council of Economic Advisers, U. S. Goverment Printing Office, Washington, D.C., 1985, pps. 159-160.

[6]Jennings, Marian C. and Susanna E. Krentz, "Private Payment for Long Term Care: The Untapped Mechanism," Topics in Health Care Financing, Spring 1984, p. 1.

[7]CEA, op. cit., p. 160.

for people 75 to 84, 1.58 percent for those 65 to 74 and 1.61 percent for the general population.[8] By the year 2020, according to projections, one person in five will be over age 65[9] and the United States as a whole will have the same proportion of elderly as Florida today.[10] These facts led the President's Council of Economic Advisers to conclude in their 1985 Annual Report: "The proportion of the population that is elderly is growing; it will explode as the baby-boom generation retires . . . No other demographic change will influence the Nation in the next 50 years as much . . . Every American and every facet of the society will be affected."[11]

One way we will be affected is in the cost of long-term care. As mortality rates declined in the twentieth century, morbidity rates did not keep pace. Consequently, we not only have more elderly people today, but more of them require greater and longer care. About eight million people needed long-term care in 1977. Of these, twenty percent were in nursing homes.[12] Expenditures for nursing home care increased from $2.1 billion in 1965 to $24.2 billion in 1981. By 1990, nursing home costs are expected to account for ten percent of all health care expenditures at a cost of $76 billion per year.[13] Current efforts to

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[8]Scanlon and Feder, op. cit., p. 30.

[9]Jennings and Krentz, op. cit. p. 1.

[10]CEA, op. cit., p. 160.

[11]Ibid.

[12]Scanlon and Feder, op. cit., pps. 19-20.

[13]Jennings and Krentz, op. cit., p. 3.

divert long-term care patients to less costly home and community-based care may help somewhat. "Assuming current age-specific use rates remain stable," however, "the total nursing home population will increase four times faster than the U.S. population as a whole over the next fifty years."[14] Although only five percent of the elderly live in nursing homes, this rate has nearly doubled since the establishment of Medicare and Medicaid in 1966.[15] Given the increasing costs and tighter controls on public financing, where will the resources come from to pay for the needed care?

There are only two sources: public or private funds. Of the $24.2 billion spent on nursing home care in 1981, over $10 billion (43 percent) came directly from patients and $13.6 billion (56 percent) came from public sources. Medicaid provided 90 percent of the public funds.[16] "Although clearly not an intent of the original legislation, Medicaid has become the primary public payor for nursing home care. Recipients of nursing home care comprised just 7.3 percent of the total Medicaid population in 1982, yet nursing home costs comprised 43 percent of all expenditures."[17] Because of past increases and the current disproportionate share of Medicaid funding for long-term care, public policy makers will need to look beyond Medicaid for new money. Medicare and other government sources, which paid only 1.7 percent and 4.6 percent of nursing

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[14]HCFA, op. cit., p. 122.

[15]CEA, op. cit., p. 169-170.

[16]Scanlon and Feder, op. cit., p. 25.

[17]HCFA, op. cit., p. 121.

home costs in 1981, respectively, are unlikely to absorb large increases.[18] The same fiscal constraints operating on existing medical programs have made the panacea-of national health insurance more illusive today than ever. Some analysts now conclude that "it is imperative that non-public payment sources for long-term care be explored and developed to ensure that those requiring services can obtain them."[19]

Private payment sources of a magnitude commensurate to the problem, however, are hard to find. In their paper entitled "Private Payment For Long-Term Care: The Untapped Mechanism," Jennings and Krentz identify five categories of "nonpublic" payment sources for long-term care.[20] They conclude that the first three sources -- national foundations, local charitable organizations, and private donors -- cannot be expected to contribute much more than they already do toward long-term care services.

Their fourth source, private insurance, contributed only .8 percent toward nursing home expenditures in 1980, and is fraught with technical and practical problems in the future.[21] Actuarial and other issues aside, however, the Health

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[18]Scanlon and Feder, op. cit., p. 25.

[19]Jennings and Krentz, op. cit., p. 10.

[20]Ibid.

[21]These problems include "moral hazard," actuarial assessment and modeling, high-risk enrollee preference and perception of sufficient coverage as explained in Ibid., p. 15-16.

Insurance Association of America assumes "that the potential for private insurer involvement could increase if Medicaid became less attractive for people with mid-level incomes."[22] In other words, while Medicaid is readily available, most people will not pay premiums for private long-term care insurance. This problem is further exacerbated by the common misconception that Medicare covers all health care needs after age 65.[23] Pending changes in public funding mechanisms and in the public's perception of them, private long-term care insurance is not economically viable.

The fifth private payment source for long-term care is self-paying individuals. Individuals already pay 43 percent of the country's nursing home costs. The means to increase this percentage are difficult to identify. Health retirement accounts, or medical IRA's would take a generation to fund with private investments induced by tax incentives. Life care communities are very expensive and may not meet the needs of the middle-income elderly. Reverse annuity mortgages have great potential, but so far their commercial success has been disappointing. The payments they generate can render otherwise coverable Medicaid applicants ineligible. Finally, family contributions and care are unlikely to grow significantly.

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[22]Lifson, Arthur, "Financing Long-Term Care: HIAA's Evaluation," Health Care Financial Management, Vol. 38, No. 3, March 1984, p. 64, emphasis added.

[23]Jennings and Krentz, op. cit., p. 16. Misconceptions about Medicare's coverage of long-term care have been common since President Johnson said at the bill-signing ceremony: "No longer will illness crush and destroy the savings that have so carefully been put away over a lifetime so that (older Americans) might enjoy dignity in their later years." People, like Hyman Freed on a recent Frontline docu-drama, got the wrong idea:

> You know, it's strange, you, I started payment into this Medicare system from the day one, from the day it started. And while I never read the law, always in the back of your mind, as a young person

Although the elderly relied traditionally on their children for housing and financial support, they receive less than one percent of their income from their offspring today.[24] The percentage of elderly people who live with their children declined from 31 percent in 1950 to 9 percent in 1970.[25] Even the 60 to 80 percent of non-nursing home long-term care provided by families and friends of the elderly is likely to decrease.[26] With longer life spans, the children of the elderly are often elderly themselves and unable to provide care. As the traditional caregivers, daughters and daughters-in-law, enter the labor market, they also become less readily available to help. Scanlon and Feder concluded that "a larger share of dependent persons than in the past may therefore have to seek services from formal providers."[27]

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> working and paying for this thing, week after week they take it out of your salary. They don't give you a choice, you just pay it. And you have the mistaken idea, that well when you get old if you get sick, Medicare's gonna take care of you. You don't have to worry about that . And then comes the horrible awakening. You retire and you do get sick and you find out that Medicare has more rules than the Bible. There's no--they don't pay for this, they don't pay for that, they don't pay for anything, darn near. Except certain short term acute care things. Good god, the average person can afford to handle an occasional acute care thing without paying all their life into it. And that's all they pay.

Frontline, "What About Mom and Dad," May 21, 1985, #320, p. 16.

[24]CEA, op. cit., p. 159.

[25]Ibid., page 169.

[26]Jennings and Krentz, op. cit., p. 3.

[27]Scanlon and Feder, op. cit., p. 34.

All of the commonly cited private payment sources for long-term care have serious problems. Moreover, the public sources often work at cross-purposes with the private sources as when Medicaid rules encourage high cost institutionalization and discourage family contributions.[28] Nevertheless, the financial wherewithal of the elderly, including their ability to pay for their own care, is greater today than it has ever been. If there are solutions to these long term care funding problems, they will come from this enhanced economic well-being.

## III. The Financial Status of the Elderly

The dire financial status of old people in the United States was part of the conventional wisdom of the inflationary 1970's. Recent studies, however, show a different picture. According to the Council of Economic Advisers:

> Thirty years ago the elderly were a relatively disadvantaged group in the population. That is no longer the case. The median real income of the elderly has more than doubled since 1950, and the income of the elderly has increased faster over the past two decades than the income of the non-elderly population. Today, elderly and non-elderly families have about equal levels of income per capita. Poverty rates among the elderly have declined so dramatically that in 1983 poverty rates for the elderly were lower than poverty rates for the rest of the population.[29]

Several reasons underlie this financial turn for the better. The effects of the Depression and World War II on the work lives of the elderly are disappearing.

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[28]Systemetrics, Inc., Financial Incentives for Family Care: Draft Final Report, prepared under contract number 500-83-0056 for the Health Care Financing Administration, May 17, 1985. Chapter 2 of this report, "Medicaid Eligibility and Incentives for Family Care," examines Medicaid's institutional and "anti-family" bias.

[29]CEA, op., cit., p. 160.

Their incomes, buttressed by social security, are now largely resistant to inflation. Heavy reductions in public assistance programs during the past few years did not disadvantage the elderly proportionately. Finally, the real estate inflation of the 1970's had windfall proportions for property-holding elders. The magnitude of these changes is evident when we look at the statistics.

The elderly receive 15 percent of their cash income from earnings, 15 percent from pensions, 25 percent from asset yields, and 40 percent from social security.[30] These income sources have in common their relative resistance to inflation. Earnings, the least resistant, have declined in the past few decades from the predominant income source for the elderly to one of the smallest. Social security income, the most resistant to inflation because of automatic increases tied to the Consumer Price Index, has grown to number one. The proportion of elderly receiving social security benefits rose from 16 to 94 percent from 1950 to 1983. Since 1970, real[31] social security benefits increased by 46 percent while wage and salary earnings, the major source of income for the non-elderly, decreased by 7 percent in real terms.[32] Summarizing their article in The Gerontologist, Clark and Sumner say: "The hypothesis that the elderly are more vulnerable to inflation is carefully examined and then rejected. We find that older persons do not live on fixed nominal incomes. Data from the Retirement History Study show that income sources of the elderly were not fixed in nominal terms but increased as prices rose."[33]

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[30] Ibid., pps. 169-177.

[31] I.e., adjusted for inflation.

[32] CEA, op., cit., p. 165.

[33] Clark, Robert L. and Daniel A. Sumner, "Inflation and the Real Income of the Elderly: Recent Examples and Expectations for the Future," The Gerontologist, Vol. 25, No. 2, 1985, p. 146.

Although income has grown faster for the elderly, they have been far less affected than other population groups by recent benefit reductions in public assistance programs. The changes made in OBRA (The Omnibus Budget Reconciliation Act of 1981), TEFRA (The Tax Equity and Fiscal Responsibility Act of 1982), and the Social Security Amendments of 1983 will reduce outlays for all human services by 7 percent from 1982 to 1985. The reduction in programs affecting the elderly is only 4 percent.[34] According to Ruggles and Moon in a recent article in The Gerontologist:

> As a share of benefits received, elderly households face much smaller reductions in benefits than do younger households. Benefit reductions enacted since 1981 have, in general, fallen more heavily on means-tested programs than on the social insurance programs on which the elderly are more likely to rely. For example, the largest social insurance programs serving the elderly -- Social Security and Medicare -- were reduced by about 3% and 5%, respectively. Furthermore, the only means-tested program that does primarily benefit the elderly, SSI, has been exempted from the larger reductions generally occurring in such programs and will actually increase by 4% over the period as a result of legislative changes.[35]

By comparison, Food Stamps and AFDC (Aid to Families With Dependent Children), which benefit only a small percentage of the elderly, were reduced by 13 percent and child nutrition programs were cut 28 percent during the same three year period.

Even as their incomes increased more and their benefits declined less than other groups, the elderly also prospered disproportionately from the real estate

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[34]Ruggles, Patricia and Marilyn Moon, "The Impact of Recent Legislative Changes in Benefit Programs for the Elderly," The Gerontologist, Vol. 25, No. 2, 1985, p. 156.

[35]Ibid. "SSI" stands for the Supplemental Security Income Program, Title XVI of the Social Security Act.

inflation of recent years. People over 65 account for 21 percent of all housing units occupied year round.[36] Seventy percent of them own instead of rent their homes. Mean home equity of the elderly who own homes is $58,269 and median equity is $41,857.[37] Eighty percent of homeowners aged 65 to 74 and 95 percent of those 75 and over, own their homes free and clear of mortgage debt.[38] Moreover, home ownership is not limited to the upper and middle income elderly. According to Jacobs and Weissert, "about 65 percent of all elderly poor are homeowners, and many low-income elderly people have substantial assets in their homes. . . 22 percent of the poor and 32 percent of the near poor have more than $50,000 in net home equity."[39] The total home equity owned by the elderly today exceeds $600 billion.[40]

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[36]General Housing Characteristics--1980 Census of Housing, Table 1: Summary of General Housing Characteristics: 1980 (HC80-1-A). By comparison, the elderly account for only 19 percent of all heads of household (Source: See footnote 37.)

[37]Avery, Robert B., et. al., "Survey of Consumer Finances, 1983," Federal Reserve Bulletin, September 1984, pps. 679-692. This survey was a joint project of the Board of Governors of the Federal Reserve System, the Department of Health and Human Services, and five other federal agencies. Comparative figures for all families show that only 60 percent own their homes. Total home owning families have mean and median home equities of slightly less than the elderly's at $56,133 and $41,261 respectively.

[38]Avery, Robert B., et. al., "Survey of Consumer Finances, 1983: A Second Look," Federal Reserve Bulletin, December 1984. The comparable figure for all homeowners is only 43 percent.

[39]Jacobs, Bruce and William Weissert, "Home Equity Financing of Long-Term Care for the Elderly," in Conference Proceedings, Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives, January 24, 1984, Washington, D.C., published by the Health Care Financing Administration, Publication No. 03174, p. 83.

[40]Ibid.

Clearly, the financial status of the elderly has improved in recent years. In 1983, their poverty rate, when in-kind income such as food, housing and medical benefits are considered, was only 3.3 percent. The comparable rate for the population under 65 was more than three times as high at 11.1 percent.[41] The biggest financial spectre which still faces the elderly is how to pay for long term care if chronic illness strikes. Most will qualify for Medicaid and Medicaid will pay.

## IV. Medicaid Eligibility

Medicaid eligibility is bewilderingly complex. Distilled to the essentials however, it means that an elderly individual with a certified medical need can qualify for long term institutional care paid for by Medicaid in whole or in part for the rest of his life[42] if his resources, excluding the personal residence, are less than $1600 and his monthly income is less than $975.[43] Many of the complexities in Medicaid eligibility pertain to ways that a person can have even

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[41] CEA, op., cit., pps 167-168. Measured on a cash income basis, the poverty rate for the elderly was 14.1 percent as compared to 15.3 percent for the non-elderly. Because the elderly are more likely to receive medical benefits, the impact of in-kind (medical) income is much greater on their poverty rate than on the non-elderly's.

[42] According to HCFA, op. cit., pps 128-130, 85 percent of Medicaid nursing home recipients remain in some kind of institutional facility for the remainder of their lives.

[43] According to Section 1903(f)(4)(C) of the Social Security Act, states may provide Medicaid to persons who are in long term care institutions and have income up to 300 percent of the current federal benefit rate (FBR) for Supplemental Security Income. The FBR for 1985 is $325, but it increases annually. If they wish, States may apply more restrictive income standards.

more income, and still qualify for Medicaid.[44] The formula given here is a general standard which any state may apply.

Applying this general eligibility standard, more than half of the elderly in the United States can qualify for Medicaid within a few months of beginning private pay institutional care. The median[45] annual income of families whose head of household is aged 65 to 74 is $12,538. If the family head is 75 or over, the income level drops to $7,176. These same family groups hold $11,400 and $10,350 respectively in total financial assets.[46] The home equity of families with head of household over 65 is $41,857. Finally, families headed by someone 65 to 74 have a net worth of $50,181 while those with a family head 75 or over average $35,939.[47] Comparing this data to the Medicaid eligibility standards, we find that:

(1) Most of the elderly's net worth is in their homes which are exempt.

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[44]For example, medically needy Medicaid programs allow recipients to "spend down" to income eligibility levels by incurring medical costs. This allows people with higher income (and higher medical costs) to qualify for Medicaid even though they cannot meet lower categorically needy income limits. Thirty-five states have medically needy programs. Of these, 28 cover institutional long term care.

[45]The median, instead of the mean, is used for all income and resource figures cited here unless otherwise stated. The data is from Avery, op. cit., September 1984.

[46]These are median financial assets held by families who hold such assets. Eighty-eight percent of all families headed by someone 65 to 74 hold such assets; the figure drops to 86 percent for those 75 and over. "Financial assets include liquid assets plus stocks, other bonds, nontaxable holdings (municipal bonds and shares in certain mutual funds), and trusts. Liquid assets include checking accounts, savings accounts, money market accounts, certificates of deposit, IRA and Keogh accounts, and savings bonds." (Ibid., p. 685)

[47]Avery, op. cit., December 1984.

(2) The annual income for families over age 75 ($7,176) is well within Medicaid eligibility limits, while income for families aged 65 to 74 is only slightly over the limit -- $12,538 compared to $11,700 (12 months times $975 per month). Usually this overage will not disqualify a family-member because Medicaid eligibility rules allow separate treatment of income when one member of a couple enters a nursing home permanently. In any case, the excess income will be eliminated as asset yields disappear when families spend down to Medicaid resource limits in private pay nursing home status.

(3) Although the financial resources held by the elderly considerably exceed welfare standards -- by $9,800 for those 65 to 74 and by $8,750 for those 75 or over -- such assets are quickly expended through private pay nursing home and other medical costs ranging easily from $1,000 to $3,000 per month.

Medicaid eligibility, therefore, is well within the reach of the average elderly family in America when we apply the general eligibility standards permissible in law and the family has not prepared in advance.[48]

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[48]One should note, however, that qualifying for Medicaid does not by itself solve the long term care problem for many families. A very common situation, dramatized in Frontline, op. cit., pps. 19-21, occurs when one member of an elderly couple, usually the man, becomes ill and requires institutionalization. Medicaid cost sharing rules require that his income, e.g. pensions, social security etc., must be applied to the cost of care except for an amount equal to poverty level subsistence ($325 per month) which remains available to the wife. Income of the well spouse, however, is not deemed available to the institutionalized spouse. Thus, if the person left at home has an independent income source, there may be no problem. As the wife is most likely to remain home the longest and is least likely to have an independent income source, however, she often ends up with too little income to manage. Ironically, she may be living in an expensive home owned free and clear when her husband's Medicaid eligibility leaves her impoverished.

When less restrictive standards of income and resources are applied, Medicaid eligibility extends to elderly families far above the median. Additional elderly people with higher incomes, for example, will qualify for Medicaid under the more liberal medically needy programs. Those who consult an attorney, will learn how to shelter much higher resource levels than are otherwise allowed by using special trusts. Finally, anyone, irrespective of income or wealth, who begins estate planning at least two years before the need for long term care arises, can structure his financial affairs so as to qualify for Medicaid. He needs only to transfer enough assets to other people to reduce his income and resources to within welfare limits.[49] Relieving the family of nursing home expenses in this way is very profitable. At an average nursing home cost of $1,000 per month and an average long term care stay of two and one-half years, the expected savings is $30,000.[50]

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[49]Transfer of assets restrictions for SSI (1613c of the Social Security Act) and Medicaid (1917c) place no limits or conditions on transfers which occur more than two years prior to the application for public assistance. One should not confuse this fact with the provisions in 1917c which permit states to impose periods of ineligibility in excess of 24 months under certain conditions. No penalty of any duration will occur if the transfer was made more than two years in advance.

[50]HCFA, op. cit., p. 128. Data at Ibid, p. 133 show that the average Medicaid nursing home cost per recipient in 1982 was $7,855 in a skilled nursing facility and $6,499 in an intermediate care facility. These figures are less than the true cost of care, however, because (1) Medicaid rates are considerably below the private rates a family would have to pay without Medicaid, and (2) Medicaid recipients are required to contribute toward the cost of their care based on their income level. To estimate the real value of Medicaid to the recipient, we must also take into consideration the non-long-term care service costs which do not require recipient cost-sharing. These include inpatient and outpatient acute care, prescription drugs, laboratory and x-ray services, home health care, and the optional Medicaid services. The average Medicaid cost for inpatient hospital care in 1982, for example, was $1,832. (This figure does not take into account the disproportionately high utilization of acute care by the institutionalized elderly.) Thus, the true value of Medicaid to the recipient and his family is much higher than average Medicaid nursing home cost figures would suggest.

The mass public is not yet widely aware of these Medicaid "loopholes". Nevertheless, information on welfare resource avoidance is readily available to those who look. In March 1985, Money Magazine wrote that:

> Two government programs in particular are designed to supplement income and cover the medical costs of the needy--Supplemental Security Income (SSI) and Medicaid. . . .As your parents age, it may thus be advisable to help them gradually transfer ownership or convert to exempt property so they could get government assistance if they were to need it.[51]

In the same month, Business Week published a similar article which said:

> As distasteful as the mere idea of pleading proverty may be, you might find consolation in knowing that such a plea can ultimately allow you to obtain a highly valuable medicaid card. . . ."The same people who rely on tax planning and make use of every loophole in the tax laws to build up their assets," says Robert, "can use the same techniques to keep them--and still qualify for medicaid."[52]

Some people use far cruder methods to achieve the same goal. According to syndicated columnist Jane Bryant Quinn:

> The high price of nursing homes can devour an elderly parent's assets, leaving no inheritance for the children. To protect their patrimony, some adults take their parents' savings for themselves, register the parent as "poor" and turn to Medicaid for help.[53]

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[51]Keeffe, Patrick "Ten Questions to Ask Your Parents," Money Magazine, March 1985, p. 168.

[52]Dunn, Donald H., "Easing the Burden of Nursing Home Costs," Business Week, No. 2883, March 11, 1985, p. 123. The person quoted is Charles Robert of Robert & Schneider, a law firm in Hempstead, N.Y., specializing in the health care problems of the elderly.

[53]Quinn, Jane Bryant, "Family Obligations," Newsweek, August 29, 1983, p. 56.

This latter practice, although clearly illegal, is commonplace and difficult to monitor.[54]

Misrepresentation and fraud are unnecessary, however, if the family has access to a good lawyer. Law journal articles are proliferating which teach attorneys how to shelter their clients' financial assets from Medicaid resource limitations. Like tax avoidance counseling, this new area is both legal and ethical.[55] Its practical impact, however, is that people who retain a lawyer keep their property intact and those who do not, lose everything. William G. Talis summarized his classic article on the subject in this way:

> Structuring the finances of elderly persons to qualify for health care assistance under the Medicaid program is presented in this article as a viable estate planning goal, together with considerations under limiting federal and state regulations and of conveyancing and trust law which must be recognized in attaining this goal."[56]

Other similar articles in the legal literature include Mitchel M. Simon's "Estate Planning and Resource Maximization for the Elderly: Medicaid Considerations"[57] and Charles M. Delbaum's "Financial Planning for Nursing Home Care:

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[54]Many examples of financial exploitation may be found in Volumes II and IV.

[55]Speaking of tax avoidance, Justice Learned Hand, the famous New York Jurist said: "Anyone may so arrange his affairs that his taxes shall be as low as possible: He is not bound to choose that pattern which best pays the Treasury. Everyone does it, rich and poor alike, and all do right; for nobody owes any public duty to pay more than the law demands." (Quoted in VanCaspel, Venita, Money Dynamics for the 1980's, Reston Publishing Company, Reston, Virginia, 1980, p. 345). One wonders, however, if the principle is really the same. Does it follow from what Justice Hand said about tax avoidance that anyone may legally and ethically arrange his financial affairs so that he qualifies for welfare and his benefits are as high as possible?

[56]Talis, William G., "Medicaid as an Estate Planning Tool," Massachusetts Law Review, Spring, 1981, p. 89.

[57]Simon, Mitchel M., "Estate Planning and Resource Maximization for the Elderly: Medicaid Considerations" New Hampshire Bar Journal, Vol. 25, No. 2, January 1984, pps 101-108.

Medicaid Eligibility Considerations."[58] These articles provide a menu of welfare resource avoidance techniques which include (1) the purchase of exempt resources, (2) the use of irrevocable trusts and (3) legal ways to transfer property for less than fair market value and still qualify for Medicaid. Although Congress has attempted to suppress welfare resource avoidance in recent years, the Clearinghouse Review concluded in June 1984 that:

> With long-range planning, the cooperation of relatives, some good health, and maybe a little luck, couples will be in a position to negotiate between the rock and a hard place that Congress has placed in the Medicaid path.[59]

Based on the regulatory experience so far, their analysis is probably correct.

Until the Boren-Long Amendment of 1980, there were no Federal Medicaid eligibility restrictions on asset transfers for less than fair market value. Anyone, faced with the need for long term care, could give away all of his assets and enter a nursing home on public assistance. From 1980, until the Tax Equity and Fiscal Responsibility Act (TEFRA) in 1982, the transfer restriction did not apply to exempt property.[60] TEFRA itself places only a two year limit on such

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[58] Delbaum, Charles M., "Financial Planning for Nursing Home Care: Medicaid Eligibility Considerations," Ohio State Bar Association Report, Vol. 57, No. 14, April 2, 1984, pps. 372-381.

[59] Deford, Gill, "Medicaid Liens, Recoveries, and Transfer of Assets after TEFRA," Clearinghouse Review, June 1984, p. 139.

[60] This means that before TEFRA, property considered exempt from Medicaid eligibility determination could be transferred to anyone without regard to compensation. Recipients were wise to transfer such property because, although it did not affect current eligibility, the property could become non-exempt (as upon the death of a resident spouse) and cause ineligibility. Also, the property would be recoverable from the recipient's estate unless transferred to another party. TEFRA closed the loophole which permitted transfer of exempt property, but not entirely. A recipient may still transfer an exempt property to a spouse or a minor or disabled child. Then, the spouse can transfer the property to

transfers and even this restriction is a state option.[61]

Do these weaknesses in the transfer restrictions matter, however, inasmuch as TEFRA also allows states to place liens on recipients' real property and to recover benefits paid from their estates? Like the restriction on asset transfers, TEFRA's lien provisions are optional. Congress placed so many qualifications on the use of liens when Medicaid benefits were correctly paid[62] that, as of mid-1985, only one state in the country--Alabama--used the provision. Only five states[63] were using the relatively unrestricted right to place liens on account of benefits incorrectly paid. Thus, most states do not have an effective means to insure that exempted assets remain in recipients' estates until recovery can be effectuated after their deaths.

This deficiency, however, is moot in most cases. TEFRA recovery provisions are also optional. Twenty-eight states have no state statutory authority to pursue Medicaid estate recoveries. Four states, which do have the necessary authority,

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someone else leaving it free and clear of future eligibility considerations or estate recovery. Legal counselors on welfare resource avoidance frequently recommend this ploy. (See Delbaum, op.cit., pps. 377-378. The passage is included in the Data Book (Volume II, Exhibit II-2).)

[61]The lien, recovery and transfer of assets provisions of TEFRA are in Section 1917c of the Social Security Act. A copy of this section is included at the end of Volume II, Exhibit II-7. The best and most recent analysis of the TEFRA provisions is the piece by Gill Deford already cited called "Medicaid Liens, Recoveries, and Transfer of Assets After TEFRA." This article is reprinted with permission of the Clearinghouse Review in Volume II, Exhibit II-2.

[62]Such liens can be used only if (1) the recipient is institutionalized, (2) he applies most of his income to his cost of care, (3) he cannot be expected to return home, and (4) he has no spouse, child under 21 or disabled, or sibling with an equity interest living in the home. Complicated procedural requirements at 42 CFR 433.36(d) through (i) must also be met.

[63]Alabama, Massachusetts, Mississippi, New Hampshire and Utah. See Volume II, Table II-3.

do not use it. Only eighteen states and the District of Columbia actually pursue benefit recoveries from the estates of deceased Medicaid recipients. Among these programs, the annual collection rates by per capita of caseload vary widely from $25.03 per recipient in Oregon to $.35 per recipient in Alabama with a national average of $3.33.[64] Thus, the majority of state Medicaid programs do not recover from recipient estates, and most of those which do, recover at a rate which is only a small fraction of the potential.

According to legislative history, Congress intended the Tax Equity and Fiscal Responsibility Act:

> 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 costs of supporting the individual in the institution.[65]

After almost three years of experience under TEFRA, congressional intent remains unfulfilled.

## V. How Recipient Assets Are Lost To Medicaid Recovery[66]

The chart on page 21 displays the major reasons why recipient assets are lost to

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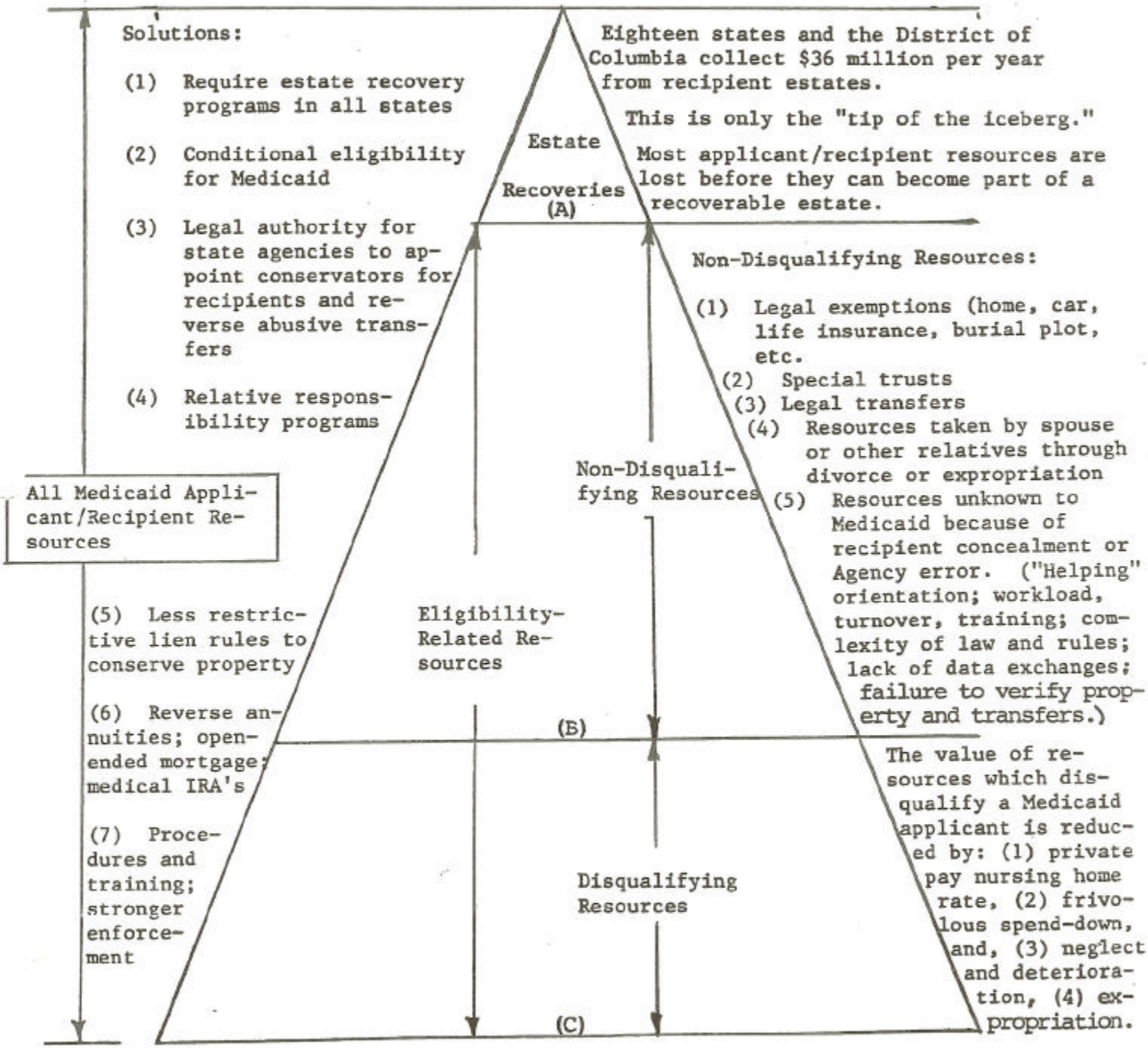
[64]This data comes from a survey of state Medicaid programs conducted for this study. See Volume II, Table II-2 for further information.

[65]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 Co., p. 814. TEFRA has no time limit on recovery. According to Deford, op. cit., p. 137 ". . .after a recipient's death while a surviving spouse or dependent child remains alive . . . the state could apparently wait for years to effect recovery."

[66]This chapter is derived from our own research in Oregon and Idaho which is described in Chapter VI: Toward a Solution and in Volume III: The Idaho Transfer of Assets Project Report. Also, Volume IV: The Idaho Project Data Book contains individual case write-ups and a "recurrent themes analysis" which sutstantiate the points made here.

ChartI-1: How Recipient assecs are Lost as a Source of Reimbursement for Medicaid Payments

Thirty-two states do not reimburse Medicaid from the resources of deceased recipients: 28 states have no state statutory authority to recover Medicaid benefits which were correctly paid and four states do not use the legal authority that they have.




The full potential of estate recoveries as a non-tax revenue source is frequently over-looked because we fail to see the connection with eligibility. Most recipient resources are taken by someone before they can become part of a recoverable estate. The solution is (1) stronger Federal and state laws to protect recipient resources until their death, and (2) mandatory estate recovery efforts for all Medicaid programs.

Medicaid recovery. The whole triangle represents the net worth of all Medicaid applicants and recipients. The bottom two tri-sections stand for resources which are considered in determining a person's eligibility for Medicaid. Tri-section C contains those resources which, if known to the Medicaid agency, will disqualify an applicant for assistance. Such resources include all non-exempt real and personal property in excess of eligibility limits.

When a person in need of long term institutional care is disqualified for Medicaid because of excess resources, a spend down process begins. The sick person enters or remains in a nursing home at the private pay rate which is often 15 to 20 percent higher than what Medicaid pays. His family, now privy to Medicaid eligibility rules, begins actively exploring ways to qualify him for public assistance. They probably have his best interests in mind, but this concern is counterweighed by the knowledge that their own inheritances are being rapidly consumed by nursing home bills. Frivolous spending on exempt property and unrecorded asset transfers become an immediate temptation. There is pressure to dispose of non-exempt property at any price. Waste or expropriation often occurs during this period. The patient becomes a target for hucksters and swindlers including unprincipled family members.[67] If a married couple is

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[67]The growing literature on "elder abuse" talks increasingly of "financial exploitation." For example: ". . .abusive acts can include both passive and active neglect, mental anguish, financial exploitation, and the denial of medicines and medical care . . . And, financial exploitation, although not life threatening, is a criminal act and deprives the victim of independence, income, and assets . . . Financial exploitation involves the theft or conversion of money or objects of value to an elderly person by a relative or caretaker. It can be accomplished by force or through misrepresentation." (Giordano, Nan Hervig and Jeffrey A. Giordano, "Elder Abuse: A Review of the Literature," Social Work, Vol. 29, No. 3, May-June 1984, pps. 232-233, emphasis added.)

involved, attorneys frequently recommend a divorce. The property settlement can then be arranged to preserve the family's assets for the well spouse and leave the ill spouse destitute and eligible for Medicaid.[68] While these or other machinations are going on, the patient's larger assets, such as real estate or automobiles, may suffer from neglect and deterioration. Whatever the means, intentional or otherwise, the outcome is quite predictable. The patient is rendered eligible for Medicaid usually within six months.[69] (We are not suggesting by the preceding scenario that all families follow this pure economic self-interest model of behavior. They do not. It is only true that the system provides strong financial incentives for them to do so.)

Tri-section B of Chart I-1 represents resources which do not render an applicant or recipient ineligible for Medicaid. This category includes the exempted property, special trusts, and legal transfers discussed above. Exempt property may become non-exempt upon the deaths of the recipient and his surviving

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We know that the most common cause of elder abuse is the strain on adult caretakers who become "over-taxed by the requirements of care for a frail dependent adult." (Douglass, Richard L., "Domestic Neglect and Abuse of the Elderly: Implications for Research and Service, "Family Relations, July 1983, p. 401.) Such caretakers have the opportunity to know the elders' finances and they may feel entitled to compensation. The result is frequently expropriation. The perpetrator may be a family member, friend, neighbor, or a paid helper. Volumes II and IV include many examples of such cases.

[68]A Portland attorney frequently represents the State of Oregon as conservator for Medicaid recipients victimized by financial exploitation. He says attorneys often recommend divorce to protect the assets of a well spouse when a sick partner needs long-term care institutionalization. Examples of such advice in the popular media include (1) a scene in the Joanne Woodward movie "Do You Remember Love" in which a woman is advised to divorce her husband who has Alzheimer's Disease in order to protect her finances and (2) a Frontline broadcast (op. cit., p. 19) in which another woman is advised to sue her institutionalized husband for "lack of support."

[69]_____, "Parents in Nursing Homes: A New Burden for Kids?," 50 Plus, December, 1983, Vol. 23, No. 12, p. 9.

spouse.[70] If a Medicaid program is equipped to file a claim on a liable estate when this occurs[71], the previously exempt property may be recovered. Otherwise, it is lost. Property successfully sheltered in special trusts or legally transferred is also lost as a source of benefit recoveries. Finally, resources unknown to Medicaid because of recipient concealment or agency error are both nondisqualifying and unrecoverable because they are never known. The reasons for recipient concealment are obvious given the financial benefits of Medicaid eligibility. The reasons for agency error may be less evident. State and Federal rules on Medicaid eligibility, especially those on transfer of assets, are extremely complex. State Medicaid programs often have too few eligibility workers with too high caseloads, insufficient training and heavy turnover. The consequence can be failure to verify and pursue all cases for property or transfers. Eager to help the applying family, workers also provide valuable advice on how legally to circumvent Medicaid resource limitations. This is not improper; it is their job. The common thread in all these points is that Medicaid recipients may own and dispose of large amounts of resources either properly or improperly, without being disqualified for assistance.

Tri-section A, the "tip of the iceberg," is estate recoveries. The preceding discussion explained how disqualifying and non-disqualifying assets are lost as a source of reimbursement for Medicaid benefits before they can become part of a recoverable estate. Those assets which do become part of a recipient's estate are also lost except in eighteen states and the District of Columbia which pursue

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[70]See footnote 60.

[71]It may be many years later, after the deaths of all exempted dependents.

estate recoveries. Finally, among the states which pursue recoveries, some are aggressive and well organized, while others are inefficient.

The "bottom line" for Medicaid is that estate recoveries contribute only $36 million per year to the program. All other recipient assets are lost. It remains to examine what the potential of estate recoveries as a non-tax revenue source would be if they were efficiently, uniformly and universally pursued by all State Medicaid programs.

## VI. Toward A Solution

The State of Oregon has an exemplary estate recovery program. It is managed by an "Estate Administration Unit" (EAU) which consists of four professional estate administrators, a supervisor and support staff. Strong state statutes authorize the EAU to (1) petition for appointment of conservators to represent and protect recipients from expropriation by relatives or others; (2) prosecute civil suits to reverse illegal property transfers and (3) recover Medicaid benefits correctly paid to individuals over age 65 from their estates or the estates of their spouses. The state's claim on such estates has priority, by law, over most other claimants.[72]

Oregon's estate recovery program operates in the following way. Public assistance field staff check each month with all county assessors and recorders to see which Medicaid applicants or recipients own or have transferred

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[72]Oregon's estate recovery statutes may be found in Volume II, Exhibit II-7 and Volume III, Appendix A.

property.[73] They do not accept statements by the recipient or his representative without verification. If property ownership or a transfer is found, field staff handle the situation in most cases but difficult matters are referred to the Estate Administration Unit specialists. This relieves overloaded eligibility workers of the need to know property and probate law as well as the finer nuances of Medicaid resource policy.

If a Medicaid recipient dies leaving a surviving spouse or minor/disabled child, the state cannot file a claim against the estate until the surviving relative dies. The EAU keeps track of surviving relatives, therefore, to insure eventual recovery from their estates. Many years may pass between the death of a recipient and recovery of Medicaid benefits from the estate of an exempt surviving relative.

Finally, the Estate Administration Unit handles all problem cases involving property ownership or transfers. The typical problem they deal with involves an elderly person who needs institutional long-term care and is unable to look after his own financial interests. Family members or friends, for example, may have persuaded the elder to sign over property to them in order to qualify for Medicaid. When the EAU discovers such a situation, they petition the court to appoint a private attorney to represent the recipient's interests. Acting as conservator, the attorney does whatever is necessary to return the property to the recipient. This may include setting aside and re-litigating divorce decrees,

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[73]Such verification is not difficult. One worker in each county seat checks a list of new applicants and redeterminations once a month. This usually takes under thirty minutes. Field staff also compile lists of newly probated estates in every county each month. They send these lists and information on all Medicaid recipients who die to the Estate Administration Unit. EAU staff track the information to insure that the state files an early claim on every liable estate.

reversing property tranfers which are illegal or abusive, invading trusts, partitioning property interests, and collecting or enforcing contracts of sale. Attorney's fees are paid from the settlements.

The most innovative device used by the Estate Administration Unit and its attorneys to handle these situations is the "open-ended mortgage." When a property transfer for less than fair market value is discovered, the family of the Medicaid recipient is placed in a very difficult position. Either their elder is disqualified for Medicaid because of the transfer, as in most states, or they have to return the property to the elder, and see it managed by a State-appointed conservator. Oregon offers the family a unique alternative. They may keep the property if they sign an open-ended mortgage (OEM). The OEM says, in essence, that upon the death of their relative, the family will repay the state the total amount of Medicaid payments made or the value of the property, whichever is less. If the balance owing is large, the family may have up to twenty years to repay the debt at low interest.[74] The open-ended mortgage allows the state to guarantee eventual recovery of benefits paid while it protects the family from having to liquidate property immediately and spend down to welfare resource limits. The OEM also permits the elderly relative to pay for his own care while retaining whatever remains of his property interest as a legacy for his heirs.

Using these tools, the Estate Administration Unit collects an average of $320,000 per month or $3.8 million per year. The Unit has $4 million in accounts receivable from 400 cases which generate regular monthly payments to the

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[74]The rate has varied slightly, but is usually around 9 to 10 percent and always below prime. The value of the property is usually determined as of the time of the transfer of the property to the family.

Medicaid program. The ratio of total recoveries to all costs of recovery, including salaries, benefits, space, heat, travel, et cetera, is 15.5 to one. Estate recoveries equal approximately 1.7 per cent of total Medicaid vendor payments in Oregon.[75] Based on this record, Oregon has the most successful estate recovery program in the country. Finally, these hard dollar collection measurements do not reflect the substantial cost avoidance savings of a strong estate recovery program. We do not know how much longer families care for their elders and defer public assistance payments in order to protect their inheritances from estate recoveries.

Given that Oregon's estate recovery program saves a lot of money, can we say that other states, without such programs, are losing money proportionately? To examine this question, we conducted field research in the State of Idaho which has no estate recovery program. We attempted to estimate the proportion of Medicaid nursing home cases in Idaho with potential estate recoveries and the amount of such recoveries if Idaho had a program like Oregon's. We examined three separate case samples including a main sample of 285 cases selected by systematic random sampling and two prioritized samples designed to measure the influence of recency of application (106 cases) and level of income (96 cases).[76]

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[75]The methodology used to compute the cost effectiveness of Oregon's Estate Administration Unit is described in Volume II, Exhibit II-8.

[76]The project plan, sampling methodology and findings are described in detail in Volumes III and IV.

We found that 10.9 percent of the main sample cases contained $430,903 in assets which could have been recovered if Idaho had recovery authority and procedures comparable to Oregon's. Projecting to the population, we estimated a total of 217 cases with potential recoveries of $3 million among Idaho's Medicaid nursing home population over the age of 65 (1993 recipients).[77]

Both prioritized samples yielded even higher recovery rates. Sample cases with an application date less than three months old were almost twice as likely to yield potential recoveries (21.7 percent) as main sample cases (10.9 percent). Cases with income in excess of $500 per month had a potential recovery incidence of 14.6 percent. Recent application cases had lower potential recoveries ($8,579 per case) than main sample cases ($13,900) or high income cases ($17,875), because they have had less time to accrue large balances of paid claims. Recoveries are limited, of course, to the total of claims paid.

The main sample cases contained a total of $751,530 in recipient assets. This figure nearly equals the total Medicaid claims paid on their behalf of $754,649. Only 57.1 percent (or $430,903) of this total is recoverable, however, because many recipients owned more property than the value of the Medicaid benefits

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[77]The sampling methodology is described in Volume IV, Table IV-1. The sample allowed projection of the property/transfer attribute to the population at the 95 percent confidence level with plus or minus 3.6 percent reliability. We caution the reader that our sample size does not permit projection of the variable (i.e., potential recoveries) at acceptable levels of confidence and reliability. Dollar projections in the text are only suggestive. The reader, however, should compare the Idaho dollar projections with actual, documented recoveries in Oregon. The comparison is very favorable.

they received. The comparable percentages for the prioritized samples were 77.4 percent for recent application cases and 88.1 percent for high income cases. The higher incidence and rates of recovery in the prioritized samples further indicate their value for error prone profiling to identify potential recovery cases.

In addition to the case sample reviews, we also examined probated estates in Idaho to determine how many involved deceased Medicaid recipients. We compared the names of 1812 probated estates to the Medicaid eligibility roles and found 23 matches (1.3 percent) with potential recoveries of $139,067. The probates reviewed represented approximately one-half year of estate activity for the State of Idaho. Thus, a reasonable estimate of potential estate recoveries for Idaho by this method would be $280,000. Such an estimate is extremely conservative, however, because many of the estates reviewed had already closed and the remainder were near closing. Maximum recoveries require quick action and a priority claim such as Oregon's system assures.

In summary, by two different methods, Medicaid case sample reviews and examination of county probate records, we were able to confirm a large recoverable resource in Idaho related to recipient estates. We estimated that Idaho could have recovered $3,000,000 from its current Medicaid caseload if it had procedures in place comparable to Oregon's. We also estimated that Idaho could have recovered at least $280,000 last year and probably much more by matching probated estates with Medicaid eligibles and applying Oregon's recovery techniques. If Idaho were to recover from estates at a rate equal to Oregon's ($25.03 per recipient), Idaho's recoveries would approach $1,000,000 per

year or nearly 1½ percent of the state's total Medicaid vendor payments.[78]. We believe this is a realistic estimate and goal for an estate recovery program in Idaho.

Now, we know the actual rates of recovery in Oregon and we have demonstrated the potential for recovery in Idaho. What is the potential of estate recoveries as a non-tax revenue source if they were pursued nationally? If we apply Oregon's recovery rate of $25.03 per recipient per year to the total Medicaid caseload of 21,364,745 in Federal fiscal year 1984, we derive a potential savings of $535 million. This exceeds current annual estate recoveries of $36 million by nearly one-half billion dollars. Thus, the extra revenue potential of estate recoveries is sufficient to offset approximately 1½ percent of total 1984 Medicaid vendor payments nationally. If we consider that Oregon achieves its current recovery rate despite Federal laws which severely restrict recoveries,[79] we can see that the ultimate potential of Medicaid estate recoveries is far greater still.

As this paper has shown, most assets of Medicaid recipients do not become part of their estates because they are spent down, transferred, sheltered or concealed in order to qualify for assistance. If we closed this drain of recoverable assets, in conjunction with expanding recovery programs, the potential for Medicaid recoveries would increase dramatically. Effective stop-loss measures which can be taken are:

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[78]Idaho's Federal Fiscal Year (FFY) 1984 Medicaid caseload was 36,550. In FFY 1983, the state's caseload was 39,215. (Based on HCFA-2082 data). Depending on which caseload figure one uses, the potential estate recovery savings for Idaho is $915,000 per year (1984 data) or $982,000 (1983 data).

[79]See 42 CFR 433.36(h) for the federal restrictions on Medicaid recoveries. Volume II contains a copy in Exhibit II-7.

(1) To make Medicaid eligibility conditional upon recovery of benefits from the applicant/recipient's estate;[80]

(2) To require liens or "open-ended mortgages" for all recipient property in order to assure its availability in the recipients' estates;

(3) To extend the limitation on asset transfers for less than fair market value to five or more years;

(4) To mandate that all state Medicaid programs operate estate recovery programs with minimum qualifying recovery rates as a condition of receiving Federal Medicaid matching funds, and;

(5) To empower state Medicaid programs to appoint conservators for the enfeebled elderly as a collateral service in order to protect them from expropriation by unscrupulous family members or others.

These measures would require congressional action. They are consistent, however, with the original intent of the Medicaid program: to insure access to mainstream health care for the poor. They are also consistent with Congressional intent under TEFRA as cited above. Such measures would serve to return the Medicaid program to the poor, by assuring that middle income recipients reimburse the program up to the limits of their ability to pay.

## VII. Conclusion

Now we can answer the questions posed in the Introduction.

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[80]The reader should add "or the estate of the recipient's last surviving exempt dependent" to be precise.

Middle income Medicaid recipients are people who work hard all their lives and build substantial net worths. They live comfortably in retirement until they face the catastrophic costs of long-term institutional care. Then, their income and liquid resources are insufficient to sustain them. They turn first to Medicare and are disillusioned to learn that it covers very little nursing home care. Their families offer to help, but they either refuse this help because of their accustomed independence or the care and contributions available from the family are insufficient anyway. Finally, they turn to Medicaid.

They qualify for Medicaid, because most of their net worth is tied up in a personal residence and Medicaid exempts the personal residence from eligibility resource limits. If they are savvy and consult an attorney before the crisis begins, they learn of many other legal ways to shelter assets from welfare resource consideration. An unscrupulous few conceal their assets and qualify for Medicaid fraudulently. Whatever the route to eligibility, once they are on the roles, the tax-funded Medicaid program pays for their nursing home care for the rest of their lives without reducing their net worth or burdening their relatives.

Federal law allows state Medicaid programs to recover benefits paid from the estates of deceased Medicaid recipients. This usually does not happen for two reasons. First, thirty-two states do not have estate recovery programs. Of the eighteen states and the District of Columbia which do pursue recoveries, most are only marginally successful. Their average rate of recovery is one-eighth of

Oregon's. The second reason is that recipient assets are frequently transferred, consumed, or dissipated before they can become part of a recoverable estate. This may occur because of good estate planning, expropriation by relatives or others, neglect and deterioration of the assets, or fraud. Whatever the reason, most of the exempted or sheltered assets of middle income Medicaid recipients go to their heirs when the recipients die. The tax-payer is usually not reimbursed.

How much does this oversight cost? The State of Oregon has a model estate recovery program. The state strictly enforces property ownership and transfer restrictions, appoints conservators to protect the property of incapacitated recipients from expropriation or deterioration, and avidly pursues recoveries from the estates of Medicaid recipients and their spouses. If every state and the District of Columbia pursued estate recoveries with the same rate of success as Oregon, annual collections would be $535,000,000. As current recoveries are only $36,000,000 per year, enhanced estate administration by the Medicaid program nationally has a non-tax revenue potential of one-half billion dollars per year.

To develop this funding source under existing Federal laws, we need only to induce the states to install successful estate recovery programs. By changing some laws, however, the revenue potential of estate recoveries could be vastly increased. The necessary legal changes include (1) Medicaid eligibility contingent upon estate recoveries, (2) liens on all recipient property to assure its availability in the estate, (3) extended restrictions of five or more years on property transfers for less than fair market value, (4) minimum Medicaid estate

recovery levels as a condition for Federal financial participation and (5) a program to protect recipients and their property from financial exploitation.

Medicaid is, has been, and for the foreseeable future will remain a welfare program. It has a strict means test and it does not require "insurance" premiums. Congress and the President may some day establish a national long-term care funding source to which every citizen is entitled irrespective of wealth. In the meantime, failure to pursue estate recoveries in the current program is converting Medicaid into a de facto entitlement.[81] More and more frequently, Medicaid is only a conduit of money from American tax payers to middle income recipient heirs at the expense of the truly needy.

In truth, we do not have a long-term care funding crisis in this country.[82] We

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[81] Ironically, we see this happening at the same time that a means test for Medicare is under consideration.

[82] Jacobs and Weissert, op. cit., p. 83 say: "Three quarters of all elderly-headed households are owner-occupied. Nearly sixteen million elderly people (that is, those over 65) live in about twelve million homes they own, and more than 80 per cent of them have paid off their mortgages." The authors conclude that 66 percent of all elderly homeowners (82 percent of singles and 47 percent of couples) could pay the premium for a prototype long-term care insurance policy using one-quarter of their discretionary income in addition to a reverse annuity mortgage payment from their home. As long as Medicaid is available to middle income families for little or no cost, neither long-term care insurance nor reverse annuity mortgages will be commercially viable. If we require those who are able to repay their welfare benefits, however, they will turn to private risk sharing solutions funded by their home equities. Jacobs and Weissert caution that: "No one should believe that home equity conversion can simply replace public subsidy of the long-term health care needs of the aged." (p. 93) It might, however, de-escalate the public long-term care funding crisis to only a major problem.

have a public policy crisis. The elderly possess a $600 billion resource in their homes which is the product of many years of hard work and mortgage payments augmented by rampant real estate inflation. Many of the elderly would be able to pay for their own long-term care and comply with the principles of self-reliance by which they lived, if they could contract to reimburse Medicaid from their estates. The cost of this solution would be paid in the first generation by the middle income recipient heirs who will lose a portion of their inheritances. By the second generation, however, without the competition of easily available public funding through Medicaid, new funding sources will be able to develop such as private long-term care insurance, medical IRA's and reverse annuity mortgages. In the meantime, policy makers will be able to make more Medicaid resources available to the destitute elderly who have nowhere else to turn.